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Faith and/in Medicine: Religious and Conscientious Objections to MAiD

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Across Canada, health care institutions that operate under the umbrella of religious traditions refuse to offer medical assistance in dying (MAiD) on the grounds that it violates their Charter-protected rights to freedom of religion and conscience. This article analyses the Supreme Court jurisprudence on section 2(a) and concludes that it should not extend to the protection of institutional rights. While the Court has