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Since the Supreme Court of Canada struck down the ban on providing and obtaining abortions in its seminal decision R v Morgentaler, abortions have been a legal medical service in Canada. Accessing abortion (and contraception) remains a challenge for millions of women in Canada as the service is unevenly provided and funded. This article considers a recent challenge launched by physicians and physician advocacy groups in Ontario to policy updates by the provincial College of Physicians and Surgeons, the regulatory authority. The amended Policy on Professional Obligations and Human Rights clarified the requirements for effective referrals and the provision of urgent care in the context of religious or conscience-based objections by physicians. Those challenging the Policy argue it violates their Charter-protected rights to freedom of religion, freedom of conscience, and equality. This article assesses both sides of the legal battle:

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a woman’s rights under the *Canadian Charter of Rights and Freedoms* to reproductive autonomy and a physician’s right to shape care in line with his or her beliefs. It assesses the Charter’s application to the delivery and accessibility of abortion services and contraception in Canada. This article argues that, after years of protracted debate, courts should uphold the Policy as being a strong and balanced statement on the need to protect access to reproductive services that are legal and medically necessary abortion.
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INTRODUCTION

There is a new weapon in the decades-long battle to limit women’s reproductive rights. In 2015, a group of physicians initiated a court challenge to a regulatory requirement which obliges them to offer effective referrals in non-emergencies and provide emergency services, despite any religious or conscience objections they might have.¹ This group of physicians (and their advocacy organizations) argue that their rights to freedom of religion, freedom of conscience, and equality under the Canadian Charter of Rights and Freedoms (Charter)² supersede any professional obligations they might otherwise have in the care of patients. I think this is a dangerous new offensive in the so-called “abortion wars” and one that requires a fierce response from the pro-choice movement. Physicians are the gatekeepers to abortion and often contraception. Abortion, in particular, is a service in peril in Canada, with a dearth of providers and a lack of government leadership and support in ensuring equitable access for all women in Canada. This article considers the legal challenge as framed by the plaintiff doctors. I argue that the Charter requires the regulatory authority to balance the rights of physicians against the rights of patients. In the contest between a physician’s right to practice a desired choice of specialty and a woman’s right to bodily integrity and autonomy in decision making, the balance lies clearly with the woman/patient.

The College of Physicians and Surgeons of Ontario (College) is the regulatory authority for medical professionals in Ontario. All doctors practicing in Ontario must be members of the College.³ The College operates under a statutory regime which requires it to register physicians, conduct ongoing education and quality assurance, investigate complaints, and mete out discipline where necessary.⁴ As part of its mandate to educate and regulate physicians, the College publishes policy statements with this goal:

¹ The Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario, Ottawa, 15-63717 (Ont Sup Ct J) [Notice of Application].
³ See College of Physicians and Surgeons of Ontario [College], “About the College”, online: <www.cpso.on.ca/About-Us>.
⁴ The role of the College and its authority and powers are set out in the Regulated Health Professions Act, SO 1991, c 18 [RHPA], in the Health Professions Procedural Code, being Schedule 2 to the RHPA, and in the Medicine Act, SO 1991, c 30.
Policies provide specific guidance to physicians. The College develops policy to address issues that have broad application to either physicians or the public, to respond to an emerging or existing problem, and to fulfill our regulatory or public interest role.\(^5\)

This article examines a recent amendment to one of the College’s key policy statements: “Professional Obligations and Human Rights” (Policy).\(^6\) In March 2015, after years of uncertainty and controversy and months of public and physician consultation, the College updated this Policy, focusing in particular on this aspect: “The policy … sets out the College’s expectations for physicians who limit the health services they provide due to clinical competence or because of their personal values and beliefs.”\(^7\)

Shortly after the Policy was updated and passed by the College’s Council (its governance body), a legal challenge to overturn it was launched by a group of physicians and three physician advocacy bodies.\(^8\) The Applicants challenged the legality of two updated clauses in the Policy: the requirement that physicians make an “effective referral” when their conscience or religious beliefs prevent them from providing a service; and a requirement that physicians perform a service in urgent circumstances, even where their conscience or religious beliefs stand in opposition.\(^9\) The legal challenge has

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\(^5\) “Policies and Publications”, online: <www.cpso.on.ca/Policies-Publications>.

\(^6\) “Policy Statement #2-15: Professional Obligations and Human Rights” (March 2015), online: <www.cpso.on.ca/CPSO/media/documents/Policies/Policy-Items/Human-Rights.pdf?ext=.pdf> [Policy 2-15].

\(^7\) Ibid at 1.

\(^8\) Notice of Application, supra note 1.

\(^9\) Policy 2-15, supra note 6 at 9–10. It is beyond the scope of this article to engage in a full comparative review, but in my opinion, Ontario’s new policy represents a robust protection for both conscientious and religious objectors and patients seeking care. Because health care is constitutionally within the domain of provinces, there is a patchwork of approaches to the issue of conscientious and religious objections by physicians. So, for example, there are no policies on this issue in Nova Scotia, Newfoundland, and Manitoba. In Alberta, the applicable policy states:

> When moral or religious beliefs prevent a physician from providing or offering access to information about a legally available medical or surgical treatment or service, that physician must ensure that the patient who seeks such advice or medical
different facets. My focus is on the Charter challenge, which I will detail below. The Applicants make two different Charter arguments. One aspect

care is offered timely access to another physician or resource that will provide accurate information about all available medical options (College of Physicians & Surgeons of Alberta, “Standard of Practice: Moral or Religious Beliefs Affecting Medical Care” (1 January 2010), online: <www.cpsa.ca/wp-content/uploads/2015/07/M_Moral-or-Religious-Beliefs-Affecting-Medical-Care.pdf>).

In New Brunswick, the applicable policy is based on the Alberta policy: College of Physicians and Surgeons of New Brunswick, “Guidelines: Moral Factors and Medical Care” (April 2012), online: <www.cpsnb.org/english/Guidelines/MoralFactorsandMedicalCare.htm>.

The College of Physicians and Surgeons of Saskatchewan recently released its own updated policy that requires a physician to make arrangements for patients if care cannot be provided because of a conscientious or religious objection: see “Policy: Conscientious Objection” (September 2015), online: <www.cps.sk.ca/Documents/Legislation/Policies/POLICY%20-%20Conscientious%20Objection%20-%20NEW%20FORMAT.pdf>.

Finally, in British Columbia the policy states:

Physicians are not obliged to provide treatments or procedures to patients which are medically unnecessary or deemed inappropriate based on scientific evidence and their own clinical expertise.

While physicians may make a personal choice not to provide a treatment or procedure based on their values and beliefs, the College expects them to provide patients with enough information and assistance to allow them to make informed choices for themselves. This includes advising patients that other physicians may be available to see them, or suggesting that the patient visit an alternate [health care] provider. Where needed, physicians must offer assistance and must not abandon the patient (College of Physicians and Surgeons of British Columbia, “Professional Standards and Guidelines: Access to Medical Care” (November 2012), online: <www.cpsbc.ca/files/pdf/PSG-Access-to-Medical-Care.pdf>).

In addition, the Applicants argue that the new Policy 2-15, supra note 6, is ultra vires in that the College does not have the authority to implement policies that violate the Charter. The Applicants also argue the new Policy violates the rights of the individual physicians under the Human Rights Code, RSO 1990, c H.19, though no particular section is cited. Finally, in terms of non-Charter objections, the Applicants argue that the consultation process around the changes

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of their position is that the Charter does not apply to their actions. I call this a “defensive” Charter claim in that they argue that as physicians, they are not subject to nor bound by the Charter in their medical practice in terms of carrying out their duties as physicians. Therefore, they claim they cannot be charged with violating the Charter when their religious or conscience beliefs shape their decisions in providing care to patients. They “defend” their actions by arguing the Charter does not apply. The second argument is a positive assertion of their own rights. This affirmative Charter claim is that the new Policy clauses on effective referral and urgent care violate three of their individual Charter rights: the Section 2(a) right to freedom of conscience; the Section 2(a) right to freedom of religion; and the Section 15 right to equality (the right to equal treatment under the law without discrimination based on religion). I will examine both arguments in turn.

I. THE POLICY AND THE LEGAL CHALLENGE

An amended Notice of Application challenging the revised Policy was filed on 21 May 2015 by a coalition of individuals and physician advocacy organizations in The Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario (Notice of Application). The Applicants include:

- The Christian Medical and Dental Society of Canada (CMDS), which is described in the Notice of Application as “a national and interdenominational association of Christian doctors and dentists who strive to integrate their Christian faith with medical or dental practice.” While the CMDS’s members include Catholics, over 90% identify as Protestant Evangelicals.

To the Policy statement resulted in a denial of natural justice as the College was biased (either actually biased or, in the alternative, that its actions gave rise to a reasonable apprehension of bias): Notice of Application, supra note 1 at 12–13. While I have focused on the Charter challenge here, in my view the other grounds are equally weak and unlikely to succeed.

11 Notice of Application, supra note 1 at 13.
12 Ibid at 12.
13 Ibid at 1.
• The Canadian Federation of Catholic Physicians’ Societies, described as “a national association of Catholic Physicians’ guilds, associations and societies from eleven cities across Canada, four of which are in Ontario.”

• Canadian Physicians for Life, described as a “national association of pro-life physicians, retired physicians, medical residents and students.”

• Five individual physicians. 14

All five of the individual physicians claim that their sincerely held religious beliefs “inform and direct [their] positions on certain procedures, pharmaceuticals and procedures which a patient may request” and that these beliefs and their consciences “prevent [them] from participating in a number of procedures or providing a number of pharmaceuticals to which [they object] on religious or moral grounds.” 15 Together, the Applicants object to two clauses in the Policy. Their first concern is with “effective referral” obligations. The clause reads:

Where physicians are unwilling to provide certain elements of care for reasons of conscience or religion, an effective referral to another health-care provider must be provided

14 Ibid at 4–5. All the plaintiffs practice in Ontario. Four of the five individual plaintiffs are described as “committed Protestant Evangelical Christians”: Dr. Michelle Korvemaker, an emergency medicine, palliative care, and family physician (ibid at 5); Dr. Betty-Ann Story, a family physician (ibid at 6); Dr. Isabel Nunes, a family physician (ibid); and Dr. Donato Gugliotta, a family physician and anaesthetist (ibid at 7–8). The fifth plaintiff, Dr. Agnes Tanguay, is a family physician described as a “committed Roman Catholic.” Her claim also includes reference to a 2014 complaint filed against her for a refusal to prescribe specific pharmaceuticals or referrals for pharmaceuticals because of her conscience and sincerely held religious beliefs (ibid at 7). Dr. Tanguay has a practice at CareMedics Walk-In Clinic in Ottawa, which she runs with two other physicians. In 2014, the three sent a letter to their patients informing them that the physicians would not write prescriptions for artificial birth control because of their religious beliefs. See also Elizabeth Payne, “Debate About Doctors’ Right to Refuse Treatment for Religious Reasons Re-ignited”, Ottawa Citizen (9 February 2014), online: <www.ottawacitizen.com/news/local-news/debate-about-doctors-right-to-refuse-treatment-for-religious-reasons-re-ignited>.

15 Ibid at 5–8.
to the patient. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician or other health-care professional, or agency. The referral must be made in a timely manner to allow patients to access care. Patients must not be exposed to adverse clinical outcomes due to a delayed referral. Physicians must not impede access to care for existing patients, or those seeking to become patients.\textsuperscript{16}

The Applicants argue that mandating an “effective referral” forces physicians to “participate in a procedure or facilitate the administration of pharmaceuticals to which he or she objects on moral or religious grounds.”\textsuperscript{17} They allege that this forced participation is a violation of individual Charter rights to freedom of conscience and religion, or both.\textsuperscript{18}

The Applicants also object to a clause requiring physicians to provide pharmaceuticals or perform procedures to which they object on moral or religious grounds if the care is “urgent” or “otherwise necessary.”\textsuperscript{19} The clause states: “Physicians must provide care in an emergency, where it is necessary to prevent imminent harm, even where that care conflicts with their conscience or religious beliefs.”\textsuperscript{20}

Before I turn to the substance of my argument, there are two caveats about how I have approached this claim. First, my focus in this article will be on the implication of conscientious or religious objections to caring for the reproductive capacity of women. I am interested in the impact of the physicians’ claims on the ability of women to access contraception and abortion. The legal challenge filed by these Applicants is not restricted to this issue and there is no doubt that the physicians’ arguments have a broader scope. There are those who have conscientious and religious objections to


\textsuperscript{17} Notice of Application, \textit{supra} note 1 at 9.

\textsuperscript{18} \textit{Ibid.}

\textsuperscript{19} \textit{Ibid} at 10.

\textsuperscript{20} \textit{Ibid} at 5.
assisted death, supervised drug injection sites and other issues that arise in front line or primary care medicine. While my arguments may equally apply to those issues, I have focused here on women’s reproductive capacity as the most illustrative of the contested rights dilemma posed by conscientious and religious objections to care.\textsuperscript{21}

My second caveat: the Applicants, both as individuals and as advocacy organizations, have outlined absolute Charter entitlements. As I understand the claim, they are not offering any contingent compromises or concessions. They see the situation in absolute terms: physicians should never have to perform a course of treatment that goes against their conscience or religious beliefs, nor should they have to refer a patient to another physician who will. If the physicians’ rights are absolute, then they must be understood as potentially (perhaps even ideally) operating as a complete bar to accessing service. And for some women, that would indeed be true. In rural or remote communities, for example, other physicians may be impossible to consult. If the pregnancy is reaching a critical turning point in terms of accessing a safe abortion, if a woman desperately needs birth control because she is in an unsafe or unpredictable relationship, if a teenager had to skip school or arrange transportation and may not easily be able to do so again, if a woman is distraught and overwhelmed by an unexpected pregnancy and used up all of her emotional reserves to face one appointment, if for any reason being “resourceful” is not possible, then women will be left pregnant, or unprotected from pregnancy. My argument proceeds on the assumption that physicians with conscientious objections would assert their constitutional rights de-

\textsuperscript{21} Bioethicists Chloë FitzGerald and Carolyn McLeod argue that in the literature on conscientious refusal of medical care, not enough attention is paid to refusals to provide abortion and contraceptive services. They conclude that overlooking the specific dynamics of women’s reproductive health:

... simply misrepresents the phenomenon of conscientious refusal in health care (at least within the U.S.), which arose in the midst of heated debate about abortion and is still embedded to some degree in this political context. Conscientious refusal is tied – in health care, not in the military – generally speaking with right-wing political agendas and opposition to them, particularly agendas that favor the traditional family and women’s place within it. Portraying the phenomenon as though it either did not have this connection or was politically neutral is misleading (“Conscientious Refusal and Access to Abortion and Contraception” in John D Arras, Elizabeth Fenton & Rebecca Kukla, eds, Routledge Companion to Bioethics (New York: Routledge, 2015) 343 at 347).
spite adverse consequences for women.\textsuperscript{22} I do not assume that physicians with conscientious objections would either expect or hope that someone else will perform abortions or provide contraception in their place, in order to mitigate the harm to women.

\section*{II. The Non-Applicability of the Charter (or “Defensive” Position)}

The individual Applicants argue that neither they, nor other physicians, are bound by or subject to the Charter.\textsuperscript{23} Therefore, they conclude that their refusal to participate in, or to provide certain procedures or pharmaceuticals for, an abortion or a contraceptive treatment does not amount to discrimination or otherwise violate the Charter rights of patients. In essence, they argue that since they are not subject to the Charter, they cannot be accused of violating it in how they deliver services to clients.

There are two aspects to this claim. First is the allegation that physicians are not subject to Charter obligations in performing their duties as physicians. I will explore this in greater detail. Second is the implied understanding of the Applicants that, but for the fact they are not subject to the Charter, they could indeed face Charter challenges from patients whose care was affected by a physician’s failure to comply with the Policy. In other words, I assume that underlying their argument is a concern that if the Charter applies to their decision making as physicians, it could limit their conscience claims. It is a good strategic move for the physicians to argue both aspects of their Charter claim. The applicability of the Charter to physicians is a legally unsettled question to date. The Policy itself is ambiguous on whether the Charter governs physicians in their practice. It states:

Where physicians choose to limit the health services they provide for reasons of conscience or religion, this may impede access to care in a manner that violates patient rights under the Charter and [Ontario Human Rights] Code. The courts have

\textsuperscript{22} It is my position that women will suffer adverse consequences if front line emergency or family physicians are unable to provide information on the full set of options for contraception or pregnancy management. Any physician-imposed limit on women’s legal choices constitutes an adverse consequence in my view.

\textsuperscript{23} Notice of Application, \textit{supra} note 1 at 13.
determined that there is no hierarchy of rights; all rights are of equal importance.\textsuperscript{24}

This statement recognizes that patients’ Charter rights protect the kind of care they receive, which would necessarily suggest that physicians are subject to the Charter in the delivery of that care. Surprisingly, this remains an unresolved legal question.

\textbf{A. Does the Charter apply to physicians?}

While the Notice of Application does not state the basis for the physicians’ assertion that they are not bound by the Charter in the performance of their duties, presumably they see themselves as arm’s-length contractors to the State and not salaried employees. In this way, they distinguish themselves from other public services like the police, who are paid directly by government (provincial, federal, or municipal depending on the force). On the one hand, it may make little practical difference whether physicians are subject to the Charter. When a doctor behaves in a discriminatory, harassing, or negligent way, the usual course of action for a patient is to pursue disciplinary proceedings under the relevant regulatory body\textsuperscript{25} or to launch civil proceedings.\textsuperscript{26} Patients may also make human rights complaints that

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{24} Policy 2-15, \textit{supra} note 6 at 4.
\item \textsuperscript{25} The complaint process in Ontario is outlined on the website of the College, “Complaints Process”, online: <www.cpso.on.ca/Policies-Publications/Complaints/The-Complaints-Process> (there is a graduated list of possible outcomes, from dismissal of the complaint to a referral of the complaint to the Discipline Committee).
\item \textsuperscript{26} See e.g. \textit{Norberg v Wynrib}, [1992] 2 SCR 226, 92 DLR (4th) 449 [\textit{Norberg} cited to SCR]. In \textit{Norberg}, Justice McLachlin (as she then was) analyzed the relationship between doctor and patient as a fiduciary relationship and concluded:
\begin{quote}
I think it is readily apparent that the doctor-patient relationship shares the peculiar hallmark of the fiduciary relationship – trust, the trust of a person with inferior power that another person who has assumed superior power and responsibility will exercise that power for his or her good and only for his or her good and in his or her best interests. Recognizing the fiduciary nature of the doctor-patient relationship provides the law with an analytic model by which physicians can be held to the high standards of dealing with their patients which the trust accorded them requires (\textit{ibid} at 272).
\end{quote}
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come with a more direct set of remedial options. A patient’s Charter challenge alleging, for example, discrimination by a physician under Section 15, would result in a hollow victory for the patient-claimant. The court could issue a declaration that a patient’s Charter rights had been violated. Some small monetary damages could be assessed, but would likely amount to less than what would be available in tort or under the human rights regime. Practically speaking, a wronged patient is unlikely to pursue a Charter case. 

This further supports the existence, at least in a civil litigation context, of a physician’s obligations of both full disclosure of their own limitations (both in skill and in conscience) and of effective referral to a colleague who can exercise fiduciary power in the woman’s best interest.

27 See e.g. Human Rights Code, supra note 10. Section 1 mandates equal treatment in the delivery of services without discrimination based on sex (in addition to other grounds). Services include hospital and health care services. Relevant to our context is subsection 10(2): “The right to equal treatment without discrimination because of sex includes the right to equal treatment without discrimination because a woman is or may become pregnant.” Subsubsection 45.2(1) sets out the remedial powers of the Human Rights Tribunal and includes the payment of monetary compensation, restitution, or any other remedy the Tribunal deems necessary.

28 Section 24(1) is the Charter’s very broad remedial provision: “Anyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances” (supra note 2). The Court has been unremarkable in its remedies when unconstitutional government action is involved: see e.g. Little Sisters Book and Art Emporium v Canada (Minister of Justice), 2000 SCC 69, 2000 SCC 69, [2000] 2 SCR 1120 (see especially Iacobucci J, dissenting at paras 258–61, on the inadequacy of declaratory judgments in some cases).

29 See Vancouver (City) v Ward, 2010 SCC 27, 2010 SCC 27, [2010] 2 SCR 28 (the leading Supreme Court of Canada decision on monetary damages for Charter breaches).

30 See Doe v Metropolitan Toronto (Municipality) Commissioners of Police (1998), 39 OR (3d) 487, 160 DLR (4th) 697, (Ont Ct J (Gen Div)), for an example of a successful Section 15 suit by a claimant against the Metropolitan Toronto Police Force on the ground of sex discrimination for a failure to warn neighbourhood women of a serial rapist in the area. The claimant received a declaration that her rights were violated and damages of almost $200,000 for both tort negligence and a Charter breach were awarded. The court did not award a specific amount for the Charter breach (the remedies for tort and Charter-
On the other hand, it is important to resolve the question of whether physicians are government actors for the purpose of the Charter, and not only because of the esoteric legal point. In their Notice of Application, the individual doctors claim to be protected in their conscientious objection by the Charter. In their narrative, their rights are absolute, without any countervailing Charter claims or rights. The Applicants therefore set out their claim without any need to allow for a balancing of Charter rights, or for the recognition of competing interests. Even if patients would be unlikely to pursue Charter actions against physicians, the legal reality that patients have Charter rights as against doctors who behave in Charter-violating ways is important to an assessment of the doctors’ own rights as against those same patients.

There is no case law that conclusively establishes whether the Charter applies to health care providers outside the hospital context. Eldridge v British Columbia (AG), a 1997 Supreme Court decision, remains the leading authority on the Charter’s applicability to the delivery of health care. In Eldridge, the claimants argued a violation of Section 15(1) of the Charter for the government’s failure to provide sign language interpretation in British Columbia hospitals. The claim was framed as an “adverse effects” claim, as the claimants argued that they had a right to effective communication with health care providers, a right that was compromised by their disability (deafness). The government was not charged with being directly discriminatory; rather, the claimants argued that the government failed to account for the needs of the deaf community by structuring care on a hearing model, and that this failure resulted in adverse consequences to the deaf. Justice La Forest wrote a unanimous decision for the Court upholding the claim. He acknowledged that hospitals, in the daily management of their affairs, act as private entities, and not as government ones, pursuant to Section 32(1) of the Charter. However, in implementing the government’s pro-

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31 Eldridge v British Columbia (AG), [1997] 3 SCR 624, 151 DLR (4th) 577 [Eldridge cited to SCR].

32 Ibid at para 60.

33 Ibid at paras 46–48. Section 32(1) of the Charter, supra note 2, states:

This Charter applies

a) to the Parliament and government of Canada in respect of all
gram of publicly-funded medical care to Canadians, hospitals’ actions, in how they deliver that care, could be the subject of *Charter* scrutiny. On this point, Justice La Forest distinguished the internal management of hospital operations (mandatory retirement policies, for example) from the delivery of patient care. He noted that the decisions of Boards of Directors, for example as considered in *Stoffman v Vancouver General Hospital*, were immune from *Charter* challenge when making decisions that do not implicate government policy.\(^{34}\) He concludes:

> The structure of the *Hospital Insurance Act* reveals, therefore, that in providing medically necessary services, hospitals carry out a specific governmental objective. The Act is not, as the respondents contend, simply a mechanism to prevent hospitals from charging for their services. Rather, it provides for the delivery of a comprehensive social program. Hospitals are merely the vehicles the legislature has chosen to deliver this program. It is true that hospitals existed long before the statute, and have historically provided a full range of medical services. In recent decades, however, health care, including that generally provided by hospitals, has become a keystone tenet of governmental policy. The interlocking federal-provincial medicare system I have described entitles all Canadians to essential medical services without charge. Although this system has retained some of the trappings of the private insurance model from which it derived, it has come to resemble more closely a government service than an insurance scheme...\(^{35}\)

This means, while hospitals may be autonomous in their day-to-day operations, they act as agents for the government in providing the specific medical services set out in the Act. The Legislature, matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest Territories; and

b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province.

\(^{34}\) *Elridge*, *supra* note 31 at 663–64; *Stoffman v Vancouver General Hospital*, [1990] 3 SCR 483, 76 DLR (4th) 700 concerned a challenge to mandatory retirement rules in the Board’s granting of hospital privileges.

\(^{35}\) *Eldridge*, *supra* note 31 at 665.
upon defining its objective as guaranteeing access to a range of medical services, cannot evade its obligations under [Section] 15(1) of the Charter to provide those services without discrimination by appointing hospitals to carry out that objective. In so far as they do so, hospitals must conform with the Charter.36

Following *Eldridge*, health law scholar Martha Jackman concluded:

The difficult question left unresolved by the *Eldridge* case is the application of the Charter to the actions of non-employee health care providers working in hospitals, as well as independent health care providers delivering health care services in other settings, most notably physicians. Justice [La Forest]’s analysis in *Eldridge* would appear to be equally applicable to individual as to institutional care givers. For example, while most physicians in Canada are paid on a fee-for-service basis, the insurance model for delivery of medical care in Canada is largely a historical anomaly. Physician services are funded

36 *Ibid* at 665. In *Eldridge*, the claimants were successful in arguing that the lack of sign language interpretation was discriminatory because of the historically disadvantaged condition of individuals with disabilities and society’s structuring of our institutions as premised on an able-bodied ability to hear (*ibid* at para 56). The issue of the Charter’s applicability to hospitals in the delivery of care will have significant consequences in upcoming debates over physician-assisted death in Canada. Physician-assisted death raises many conscience claim arguments similar to those articulated here by physicians (and will be the subject of further work by this author). More dramatically, however, entire religiously-based hospitals have asserted a conscience right not to perform that service as constitutionally mandated in Canada by the Supreme Court’s decision in *Carter v Canada (AG)*, 2015 SCC 5, [2015] 1 SCR 331 [*Carter*]. In Ottawa, for example, the Bruyère, a publicly funded Catholic health care provider, has formally announced that it will not provide physician-assisted death, nor refer patients for that service. According to CBC News, in a memorandum dated 20 January 2016, the Centre’s director Daniel Levac stated that “the organization is ‘obligated’ to stand behind its sponsor, the Catholic Health Sponsors of Ontario.” The memorandum referred to a December 2015 statement by the Catholic Health Sponsors of Ontario that it “would not provide physician-assisted death in its institutions and would not ‘directly or explicitly’ refer a patient to get the medical procedure elsewhere.” (Chloé Fedio, “Bruyère Won’t Offer Physician-assisted Death: Memo”, *CBC News* (28 February 2016), online: <www.cbc.ca/news/canada/ottawa/bruyere-doctor-assisted-death-1.3466192>.)
almost entirely through provincial health and hospital insurance regimes, and medicare remains one of the most [important] social policies and programs provided by government.\(^{37}\)

Professor Jackman therefore argues that *Eldridge* likely means physicians are subject to the *Charte* in delivering services, even when they are not employees but independent contractors. She suggests:

Like hospitals, physicians and other publicly funded health care providers can readily be characterized as acting “as agents for government in providing the specific medical services set out” in provincial health insurance legislation, under the general framework of the *Canada Health Act*.\(^{38}\)

Some of the confusion around the applicability of the *Charte* to physicians may stem from a Supreme Court decision in the criminal law and evidence context, *R v Dersch*.\(^{39}\) The decision is quite brief and focused on the provision of evidence to the police for use in a criminal law investigation. In *Dersch*, the Court considered whether it was an unreasonable search and seizure (and thus a violation of Section 8 of the *Charte*) for a blood sample taken by a physician for medical purposes to also be used for evidentiary purposes in establishing a blood-alcohol level to support criminal charges. The Court held that the doctors were not acting as agents for the State when they collected the blood sample in the provision of emergency health services, and therefore the *Charte* did not apply to the “seizure.”\(^{40}\) However, in turning over the results of the blood test to the police, the doctors’ conduct was wrong. The accused had a reasonable expectation of privacy in his medical tests and the doctors’ violated his right to confidentiality.\(^{41}\) The police acted in violation of the *Charte* in using information improperly obtained. The police, in other words, committed the *Charte* violation of an


\(^{38}\) *Ibid*, citing *Eldridge*, *supra* note 31 at 665.

\(^{39}\) *R v Dersch*, [1993] 3 SCR 768, 158 NR 375.

\(^{40}\) *Ibid* at 777.

\(^{41}\) *Ibid*.
unreasonable seizure by making use of improperly obtained blood results for criminal purposes.\footnote{Ibid at 777–78.}

In my view the Court’s reasoning in the specific factual context of this case should not be extrapolated to physicians acting as physicians in the performance of their own duties. I think that this decision must be reserved to its specific context. The Court did not say that physicians are not bound by the Charter in the performance of their duties as physicians. The doctors erred in this case by breaching patient-physician confidentiality in releasing the results of the blood tests to police. The Court makes no comment on the doctors’ own care of the patient and whether the Charter applied to how that care was carried out. It instead makes a subtler point about the role of the doctor vis-à-vis investigating police officers. The Court’s point was that the doctors were not delegated investigative criminal law authority by the police when the blood sample was taken. They were not acting as delegated police agents of the State and therefore did not engage in a Charter violating “seizure” in taking the blood. I do not interpret Dersch as applying to the entirely different question about whether the Charter applies to physicians in the course of their ordinary role.

Since Eldridge, the Supreme Court’s most significant health care decision is Chaoulli v Québec (AG).\footnote{2005 SCC 35, [2005] 1 SCR 791 [Chaoulli].} It considered whether provincial legislation that prohibited private medical insurance violated either the Charter or Québec’s Charter of Human Rights and Freedoms (Québec Charter) when the claimants were subject to long wait times for surgery in the publicly-funded medical system. A majority of the Court held that the prohibition violated the Québec Charter. Chief Justice McLachlin wrote a concurring set of reasons finding a violation of the Charter. She argued: “The Charter does not confer a freestanding constitutional right to health care. However, where the government puts in place a scheme to provide health care, that scheme must comply with the Charter.”\footnote{Ibid at para 104. Justice Deschamps, who writes the majority opinion, does not consider the Charter because in her view, the violation of the Québec Charter of Human Rights and Freedoms is sufficient to allow the appeal (ibid at para 15). Chief Justice McLachlin writes separately (with two other judges) because she thinks it important to address the Charter argument. Her decision is a persuasive authority on these issues.} She cited section 3 of the Canada Health Act, which reads:

\begin{quote}

\end{quote}
It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers. In her reasons, she adds emphasis to the phrase “facilitate reasonable access” and concludes that “[b]y imposing exclusivity and then failing to provide public health care of a reasonable standard within a reasonable time, the government creates circumstances that trigger the application of [Section] 7 of the Charter.” This reasoning is relevant to the question of whether the Charter applies to individual doctors. In creating a monopoly over the delivery of health care, the federal government, in concert with the provincial governments, guarantees “reasonable access to health services.” In Chaoulli, a lack of access to health care was analyzed as a structural problem of the health care system as a whole. In the case of individual physicians, the problem of access to health care is also structural: it stems from the effect of physician self-regulation combined with the monopoly on who can deliver services and under what circumstances. To paraphrase Chief Justice McLachlin’s words in this context, the “scheme” that the provinces have established to deliver publicly-funded health care to Canadians through regulated family physicians must be subject to the Charter even if there is no free-standing constitutional right to health care. A failure to provide reasonable access to legal and publicly-funded medical services triggers Charter scrutiny. As a self-regulated monopoly, physicians who fail to provide all legal and publicly-funded health services (those within their competence and specialty), should be subject to Charter scrutiny. This passage outlines Chief Justice McLachlin’s view of the issues in Chaoulli as compared to those raised in R v Morgentaler:

In this appeal, delays in treatment giving rise to psychological and physical suffering engage the [Section] 7 protection of security of the person just as they did in Morgentaler. In Morgentaler, as in this case, the problem arises from a legislative scheme that offers health services. In Morgentaler, as in this case, the legislative scheme denies people the right to access alternative health care. *(That the sanction in Morgentaler was

45 *Canada Health Act, RSC 1985, c C-6, s 3.*

46 *Chaoulli, supra* note 43 at para 105.

criminal prosecution while the sanction here is administrative prohibition and penalties is irrelevant. The important point is that in both cases, care outside the legislatively provided system is effectively prohibited.) In Morgentaler the result of the monopolistic scheme was delay in treatment with attendant physical risk and psychological suffering. In Morgentaler, as here, people in urgent need of care face the same prospect: unless they fall within the wealthy few who can pay for private care, typically outside the country, they have no choice but to accept the delays imposed by the legislative scheme and the adverse physical and psychological consequences this entails. As in Morgentaler, the result is interference with security of the person under [Section] 7 of the Charter.\footnote{Chaoulli, supra note 43 at para 119 [emphasis added].}

Of significance in this comparison is her bracketed observation that it matters not that one case concerned criminal law while another is set in the administrative context. She emphasizes that what matters is the legislated nature of the health care context.

In Morgentaler, the Court struck down criminal law regulation of abortion as violating a woman’s Section 7 rights to security of the person. There was no question the Charter applied to a Criminal Code provision. In Chaoulli, Chief Justice McLachlin is clear that the applicability of the Charter is not reserved for criminal law clashes with health care. A similar point seems to be made in the Court’s recent decision in Carter v Canada (AG) (Carter) to strike down a criminal law ban on physician-assisted dying.\footnote{Carter, supra note 36.} As in Morgentaler, there is no question the Charter applies to the Criminal Code, but the Court also remarks:

In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians’ colleges, Parliament, and the provincial legislatures. However, we note – as did [Justice] Beetz ... in addressing the topic of physician participation in abortion in Morgentaler – that a physician’s decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief (pp. 95-96). In making this observation, we do not wish to pre-
empt the legislative and regulatory response to this judgment. *Rather, we underline that the Charter rights of patients and physicians will need to be reconciled.*

Taken together, *Chaoulli* and *Carter* recognize the broad applicability of the *Charter* to contexts outside the criminal law realm. This passage from *Carter* also lends support to the notion that patients do have Charter rights as against their physicians in terms of legal and funded care and that physicians’ own Charter rights will have to be reconciled with those of his or her patients.

The case law is sparse in this area, but one interesting civil action was in part premised on the argument that the Charter applied to physicians in delivering services. In a torts claim for negligence against a surgeon, the plaintiffs filed a “Notice Under the *Constitutional Questions Act*” (Notice) which assumed as one of its “facts giving rise to the constitutional questions” that, “[t]he integrated federal-provincial medicare system entitles all Canadians to access essential medical care without discrimination.”

The Notice also claims: “Hospitals and doctors are agents of government when they are providing medically necessary services. In so doing, hospitals and doctors must conform to the *Canadian Charter of Rights and Freedoms*.”

In this case, *Hobbs v Robertson*, the plaintiff family members argued that their deceased wife and mother was forced to sign a liability release form for her refusal to accept a blood transfusion. The deceased was a Jehovah’s Witness with a sincere religious belief that she could not accept a blood transfusion. She needed a hysterectomy, and when she arrived at the hospital to be admitted, she was presented with a liability release form. She died in surgery at the admitted negligence of her surgeon. Her family sued in negligence but the doctor argued the release was a waiver of liability.

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50 *Ibid* at para 132 [emphasis added].

51 *Hobbs v Robertson*, 2006 BCCA 65, 265 DLR (4th) 537, Schedule B, Notice Under the *Constitutional Questions Act* of the Plaintiffs at para 2 [*Hobbs*, Schedule B]. The litigation history in this case is a tortured one, with the case being sent back for a new trial some ten years after the patient’s death. I can find no record of the second trial, nor can I find any indication of a response to *Hobbs*, Schedule B. I assume the case was settled out of court.

52 *Ibid*.

53 *Ibid* at paras 1–3.
of liability for negligence in order to access government-funded health care infringed her Sections 2(a), 7, and 15 rights.\textsuperscript{54}

To conclude on the applicability of the Charter to the work of physicians in delivering services to patients, given a monopoly in delivering a government-funded public service (insured medical care), one consequence of the privilege of self-regulation should be compliance with the Charter. The Charter might conceivably apply to require non-discriminatory care under Section 15 or to obligations around securing informed consent, so as not to violate a patient’s Section 7 right to security of the person. Section 7 might also be implicated if a prescribed course of treatment (or a refusal to provide treatment) threatens the life or security of the person of a patient. Section 2(a) conscience rights might also be implicated when a patient is denied the ability to make treatment decisions according to her own conscience, when the physician’s conscience operates as an override or veto. In the Part to follow, I briefly consider the constitutional issues for women in a physician’s refusal to provide or refer for contraception and abortion. If the Charter applies to physicians in their delivery of care, these are some of the claims that women might bring if the Policy on effective referral or urgent care is not followed.

\textbf{B. The constitutional rights of patients}

\textbf{1. Section 15}

Section 15(1) of the Charter states:

\begin{quote}
Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.\textsuperscript{55}
\end{quote}

Section 15 could be invoked by a client who is refused service on the basis of any of the enumerated or analogous grounds (including the analogous ground of sexual orientation). In the context of reproductive health choices

\textsuperscript{54} \textit{Ibid} at paras 4–5.

\textsuperscript{55} \textit{Supra} note 2.
for women, the target of many conscience- and religion-based physician objections, sex discrimination claims could be leveled for a failure to provide contraceptives, perform an abortion, or fulfill the Policy’s requirement for an “effective referral” to obtain those services. Obviously a denial of abortion services is a sex discrimination issue for women since only women obtain them. Similarly, prescriptions for birth control are only available for women.

A Section 15 sex discrimination claim against doctors would require a woman to show a distinction in treatment based on an enumerated or analogous ground and to show that the treatment exacerbated or perpetuated disadvantage.\(^{56}\) Step one is fulfilled by a woman client showing that she was unable to get the complete range of necessary (and legal and funded) health services available to her – this is the distinction in treatment from a man who receives all necessary health services, and this difference in treatment is based on her sex (which it is if for example, access to abortion is the issue). Step two is fulfilled when the notions of prejudice and stereotype are explored in a reproductive context. A denial of reproductive health services furthers the stereotype that the appropriate role for women is as grateful mothers who welcome their fecundity no matter the circumstances. Women can also argue prejudice from the resulting loss of earning capacity, lack of freedom of choice in life options, child care burdens and expenses, and other concerns which can follow a pregnancy carried to term.

It is well-established that despite efforts to improve access and funding for child care and some changes to gendered parenting assumptions around care, women still bear the primary economic and social costs of child-bearing and child-rearing. Denying women reproductive control is not only about the nine months of an unwanted pregnancy, but the potential imposition of a lifetime of child care obligations. In her powerful dissent in a recent abortion decision by the Supreme Court of the United States, Gonzales v Carhart, Justice Ginsburg set out a sex discrimination argument to restrictions on accessing abortion. Justice Ginsburg argued:

> Women, it is now acknowledged, have the talent, capacity, and right “to participate equally in the economic and social life of the Nation.” Their ability to realize their full potential … is intimately connected to “their ability to con-

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\(^{56}\) See below for a more fulsome discussion on the steps of a Section 15 challenge. This two-part test comes from the Supreme Court’s decision in R v Kapp, 2008 SCC 41 at para 25, [2008] 2 SCR 483 [Kapp].
trol their reproductive lives.” Thus, legal challenges to undue restrictions on abortion procedures do not seek to vindicate some generalized notion of privacy; rather, they center on a woman’s autonomy to determine her life’s course, and thus to enjoy equal citizenship stature. 57

In *Morgentaler*, Justice Wilson framed her assessment of the liberty interest under Section 7 as including equality rights for women:

The more recent struggle for women’s rights has been a struggle to eliminate discrimination, to achieve a place for women in a man’s world, to develop a set of legislative reforms in order to place women in the same position as men … It has not been a struggle to define the rights of women in relation to their special place in the societal structure and in relation to the biological distinction between the two sexes. Thus, women’s needs and aspirations are only now being translated into protected rights. The right to reproduce or not to reproduce which is in issue in this case is one such right and is prop-

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> Adolescents and indigent women, research suggests, are more likely than other women to have difficulty obtaining an abortion during the first trimester of pregnancy. Minors may be unaware they are pregnant until relatively late in pregnancy, while poor women’s financial constraints are an obstacle to timely receipt of services (at 173).

This is an important argument in our context because these two groups are also those who may have fewer emotional, financial, or supportive resources to obtain information about their options in the face of a refusal to provide urgent care or refer the patient to a physician who can provide this care. The majority decision in *Gonzales* was written by Justice Kennedy. At issue was the “Partial-Birth Abortion Ban Act,” Congressional legislation that banned a certain kind of abortion procedure (*ibid* at 132). The majority of the Court upheld the legislation as not constituting an “undue burden” on women in accessing abortion services (*ibid* at 146–47). “Undue burden” is the American term of art for the constitutional requirement that any laws regulating abortion before fetal viability not act as a significant obstacle to women in accessing the service.
erly perceived as an integral part of modern woman’s struggle to assert her dignity and worth as a human being.\textsuperscript{58} Justice Ginsburg also condemns the judicial imposition of a moral code in assessing laws that restrict access to the fundamental right to abortion. She invokes the Court’s seminal abortion decision in \textit{Planned Parenthood of Southeastern Pa v Casey} and concludes:

Notably, the [moral] concerns expressed are untethered to any ground genuinely serving the Government’s interest in preserving life. By allowing such concerns to carry the day and case, overriding fundamental rights, the Court dishonors our precedent. See, e.g., \textit{Casey} (“Some of us as individuals find abortion offensive to our most basic principles of morality, but that cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code.”)\textsuperscript{59}

This is helpful in our context of considering a woman’s claim that she is owed non-discriminatory care by her physician. If judges cannot impose their moral code in assessing laws that compromise a woman’s fundamental rights, physicians subject to the \textit{Charter} should not be able to do so either. If they do, this conscience override exacerbates the disadvantage experienced by women in the full realization of their autonomy and dignity. This constitutes a violation of equality rights under Section 15.

\section{Section 7}

Section 7 claims require a claimant to show that one of the protected interests – life, liberty, or security of the person – has been compromised by state action and that the violation is not in accordance with the principles of

\textsuperscript{58} \textit{Morgentaler, supra} note 47 at 172 [emphasis in original].

\textsuperscript{59} \textit{Gonzales, supra} note 57 at 15 [reference omitted]. The decision to which Justice Ginsburg refers, \textit{Casey, supra} note 57 at 850, is the leading Supreme Court precedent on abortion regulation in the United States. It affirmed that the Constitution protects a fundamental right to accessing abortion for women as both a liberty and privacy interest. In short, before viability, states can legislate to make abortion safer for women as long as they do not place an “undue burden” on access. After viability, states can legislate to protect the potential life of the fetus even to the point of banning abortion, as long as an exception is made to protect the life of the pregnant woman.
fundamental justice. The Supreme Court has already held that the inability to obtain an abortion constitutes a violation of a woman’s security of the person interest.\textsuperscript{60} The lack of access potentially endangers her life but it also implicates her psychological integrity by taking a life-altering decision out of her hands. Physicians who impeded access to abortion services (or birth control) could conceivably cause high levels of psychological stress in women, stress that is State-imposed if the physician is operating as a state agent in delivering care.\textsuperscript{61} The operative principle of fundamental justice is gross disproportionality. In \textit{Carter}, the Court set out the meaning of this principle of fundamental justice: “The inquiry into gross disproportionality compares the law’s purpose, ‘taken at face value’, with its negative effects on the rights of the claimant, and asks if this impact is completely out of sync with the object of the law.”\textsuperscript{62} It is understood that physicians have consciences and may bring moral judgment to bear in their work. The Policy offers protections for conscience-based objections by allowing physicians to opt out (unless the situation is an emergency). Physicians are normally required not to discriminate in providing services, but the Policy contemplates circumstances where discrimination is permitted. When, however, the denial of service impacts on the security of person of a patient, a physician’s conscience-motivated conduct in denying medical services is grossly disproportionate. Allowing a physician’s conscience to trump the security of the person of a patient operates entirely to the benefit of the physician to the great detriment of the patient. This is especially evident in a denial of effective referral where the physician is not even required to provide the service, and yet the patient is left without any course of treatment.

\textsuperscript{60} \textit{Morgentaler, supra} note 47 represents the Canadian Supreme Court’s only substantive treatment of an abortion law. It was narrowly framed in a legal sense as a challenge to the existing ban on abortion and in particular, the exceptions set out in the \textit{Criminal Code}. The Court did not consider whether any criminal regulation would be unconstitutional, but many scholars interpret the decision as protective of a woman’s constitutional right to access abortion. While only the challenged regime was deemed unconstitutional, the Court’s reasoning would make it impossible for a government to completely ban abortion (for example). The language used by both Justice Dickson (see e.g. \textit{ibid} at 56) and Justice Wilson (see e.g. \textit{ibid} at 171–74) suggests that a woman’s security of the person and liberty rights require some access to abortion services.

\textsuperscript{61} See discussion above on whether the \textit{Charter} applies to physicians in the performance of their duties.

\textsuperscript{62} \textit{Carter, supra} note 36 at para 89.
3. Section 2(a) freedom of conscience

There is little jurisprudence on the meaning and content of a right to freedom of conscience, though it is clear that the Supreme Court does see it as a freedom with meaning distinct from freedom of religion. The leading Supreme Court decision remains Justice Bertha Wilson’s concurring set of reasons in Morgentaler. In Morgentaler, the Court struck down the criminal ban on abortion as the process for obtaining an exemption to prosecution was arbitrary, inconsistently applied across the country and unequally available to all Canadian women. The majority decision, by Chief Justice Dickson, rested on Section 7 of the Charter and described the main problem as a violation of a woman’s security of the person. Justice Wilson’s concurring reasons went much further:

This decision [to procure an abortion] is one that will have profound psychological, economic and social consequences for the pregnant woman. The circumstances giving rise to it can be complex and varied and there may be, and usually are, powerful considerations militating in opposite directions. It is a decision that deeply reflects the way the woman thinks about herself and her relationship to others and to society at large. It is not just a medical decision; it is a profound social and ethical one as well. Her response to it will be the response of the whole person.

While she agreed with the majority that the criminal provision violated a woman’s Section 7 rights, she framed her analysis of the principles of fundamental justice as being shaped by a woman’s freedom of conscience. She concluded:

Accordingly, for the state to take sides on the issue of abortion, as it does in the impugned legislation by making it a criminal offence for the pregnant woman to exercise one of her options, is not only to endorse but also to enforce, on pain of a further loss of liberty through actual imprisonment, one

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63 For an excellent overview of the history and meaning of Section 2(a) freedom of conscience, see Richard A Haigh, A Burl on the Living Tree: Freedom of Conscience in Section 2(a) of the Canadian Charter of Rights and Freedoms (SJD Thesis, University of Toronto Faculty of Law, 2012).

64 Morgentaler, supra note 47 at 56–63.

65 Ibid at 171.
conscientiously-held view at the expense of another. It is to deny freedom of conscience to some, to treat them as means to an end, to deprive them, as Professor MacCormick puts it, of their “essential humanity”. Can this comport with fundamental justice? Was [Justice] Blackmun not correct when he said in *Thornburgh*:

“A woman’s right to make that choice freely is fundamental. Any other result ... would protect inadequately a central part of the sphere of liberty that our law guarantees equally to all”.  

In this passage, Justice Wilson touches on one of the most troubling aspects of the abortion debate. At its heart, it is a contest between competing conscience claims. Justice Wilson understands this but puts the choice starkly: if one person’s conscience is to triumph over another’s, surely the “winner” must be the one making the choice to abort. No one should be forced to undergo an abortion (or forced sterilization), for example, and in a eugenic contest of conscience between a pregnant woman and a physician who thinks she should not be allowed to have a baby, it is clear whose conscience we would support.  

As Justice Wilson notes in *Morgentaler* in assessing the absurdity of requiring a committee decision on whether an abortion proceeds:

> The fact that the decision whether a woman will be allowed to terminate her pregnancy is in the hands of a committee is just as great a violation of the woman’s right to personal autonomy in decisions of an intimate and private nature as it would be if a committee were established to decide whether a woman should be allowed to continue her pregnancy.  

The simplicity of “choice” allows a pregnant woman to make the decision (even if her choices are deeply constrained by economics, health, family, religion, and other factors). It is her conscience that prevails when

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68 *Morgentaler*, supra note 47 at 172.
the pregnancy presents a challenge. In his recent article “The Right to Conscience,” Bernard M Dickens uses Justice Wilson’s decision in Morgentaler to highlight this fundamental premise:

It is arrogant and impertinent for strangers to this woman’s circumstances, whether they have the power of legislators, the authority of judges, the piety of ministers of religion, or the learning and experience of doctors, to believe that their conscientious resolutions of this woman’s competing family interests are superior to hers.69

Richard Haigh refers to the process of reviewing the case law on freedom of conscience as a “Quixotic Journey.”70 He considers the Federal Court decision in Maurice v Canada (AG)71 to be the “apogee” of conscience jurisprudence and concludes, “[t]ogether with [Justice] Wilson’s decision in Morgentaler, it provides hope for my view that a differentiated conscience could, and should, flourish in Canada.”72 Maurice is a trial court decision granting a free-standing conscience right to a vegetarian diet in prison on ethical grounds. A former member of the Hare Krishna faith, Mr. Maurice renounced his faith but wanted to maintain his once religiously-inspired vegetarian diet.73 Correction Services Canada refused on the ground that there was no religious or spiritual need for the diet.74 The court held that Section 2(a) protected his right to a belief that the consumption of animal products is morally wrong and that the prison had no justification for denying him a vegetarian diet when that preference is accommodated under religious grounds.75 Justice Campbell offered this rationale:

In R. v. Big M Drug Mart Ltd., [Justice] Dickson stated that the rights associated with freedom of individual conscience

70 Haigh, supra note 63 at 117.
71 2002 FCT 69, 215 FTR 315 [Maurice].
72 Haigh, supra note 63 at 136.
73 Maurice, supra note 71 at para 3.
74 Ibid at para 4.
75 Ibid at paras 14–15.
are central to basic beliefs about human worth and dignity, and that every individual should be free to hold and manifest whatever beliefs and opinions his or her conscience dictates. Justice Dickson further articulated the broad scope of [Section] 2(a) as follows:

Freedom means that, subject to such limitations as are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others, no one is to be forced to act in a way contrary to his beliefs or his conscience.76

In *Gonzales v Carhart* Justice Ginsburg argued:

> [T]his Court has repeatedly confirmed that “[t]he destiny of the woman must be shaped ... on her own conception of her spiritual imperatives and her place in society” ... (“[M]eans chosen by the State to further the interest in potential life must be calculated to inform the woman’s free choice, not hinder it.”)77

Whether the woman’s decision is easy or traumatic, the choice clear or agonizing, the only conscience that can ultimately prevail is the one guiding the woman’s choice to abort or not. She is the one who bears the full cost of the decision. She has the right to choose. Furthermore, conscientious objection to effective referrals to a physician who can counsel as to the full range of options available for pregnant women, “misconstrues the purpose of abortion referral ... which is not simply for abortion but for consideration of a range of legitimate options, of which abortion is one.”78 The case law on Section 2(a) freedom of conscience thus far supports a freestanding protection of a woman’s right to choose her maternal destiny as a matter of individual conscience that cannot be superseded by the state’s conception of what is good or right. While the majority of the Court in *Morgentaler* did not have to go this far in order to strike down the *Criminal Code* ban (and given the sensitivity of the issue, it is predictable that the Court would decide the issue as narrowly as possible), in my view *Morgentaler* would now

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77 *Gonzales, supra* note 57 at 185.

78 *Dickens, supra* note 69 at 229–30.
be read, in combination with the Supreme Court’s Section 2(a) case law to pave the way for reproductive autonomy and access to contraception and abortion as Constitutional rights.

C. Conclusion on the negative rights or “defensive” Charter arguments

Assuming the Charter applies to physicians in the course of their treatment of patients, and given the Charter rights at stake for women in accessing reproductive care, the Courts will have to balance the competing constitutional rights. This is a familiar task. In the context of women’s reproductive rights, it is imperative that access to birth control and abortion be situated as a Charter equality right. It is equally necessary that we recognize a denial of access as a serious violation of a woman’s Section 7 rights to security of the person. Whether or not women pursue legal action against doctors for individual declarations of violations of those rights, any consideration of a physician’s rights to determine a course of treatment for women in their reproductive capacity must grapple with choice in the context of what is constitutionally at stake for women.

While in my view, physicians are subject to the Charter as state actors with a monopoly in delivering state-funded public health care, it will not be determinative of the balancing of rights if they are not. If women cannot launch a challenge under the Charter as against their doctors, they still have Charter rights to reproductive autonomy as freestanding claims. Women

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79 For a recent decision on reconciling competing Charter rights, see R v NS, 2012 SCC 72, [2012] 3 SCR 726. The Court had to balance the freedom of religion of a Muslim complainant in a sexual assault case, who claimed a Section 2(a) right to wear a niqab while testifying, against the Sections 7 and 11 fair trial rights of an accused. The Court emphasizes: “[O]ur jurisprudence teaches that clashes between rights should be approached by reconciling the rights through accommodation if possible, and in the end, if a conflict cannot be avoided, by case-by-case balancing” (ibid at para 52). The balancing exercise is evocative of the Court’s approach under Section 1 of the Charter and asks judges to assess the salutary effects of preferring one right (in our context, the salutary effects of preferring a physician’s Section 2(a) or Section 15 rights) versus the deleterious effects on the competing right (in our case, the deleterious effects on a woman’s Sections 2(a), 7, and 15 rights). See the framework established in Dagenais v Canadian Broadcasting Corp, [1994] 3 SCR 835 at 886–90, 120 DLR (4th) 12; R v Mentuck, 2001 SCC 76 at paras 28–39, [2001] 3 SCR 442 (for further discussion of how lower court judges should approach the balancing of interests).
have Sections 2(a), 7, and 15 rights to both birth control and abortion. Legislative attempts to curtail those rights have been subjected to many legal challenges over the years. Even if doctors cannot be personally sued for violations, the free-standing rights of women operate to check the absolute exercise of physicians’ own Charter rights. I will elaborate this point below in my discussion on freedom of religion.

And so what of that balancing of rights? In whose favour does it lie? I will outline in greater detail below the shape and content of the rights claimed by physicians. In short, though, there is on the one side, the economic rights of an individual to his or her chosen employment, and on the other side, a woman’s right to control her body and determine her future as mother or not. I hope when presented as starkly as this, it is clear which side “wins.”

Bernard Dickens describes a judgment by Chief Judge Posner of the US Court of Appeals in Rodriguez v City of Chicago. In the case, a police officer assigned to protect an abortion clinic against protesters’ violence and assaults objected to the assignment as he considered it would facilitate abortion, contrary to his Roman Catholic beliefs. Judge Posner concluded that he was an agent of the State performing a public function and was not free to choose what or whom he would protect, just as a firefighter could not choose to let the abortion clinic burn down. “By analogy,” offers Dickens, “doctors should not deny lawful procedures that patients want when they are

Some of those who made submissions to the College during its consultation period for revising the Policy took the opposite view on who should suffer the consequences of a clash between a physician and patient on a course of treatment:

Ultimately, patients should have the final say in their treatment. Please do not interpret this submission as a call for doctors to force their will on their patients. However, there is a clear line between a patient having the final say in their treatment and patients forcing a particular health practitioner to then be involved in that line of treatment. A patient can get another doctor. No patient should have the right to force a particular doctor to do anything against the doctor’s conscience (Association for Reformed Political Action Canada, “Re: Request for Submissions on Policy Statement #5-08” (5 August 2014), online: <www.arpacanada.ca/attachments/article/2024/ARPA%20Canada%20Submission%20to%20CPSO%20Human%20Rights%20Policy%205-08.pdf>).

Dickens, supra note 69 at 233; 156 F (3d) 771 (7th Cir 1998), 77 Fair Empl Prac Cas (BNA) 1421 [Rodriguez cited to F (3d)].
the only ones trained, qualified, and available to undertake them on the basis of their personal beliefs.\textsuperscript{82}

\section*{III. THE POSITIVE RIGHTS CLAIMS OR “OFFENSIVE” CHARTER ARGUMENTS}

I have outlined above the negative rights claims or “defensive” Charter arguments presented by the Applicants in this case: that individual physicians are not subject to the Charter in the performance of their duties as physicians. This is the lesser claim arising in this case and while I think it raises important questions as to the balancing of rights at stake, the heart of the Application is in the Applicants’ claim to their own Charter rights and protections. Specifically, the individual Applicants argue rights under Section 2(a) freedoms of religion and of conscience, as well as Section 15 equality rights.\textsuperscript{83} I begin this Part with a brief overview of the conscience and religion claims at issue. What lies beneath the constitutional arguments? What is the philosophical justification for alleging a right to practice medicine in accordance with one’s conscience? I will then examine the specific Charter arguments of the physicians in turn.

\subsection*{A. Conscience exemptions in health care}

Before turning to the legal claims made by the Applicants, the article will briefly consider the bioethical contours of two aspects of the debate. There is significant literature on conscientious refusal or objection by physicians and it is beyond the scope of my legal analysis to do it proper justice here. I think it valuable, however, to have some sense of the philosophical issues at play in understanding their influence on the legal analysis of the College’s Policy.\textsuperscript{84} Two discussions are particularly relevant. First is the issue of ordering protections for religion and conscience claims, and the

\begin{thebibliography}{1}
\bibitem{82} Dickens, \textit{supra} note 69 at 233.
\bibitem{83} Notice of Application, \textit{supra} note 1 at 3.
\bibitem{84} \textit{Supra} note 6. An interesting aspect to conscience claims that is not relevant in this context, but which shapes the debate elsewhere, is a physician’s assertion of conscience protections not to be complicit in unethical or unlawful acts. Physicians argue, for example, that it is unconscionable to participate in abhorrent medical experiments on prisoners or patients with mental illnesses. Arguments that physicians should not be forced to participate in either ethical or legal violations offer support to arguments for conscientious objections, but
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need to position both personal and social expectations in formulating workplace protections for objectors. Second is the development of philosophical arguments for the moral necessity of both referral and urgent care in the medical context.

1. The bioethical dimensions to religion and conscience

Bioethicist Daniel Weinstock describes a distinct “conscience” claim as founded in the citizen as a reflective moral being with an “ability to reflect upon moral issues and controversies that arise in her community or elsewhere and arrive at judgments about what the right thing to do is in such controversies.”

Moral reasoning by one’s conscience is distinct from a different normative consideration brought to bear in one’s life through religion. Religious claims derive from tradition and the shared practices and rituals of membership in a community.

According to Weinstock, conscience is an outward manifestation of belief that enables a more fulsome democracy and encourages participation in civic society. Religion is more internal and shapes the self (as opposed to shaping society). Weinstock characterizes the key difference between conscientious integrity and religious integrity this way:

Whereas the former protects the process and the results of moral reflection, the latter protects the agent’s ability to continue to participate in rites and practices, and to follow communal rules, the principal function of which have to do with individual identity, with the need felt by many people actively to identify with a temporally extended, rule-governed community in order to forge a stable sense of identity.

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do not undermine the need for urgent performance of medically necessary care or effective referral.


86 Ibid.

87 Ibid.

88 Ibid at 11 [emphasis in original].
Given the difference, and supported by the Charter’s articulation of conscience and religion as separate fundamental freedoms under Section 2(a), Weinstock argues there can and should be different protections assigned to each. Conscience is deserving of a higher degree of protection in the health care field than religion should be accorded. He describes several reasons to protect conscience claims by health care providers. First, as moral agents, physicians need space to express themselves. Second, health care institutions benefit when providers “reflect about the laws, rules, codes of conduct and protocols that govern their professional practice.” Third, the health care field has many issues that present moral quandaries and controversies. Recognizing conscience claims acknowledges that as individuals, health care providers are reflective of the divide in society over difficult questions. These reasons justify recognizing conscientious objection by health care providers (though they do not lead to an inevitable conclusion as to the limits of accommodation or the reconciliation of competing claims).

These reasons do not apply in the case of religion, however, and, for Weinstock, the case for recognizing religious claims in health care provision is a weaker one. He argues that the benefits of recognizing conscience rights accrue to institutions (and therefore to the larger society),

by helping us to get clearer than we might otherwise have been on controversial moral issues to which the arguments grounding her refusal contribute, or by opening our eyes to unjust or unethical practices that have seeped their way into medical practice as a result of the application to the decision-making process within the [health care] sphere of the wrong kinds of pressures and interests.  

On the other hand, no such institutional or larger societal benefits accrue from a recognition of religious rights which are entirely personal to an individual or as Weinstock puts it, “identity-stabilizing.” Weinstock acknowledges that Bills of Rights (like the Charter) offer protections for freedom of religion but points out that these merely enable believers to live within the dictates of their faith. This does not mean they have an additional entitlement to practice a particular profession within the dictates of that faith. He concludes:

89 Ibid.

90 Ibid at 13.
It is not central to the practice of any religion of which I am aware that the faithful are required to practice a specific profession. Where the dictates and prescriptions of a religion make demands upon the faithful that would be dysfunctional in a particular professional setting, and where a particular individual feels unable to deviate from these prescriptions, it does not seem unreasonable to require of her that she practice a profession that can more easily accommodate the demands that they place upon her.91

If one accepts Weinstock’s assertion that conscience claims are deserving of a higher order of protection than religious claims, what is the meaning of conscience? Bioethicist Carolyn McLeod describes the dominant view of conscience as focused on internal harmony or integrity. She outlines two dimensions to conscience:

(1) [B]eing alert to signs of discord between one’s actions or thoughts and one’s deep moral commitments; and (2) being inclined to assuage the discord. The “voice” of conscience is this alertness and this inclination –our conscience “speaks” to us when we are attentive and prepared to eliminate inner moral discord.92

McLeod takes a different view than Weinstock on the personal versus social aspects of conscience and religious rights. McLeod suggests that the dominant philosophical view on conscience is not sufficiently relational whereas Weinstock justifies conscience protections as based on the rela-

91 Ibid. He blunts the harshness of this conclusion with an important caveat: in declining to extend objector-protection on the basis of religion, he is focused only on religious beliefs that are “irreducibly religious,” i.e. those that cannot be given any distinct moral content (at 14). If a religious belief or practice is framed with the same moral or ethical content as a purely conscience claim might be, it can be treated like a conscience claim in terms of the need for consideration and possibly accommodation. He adds in conclusion that health care institutions may well want to accommodate the objections of “irreducibly religious” objectors for extrinsic reasons of outreach to minority populations, fostering trust with religious communities and increasing tolerance between health care providers more generally (at 15).

tional value of ethical reflection. McLeod argues that ethicists do not give adequate regard to the constant social shaping of conscience:

Granted, the dominant view is not as extreme as some religious views that instruct us to tune in to our conscience and put our lives in conformity with it, without questioning what it says. Advocates of the dominant view do accept that at times we might, or indeed should, scrutinize the demands of our conscience. However, they do not associate the value of conscience with its ability to inspire attempts at taking responsibility for what we value.93

For McLeod, the social value of retooling one’s conscience should lead to reflective practice training for health care professionals.94 A physician with a well-functioning conscience with respect to reproductive rights for women should have some understanding of how their conscientious objection to referral or provision of service affects women. She argues that “any right to have one’s conscience protected should be accompanied by a duty to ensure the cultivation of a well-functioning conscience.”95 In my view, McLeod’s argument is significant to a legal assessment of this Notice of Application to understand conscience claims as both personal and requiring constant self-reflection and revision in the face of socially-competing conscience views. It is philosophically insufficient to simply assert a conscience claim without understanding it as personal (and therefore subject to overriding claims with a greater social benefit) and contingent (and therefore subject to requests from a regulatory body that the impact of one’s conscience be reconsidered or limited in the face of competing social claims). Chloë Fitzgerald argues that the dominant view of conscience has a serious flaw in its focus on explicit attitudes at the expense of implicit attitudes or biases.96 In the context at issue here around conscience refusals in reproductive care, I argue that physicians who have unexamined but implicit attitudes about the proper role of women may not adequately reflect on the role those biases play in their conscientious objections.

93 Ibid at 173.
94 Ibid at 176.
95 Fitzgerald & McLeod, supra note 21.
2. The moral argument for referral

Carolyn McLeod makes a forceful argument that those concerned with increasing access to reproductive rights for women must engage in the “battle” over physician referral as the “pro-life” side is winning. She describes the conflict as resulting in this compromise: “pro-choice people have agreed to allow conscientious objectors to opt out of performing abortions so long as these objectors make referrals for abortions.” However, those opposed to abortion see this as a false compromise, as it makes physicians complicit in the performance of acts they find morally forbidden. This is the basis of the physicians’ objections in the Notice of Application to the referral clause in the updated Policy. In McLeod’s view, the case for abortion is morally justified, and hence, doctors should have to perform them. The case for a lesser obligation – that of a referral – is permissible only where that referral is accessible to the patient. If not, the doctor should have to perform the service. The justification for allowing a referral is patient well-being: “Simply put it is better for patients to have physicians who can perform abortions with as little professional distance as possible given how emotionally trying abortions can be for patients.” However, she points out, “patients who want or need abortions are generally better off getting an abortion from a conscientious objector than not getting an abortion at all … On my approach, whenever referral is not possible, performance is required.” This is a stronger position than taken by the College. The Policy on provision of service conditions the requirement in the context of an emergency, “where it is necessary to prevent imminent harm.”

In drafting a model Conscientious Objection Policy, McLeod and her colleagues Jocelyn Downie and Jacquelyn Shaw frame the treatment requirement more broadly, in keeping with McLeod’s views on the moral justifications of conscience refusals:

98 Ibid.
99 Ibid at 42, 48.
100 Ibid at 42.
101 Ibid.
102 Ibid.
103 Policy 2-15, supra note 6 at 5.
5.4 Treating Patients: When a referral to another health care provider is not possible without causing a delay that would jeopardize the patient’s health or well-being, physicians must provide the patient with all health services that are legally permissible and publicly funded and that are consented to by the patient … This obligation holds even in circumstances where the provision of health services conflicts with physicians’ deeply held and considered moral or religious beliefs.¹⁰⁴

Their model section on information provision is much broader than that of the College, specifically requiring that “[p]hysicians must not provide false, misleading, intentionally confusing, coercive, or materially incomplete information to their patients.”¹⁰⁵ The Policy as passed by the College states:

Physicians must provide information about all clinical options that may be available or appropriate to meet patients’ clinical needs or concerns. Physicians must not withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs.¹⁰⁶


¹⁰⁵ Ibid. As noted above in describing the Notice of Application, the physicians have not expressly objected to the requirement of information provision but since it is included in the objectionable section on effective referral, presumably they take issue with it as well. There are many anti-abortion arguments grounded in the “harm” that abortion causes to women. In the US Supreme Court decision in Gonzales for example, the majority judgment by Justice Kennedy argued: “While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained severe depression and loss of esteem can follow” (supra note 57 at 159) [footnotes omitted]. This aspect of the decision was very controversial and gave judicial credence to so-called “scientific” evidence that abortion is medically harmful to women. Counselling and information provision policies for physicians must be careful to account for the provision of information that a physician personally believes true and helpful, but that is grounded in implied biases and fake science. For an analysis of this aspect of the Court’s decision, see Ronald Turner, “Gonzales v Carhart and the Court’s ‘Women’s Regret’ Rationale” (2008) 43 Wake Forest L Rev 1.

¹⁰⁶ Policy 2-15, supra note 6 at 6.
The Policy as recently reformed by the College attempts to strike a balance between a respect for the consciences of physicians, and the need to provide necessary medical services. An individual’s right to hold religious, ethical, or conscientious beliefs does not legally entail a concomitant right to impose those beliefs on others. The right to believe is much broader than the right to act on beliefs. Allowing physicians to act on their conscience by refusing to treat women with contraception or abortion goes too far in respecting a physician’s private and personal ethical boundaries.

B. The Applicants’ Charter claims: The constitutional rights of physicians

At last we come to the heart of the Notice of Application as filed by the physicians and their advocacy organizations. While their defensive position is important in setting out any balancing of rights that needs to happen, their primary argument is in favour of their own individual rights as physicians. It is important to note with precision their claim: this is not about their individual rights as private persons. The Notice of Application is firmly centered on the rights of physicians in the performance of their professional duties as doctors. They claim three separate Charter protections: freedom of religion, freedom of conscience, and equality rights.

1. Section 2(a) freedom of religion

The test to determine a Section 2(a) freedom of religion violation was set out by the Supreme Court of Canada in Syndicat Northcrest v Amselem. A majority of the Court held:

[A]n individual advancing an issue premised upon a freedom of religion claim must show the court that (1) he or she has a

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107 The updated Policy also alludes to the obligation on physicians not to abandon a patient. In its discussion on advising patients of limitations to clinical competence it states: “In order to protect patients’ best interests and to ensure that existing patients, or those seeking to become patients, are not abandoned, the College requires physicians to provide a referral to another appropriate [health care] provider for the elements of care the physician is unable to manage directly” (ibid at 4).

108 Notice of Application, supra note 1 at 3.
practice or belief, having a nexus with religion, which calls for a particular line of conduct, either by being objectively or subjectively obligatory or customary, or by, in general, subjectively engendering a personal connection with the divine or with the subject or object of an individual’s spiritual faith, irrespective of whether a particular practice or belief is required by official religious dogma or is in conformity with the position of religious officials; and (2) he or she is sincere in his or her belief.\textsuperscript{109} The Court is careful and clear that the belief need not be one that is “required” by the religion and it need only be a belief that the claimant feels connects him or her with the divine. Sincerity will be a matter of credibility but the Court is also clear that, “[b]ecause of the vacillating nature of religious belief, a court’s inquiry into sincerity, if anything, should focus not on past practice or past belief but on a person’s belief at the time of the alleged interference with his or her religious freedom.”\textsuperscript{110} If the claimant is successful at establishing a sincere belief in a practice that connects her or him to the divine, the Court then requires a claimant to show that the interference with religious belief is “more than trivial or insubstantial.”\textsuperscript{111}

Given that many religions oppose abortion, and that there are strong religious arguments against both it and birth control, I do not doubt that the Applicants will succeed at this stage. All five individual Applicants are described as “committed” to their religious beliefs. Four are Protestant Evangelicals and one is Catholic. Both traditions have theological leaders who support a ban on contraception and abortion.\textsuperscript{112} These first two parts of the freedom of religion test should pose no problem for the Applicants.

The final phase may be more challenging. Once a sincerely held religious belief is implicated and the claimant has shown that the interference is

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\item \textsuperscript{109} *Syndicat Northcrest v Amselem*, 2004 SCC 47 at para 56, [2004] 2 SCR 551 [*Amselem*].
\item \textsuperscript{110} *Ibid* at para 53.
\item \textsuperscript{111} *Ibid* at para 59.
\item \textsuperscript{112} For an interesting historical comparison, see Amelia Thomson-Deveaux, “The Strange Bedfellows of the Anti-Contraception Alliance”, *The American Prospect* (17 March 2014), online: Prospect <www.prospect.org/article/strange-bedfellows-anti-contraception-alliance>.
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more than trivial or insubstantial, the Court must consider whether the belief should be protected in the matter at hand.\footnote{Amselem, supra note 109 para 60.} In making that assessment, the Court emphasizes that freedom of religion claims cannot be examined in isolation – context is everything:

\[O\]ur jurisprudence does not allow individuals to do absolutely anything in the name of that freedom. Even if individuals demonstrate that they sincerely believe in the religious essence of an action, for example, that a particular practice will subjectively engender a genuine connection with the divine or with the subject or object of their faith, and even if they successfully demonstrate non-trivial or non-insubstantial interference with that practice, they will still have to consider how the exercise of their right impacts upon the rights of others in the context of the competing rights of private individuals. \textit{Conduct which would potentially cause harm to or interference with the rights of others would not automatically be protected.} The ultimate protection of any particular \textit{Charter} right must be measured in relation to other rights and with a view to the underlying context in which the apparent conflict arises.\footnote{Ibid at para 62 [emphasis added].}

The emphasized part of the quote from \textit{Amselem} will be an obstacle for the Applicants in this case. In my view, it should bar the claim. There is a definite risk, likelihood, and even a certainty of harm when women are denied access to contraception and abortion.\footnote{I acknowledge that many religious people may take the position that pregnancy is never a harm to women. Although the physicians do not state this explicitly, it is implicit in their position that their oath to “First do no harm” guides them to believe that the harm comes from interfering with conception and pregnancy, and not from the condition itself. I do not doubt the sincerity of this belief for some physicians objecting on religious or conscientious grounds. However, in a patient-centred medical framework where patients are capable and autonomous in decision making, the physician’s assessment of harm must give way to the patient’s decision making. If a woman sees the pregnancy as a “harm,” in the context of a country where abortion is both legal and available, the physician’s opinion that it is \textit{not} a harm is only that – an opinion – and not one that should determine the course of treatment.} A refusal to provide an effective referral for abortion, or to perform the service when urgently required, will cause serious harm to women. As I argued above, I do not think
that physicians can rely on non-objecting physicians to overcome this harm (nor do I think they are purporting to do so). In taking a contextual analysis to this claim, the Court must balance the physician’s right to practice his or her employment according to a religious belief as against a woman’s constitutionally protected right to access necessary and legal reproductive health care. Economics versus the body; a job versus a life. I do not think the claim can overcome the harm stacked against it. Physicians have no entitlement to their chosen profession (none of us do) and they certainly have no “right” to practice medicine in their chosen specialty. Medical students who anticipate a conflict between their conscience or religious beliefs, or both, do not have to enter into the practice of front line emergency or family medicine. There are specialties that would not pose the same moral, ethical, or religious conundrums to doctors. It is within this context that the claim to religious freedom must be understood. While there are appropriate instances for physicians to rely on their consciences to inform a course of action, those most often take place when patients request unlawful or medically unsound courses of treatment. Physicians should refuse to treat a patient in ways that will produce no medical benefit. The conscience claims asserted here are of a different sort and purport to replace a woman’s moral choice with the physician’s with respect to a procedure that is lawful and medically necessary when the pregnant woman believes it to be. While employment may be an important life interest, it is not as central or core to identity as bodily integrity and parenthood.

In my view, while the Applicants may hold a sincere religious belief that they cannot participate in facilitating or providing either abortion or contraception (or offering effective referrals for them), they will not be able to establish a non-trivial or substantial interference with that belief in light of the context of the claim. This is especially true with respect to the challenged clause on effective referral. A referral simply directs a patient to

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116 In addition to balancing Charter rights, the Supreme Court also analyses Charter claims with a view to upholding international human rights obligations. Article 18(1) of the International Covenant on Civil and Political Rights protects a right to freedom of religion, but it is qualified in article 18(3) which states:

Freedom to manifest one’s religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others (19 December 1966, 999 UNTS 171 (entered into force 23 March 1976, accession by Canada 19 May 1976)).
another physician. Abortion may not even result from that referral as a fully informed patient may decide to proceed with the pregnancy. An objecting physician has no way to know what the course of treatment will be when a patient is counseled as to all available options. The degree of separation in decision making in the effective referral context may still be an uncomfortable position for physicians, but it makes the balancing of rights even more clearly in the woman’s favour.

The issues are more complicated in considering the Policy on urgent provision of services. There, a physician might well be able to successfully argue a lack of competence or training to provide the service. Still, a physician must consider his or her own limitations in choosing a medical specialty. A profession that requires a physician to perform all legal and funded services within his or her competence and choice of specialty does not force doctors into a certain line of practice. Physicians should be fully trained on all treatment issues likely to arise in their chosen field.

2. Section 2(a) freedom of conscience

The claim to a violation of freedom of conscience is presented as separate from the claim to a breach of freedom of religion. Presumably, the Applicants see a difference between these two protected freedoms. As described above, the Supreme Court of Canada agrees, though the difference is not yet fully articulated.

All of the Applicants in this case have self-identified as belonging to a specific religious group. It may therefore be difficult for these particular claimants to separate a unique conscience claim unrelated to their deeply held religious tenets, but others have made the case for a secular anti-abortion position. Assuming one could articulate a reasoned anti-abortion

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117 See e.g. Kristine Kruszelnicki, “A Secular Case Against Abortion”, Pro-Life Humanists (13 May 2013), online: <www.prolifehumanists.org/secular-case-against-abortion>:

The late atheist author Christopher Hitchens, when asked in a January 2008 debate with Jay Wesley Richards whether he was opposed to abortion and was a member of the pro-life movement, replied:

I’ve had a lot of quarrels with some of my fellow materialists and secularists on this point,
belief, grounded in a scientific claim, or moral ethics, or some other firm conviction, in my view the Court would accept it as protected by freedom of conscience. Unlike freedom of religion where the Court has developed a “test” to be applied, freedom of conscience remains undefined. Presumably though, to keep the two clauses coherent, a similar test would apply. A freedom of conscience claimant would have to show that their conviction or belief is sincerely held and related as a matter of conscience and that within the context of their claimed freedom, the state inference was non-trivial or more than insubstantial. For the same reasons articulated above, this claim would fail on the last part of the test. The conscience claims, like the religious ones, pit a physician’s economic interests against a woman’s bodily integrity and equality rights. Clearly, the patient wins in this contest.

3. Section 15

Pursuant to the Kapp test for Section 15, the Applicants will have to first show a difference in treatment based on one of the enumerated or analogous grounds and second, that the differential treatment perpetuates or

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[but] I think that if the concept “child” means anything, the concept “unborn child” can be said to mean something. All the discoveries of embryology [concerning viability] – which have been very considerable in the last generation or so – appear to confirm that opinion, which I think should be innate in everybody. It’s innate in the Hippocratic Oath, it’s instinct in anyone who’s ever watched a sonogram. So “yes” is my answer to that.

See also Rob Schwarzwalder, “The Best Pro-Life Arguments for Secular Audiences”, online: Family Research Council <frc.org/arguments>.

118 Dickens argues, “Conscience may be shaped by social, philosophical, political, professional, and other convictions apart from those founded on religious faith.” Interestingly in the context of my argument, he concludes:

Religious institutions and hierarchies that, for instance, do not include women, and that expressly exclude women from positions of doctrinal authority, may be considered conscientiously flawed, and to lack relevance in their pronouncements, particularly on a matter such as abortion, in which women’s health and interests are centrally involved (supra note 69 at 211).
The equality aspect of the physicians’ claim is difficult to articulate and the Notice of Application does not lay out the specifics. I assume the physicians argue that they are treated differently from others on the basis of the enumerated ground of religion. Teasing out the contours of the claim, there are two ways in which the new Policy could be said to treat these Applicants differently. First, the difference in treatment is that some employees are allowed to shape their work life around sincerely held religious beliefs and employers are required to accommodate. So, for example, some employees could refuse to work on Saturdays or Sundays (the Sabbath days), or could wear religious attire (kippot, turbans, niqabs) and unless there is a bona fide reason to refuse to accommodate, an employer would be obligated to do so. Meanwhile, these physicians are not accommodated in the practice of their religious faith (their sincerely held belief requires them not to engage in any supportive role around contraception or abortion). This results in a difference in treatment around aspects of religious belief (some aspects could lead to accommodation, other aspects do not). The difference in treatment is not based on a religion per se, as no particular religion is singled out in the new Policy, and opposition to contraception and abortion is not limited to a single religious sect or denomination. It is, however, a difference in treatment based on the religious practitioner’s manifestation of religious beliefs. This might be sufficient to pass the first step of a Section 15 analysis. Manifestation of beliefs is clearly part of our concept of religion. To the extent that the new Policy can be read as compromising a physician’s unbridled reliance on religious beliefs in decisions on how to practice front line medical care, while other religious manifestations around clothing or scheduling can be part of front line medical care, these physicians might be successful in arguing differential treatment from other religiously-minded physicians.

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119 Kapp, supra note 56 at para 25.

120 None of the other enumerated or analogous grounds apply to this claim. The enumerated grounds are: “race, national or ethnic origin, colour, religion, sex, age or mental or physical disability” (Charter, supra note 2, s 15(1)).

121 I say “might” be successful in arguing differential treatment because another way to look at the Section 15 claim is to say that the College has made a decision that the asserted religious beliefs in this case cannot be accommodated. While the scheduling of physicians and rules around professional clothing have little to no impact on patient care, in this case the religious beliefs directly implicate patient care. The difference in treatment is then of a different quality altogether. In Withler v Canada (2011 SCC 12, [2011] 1 SCR 396) the Supreme Court of Canada did away with the rigid requirement that claimants point to a
Second, the Policy arguably treats religiously-minded physicians differently from secularly-minded physicians. This could be framed as directly discriminatory in that the burden of conforming to the Policy falls most dramatically on those who have religious objections to it. Or, the claimants might also be making an adverse effects discrimination claim, arguing that although the Policy is neutrally worded to require all physicians to make “effective referrals” or perform “urgent care,” it adversely impacts religiously-minded physicians for whom these new guidelines impose a disparate impact on the ground of religion. Non-religious doctors will face little to no change in their practice. Religious doctors may have to change practice focus or specialty. It would seem likely that the physicians could argue that the Policy is not a neutral one, and that in fact it was intended to coerce physicians to conform to the College’s position on patient care for women. The Policy arose in the context of a protracted debate about conscientious objection and was framed as the College’s definitive answer to physician obligations. The “adverse effects” in other words were not only contemplated but a necessary piece of the College bringing all front line service providers in line on this issue. The Policy therefore imposes adverse effects on some religious doctors, though these claims have been historically hard to establish at the Supreme Court of Canada.\footnote{See Jennifer Koshan & Jonnette Watson Hamilton, “The Supreme Court’s Latest Equality Decision: An Emphasis on Arbitrariness” (29 May 2015), \textit{ABlawg} (blog), online: <ablawg.ca/2015/05/29/the-supreme-courts-latest-equality-rights-decision-an-emphasis-on-arbitrariness> [footnotes omitted] (commenting on \textit{Kahkewistahaw First Nation v Taypotat}, 2015 SCC 30, [2015] 2 SCR 548 [\textit{Taypotat}]. \textit{Taypotat} is only the ninth adverse effects discrimination decision under the \textit{Charter} from the Supreme Court in the last 30 years, and the number of successful adverse effects claims still stands at only two (see \textit{Eldridge}, supra note 31; \textit{Vriend v Alberta}, [1998] 1 SCR 493, 67 Alta LR (3d) 1). In our review of the Court’s adverse effects discrimination case law, we identified a number of problems arising in this type of case: the more burdensome evidentiary and causation requirements and assumptions about choice, the reliance on comparative analysis, the acceptance of government arguments based on the “neutrality” of policy choices, the narrow focus on discrimination as prejudice and stereotyping, and the failure to “see” adverse effects discriminating a comparator group in establishing differential treatment. A claimant no longer has to find a group that mirrors his or her own but is treated differently. In this case then, the physician-claimants do not have to point to a specific group of religiously-minded physicians that receive the benefit of unfettered religiously-defined practice. Equality remains a comparative concept, however, and so the claim must show that some other religious beliefs are accommodated while these particular ones are not.}
In my view it is likely the Applicants would succeed in establishing differential treatment on the ground of religion. This is not a crystal clear case, but the Court has moved away from a rigid comparative assessment in recent years and I think there is sufficient evidence here to move the analysis along.\textsuperscript{123}

This would bring us to the second step of the \textit{Kapp} test: does the difference in treatment perpetuate or exacerbate disadvantage? In \textit{Kapp}, the Court made prejudice and stereotyping the focus of this second step in Section 15(1). More recently, it seems to have shifted emphasis to the more broadly described notion of “disadvantage” and especially “arbitrary disadvantage.” In their piece analyzing the current state of Section 15 jurisprudence, Koshan and Hamilton summarize the Supreme Court’s current majority position:

Justice Abella refers to her reasons for the majority on the section 15(1) issue in \textit{Quebec v A} for the point that the equality section requires a “flexible and contextual inquiry into whether a distinction has the effect of \textit{perpetuating arbitrary disadvantage} on the claimant because of his or her membership in an enumerated or analogous group.” Her judgment in \textit{Taypotat} goes on to use the term “arbitrary” an additional five times. Arbitrary is used as a modifier of the term “disadvantage”, as well as a synonym for “discriminatory.”\textsuperscript{124}

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nation, often as a result of the size or relative vulnerability of the group or subgroup making the claim.
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\textsuperscript{123} That said, in \textit{Taypotat, supra} note 122, the Court dismissed the claim on the first step of the Section 15(1) analysis. The \textit{Taypotat} case involved a community election code adopted by the Kahkewistahaw First Nation in Saskatchewan to govern elections for the positions of Chief and Band Councillor. The code restricted eligibility for these positions to persons who had at least a Grade 12 education or the equivalent (\textit{ibid} at para 5). The Court concluded, “[T]his case falls not on the existence of the requirement, but on the absence of any evidence linking the requirement to a disparate impact on members of an enumerated or analogous group” (\textit{ibid} at para 14). The claimant in \textit{Taypotat} argued that this qualification adversely impacted him on the analogous ground of “residential school survivors without a Grade 12 education” (\textit{ibid} at para 12).

\textsuperscript{124} \textit{Supra} note 122, citing Justice Abella in \textit{Taypotat, supra} note 122 [emphasis in original].
This step could prove challenging for the physicians, assuming they can overcome the hurdle of establishing differential treatment on the basis of religion. Certainly religious discrimination is both a historic and present phenomenon and there is no doubt that many individuals have and continue to face disadvantage because of their religious beliefs. As a group and in certain situations, religious believers should be able to establish that they are disadvantaged in a secular society. This is true even though religious institutions are quite powerful in Canada (economically and politically). What will prove challenging is for the Applicants to show that the guidelines in the Policy perpetuate or exacerbate any alleged disadvantage. As I have already argued, the context of this case puts physicians at an acute imbalance in the assessment of their rights to employment as opposed to a woman’s right to reproductive autonomy. While it is undeniably true that the challenged Policies may make the practice of front line medicine more difficult for religious doctors, the Policies do not reflect any stereotypical thinking about religious doctors. They do not impose a particular disadvantage on doctors (who can choose a different specialty and still practice as physicians). They do not reflect the imposition of any arbitrary disadvantage. The Policies are far from arbitrary but are tied to a longstanding point of debate within the regulatory body and the result of extensive consultation about what a modern medical practice requires. Many life choices make the practice of a profession more difficult (the decision to have children, to live far away from one’s place of work, to engage in significant hobbies or pastimes that present scheduling challenges, etc.). The mere presence of “difficulty” is not “disadvantage” in the eyes of the Charter. These Policies may make front line medicine more “difficult” for religious physicians, but that difficulty is not a constitutionally recognized “disadvantage” under Section 15.

125 The individual Applicants in this case are supported in this litigation by religiously-focused advocacy organizations, formed to protect and advocate for the interests of their members. In a show of unity and strength, in a recent opinion piece in the Ottawa Citizen, three of the city’s prominent religious leaders called for the College to abandon the Policy’s requirement for effective referral: Reuven Bulka, Terrence Prendergast & Samy Metwally, “Rabbi Bulka, Imam Metwally and Reverend Prendergast: Doctors have a duty to their consciences”, Opinion, Ottawa Citizen (19 February 2015), online: Ottawa Citizen <www.ottawacitizen.com/news/national/doctors-duty-consciences>.
4. Section 1

If any of the Applicants’ Charter claims are successful, the analysis will move to the justification stage under Section 1:

The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.\(^{126}\)

The Court has devised a four part test for analyzing Section 1: 1) Is the objective of the legislation (rule, policy) pressing and substantial? 2) Are the means rationally connected to the objective? 3) Is there minimal impairment of the claimant’s rights? And 4) Are the salutary effects sufficiently important to justify the severity of the deleterious effects?\(^{127}\)

Most government initiatives pass the first stage and I think it likely the Court will find the College’s objectives here to be “pressing and substantial.” The Policy is meant to set out the professional and legal obligations of physicians to provide health services without discrimination. It does this in two ways: by imposing a duty to accommodate and by setting out expectations for physicians who limit health services because of either clinical competence or personal values and beliefs. The College uses the Policy as a way to make clear its expectations of physicians, and also to make clear to patients in Ontario what they can and should expect from their interactions with primary health care providers. Transparency, clarity, and non-discrimination in physician-patient relationships are clearly important goals for the regulatory body and thus the Policy should be considered a “pressing and substantial” objective.

Are the means set out in the Policy rationally connected to the objective? There have been many years of debate as to the scope of a referral requirement for religious or conscientious objectors.\(^{128}\) The College’s decision

\(^{126}\) Supra note 2.

\(^{127}\) This is known as the “Oakes” test from R v Oakes, [1986] 1 SCR 103, 14 OAC 335.

\(^{128}\) See Downie, McLeod & Shaw, supra note 104 at 28. The authors begin by recounting the furor over a 2006 guest editorial in the Canadian Medical Association Journal by Downie and Sanda Rodgers (former Dean, University of Ottawa Faculty of Law). Downie and Rodgers argued that it constitutes mal-
to make its expectations clear is rationally connected to its desire to ensure that patients receive non-discriminatory care from physicians, and to protect physicians who are also entitled to have their Charter rights respected. The amended Policy reflects a consultation process that culminated in the new guidelines. This is a rational means to accomplish the objective of transparency, clarity, and non-discrimination.

The most fragile step in the Section 1 analysis is often the minimal impairment phase. This is where the government usually fails if it loses a Section 1 argument. The College’s goal here is modest. It is not aiming to radically alter expectations on physicians, nor is it imposing new practice rules. While the Applicants may interpret the Policy as altering the status quo, the College would argue it simply clarifies what many saw as the existing legal requirements imposed by the Charter and the Ontario Human Rights Code. Even if it does alter the status quo, the Policy does so in an incremental way. Only two clarifications trouble the physicians: the duty to provide an “effective referral” and the duty to provide care in an emergency to avoid imminent harm. There are two ways these policies can be described as minimally impairing in the context here of balancing a physician’s rights and a woman’s reproductive rights.

First, it is rarely the case that a physician would be called upon to perform an emergency abortion that does not involve saving the life of the pregnant woman. Many of those who object to abortion concede that it should be available if the life or health of the pregnant woman is at stake. Even the most restrictive laws in the United States contain that exception.  

practice for physicians to fail to provide appropriate referrals, and in a subsequent letter to the editor reaffirmed that all physicians have an obligation, under the Canadian Medical Association (CMA) Code of Ethics and policy, to refer patients seeking abortion: Sanda Rodgers & Jocelyn Downie, “Abortion: Ensuring Access”, Guest Editorial, (2006) 175:1 CMAJ 9; Sanda Rodgers & Jocelyn Downie, Letter, (2007) 176:4 CMAJ 494. The Executive Director of the CMA Office of Ethics responded that they were mistaken as to the duty to refer (Jeff Blackmer, Letter, (2007) 176:9 CMAJ 1310). This debate (and uncertainty) carried on for years before the College clarified obligations after a series of consultations.

In South Dakota for example, women face a 72 hour waiting period between a State-required counselling appointment and the procedure and that counselling is expressly designed to deter her from proceeding with an abortion. Public funding for abortions is only available if the pregnant woman’s life is in danger and state plans under the federal Affordable Care Act only fund abortions if the
It is minimally impairing of a physician’s values to require the provision of an abortion in life-threatening circumstances. If a physician is willing to provide an effective referral, in a timely and supportive manner, the need for that physician to operate in emergency conditions is further reduced. When one considers that the Policy (and medical ethics generally) would allow a physician who is untrained or incompetent in the service to opt out of performance, this is further evidence of minimal impairment. The same is true for the provision of emergency contraception. This is a circumstance where it may be more likely an objecting physician has to provide the service. There is a dramatic time crunch to the prescription of the “morning after” pill (and some provinces allow pharmacists to dispense this over-the-counter). Still, an effective referral may relieve the physician of active participation, and for many objectors abortion is considered “worse” than contraception. Proper management and disclosure in counselling patients all mitigate the likelihood that “emergencies” will arise that implicate the direct, active involvement of an objector in care he or she objects to.

Second, it is clear that no individual has the right to a particular job. It is minimally impairing to expect primary care or front line physicians to be non-discriminatory in their treatment of all clients and to fully comply with the College’s support for all legal and necessary medical treatments. It is minimally impairing to expect that physicians who are uncomfortable with their role as primary care doctors to move to a different practice area that does not present the problematic ethical dilemmas. At this stage of the analysis, the College would have to demonstrate that it considered other alternatives but felt this one (the updated Policy) to be its best resolution of the problem. The fact that the College permits front line physicians to choose an effective referral (rather than the performance of all treatment of options, other than in urgent situations) is an appropriate and minimally impairing compromise of a physician’s religious, conscience, and equality rights.

Finally, considering the fourth step of the Section 1 analysis, the balancing of salutary and deleterious effects, it is evident that a woman’s right to bodily integrity and the right to non-discriminatory health care exceed a physician’s right to have his or her values define the care they will deliver within the scope of taxpayer funded employment. The decision to refer, or to perform an abortion, or to provide emergency contraception in urgent woman’s life is in danger. For further information and a breakdown of South Dakota’s law, see The Guttmacher Institute, “State Facts about Abortion: South Dakota” (2014), online: <www.guttmacher.org/pubs/sfaa/south_dakota.html>.
situations, may pose a huge challenge to objectors. Similarly, the decision to abort or to seek birth control may be incredibly powerful and heart-wrenching moments for women. Given that contraception and abortion are legal medical services, the challenging decision is one the woman gets to make. It is her body, her psychological integrity, her life, and her future that are at stake. It is also her conscience that bears the greater brunt of the consequences of the decision. Physicians have significant interests but they cannot overcome those of the patient.

**Conclusion**

The College’s decision to updates its policy guidelines with respect to professional obligations comes after years of debate and controversy. That debate was largely centred on the issue of referrals to obtain an abortion, hence my focus here. It was within that context that the College clarified expectations: physicians who have a conscientious or religious objection to providing (or counselling around) a legal and publicly funded medical service must provide an effective referral to a colleague who can counsel fully and appropriately. In urgent circumstances, all physicians must provide all treatments they are professionally competent to provide. There is no longer any ambiguity around this issue. In many ways, this updated Policy simply brings the expectations of the College into compliance with the law. There is no legal ambiguity around women’s rights to contraception and abortion. Both are legal and women are entitled to equal access to them, regardless of where they live or who their front line physician happens to be. I predict the physicians will lose their legal challenge, as they should. The compromise struck by the College – that physicians can refer instead of perform the service themselves (unless it is an emergency) – is a compromise that recognizes and respects the rights of doctors while putting a priority on service to the broader public. In my view, physicians are subject to the Charter in the performance of their duties and must be alive to the claims they could face if they discriminate or endanger a patient by refusing to offer a legal and necessary medical service. The Policy strikes the appropriate balance and should be vigorously defended both by pro-choice advocates and by the larger population of autonomous decision makers who want to control their destinies.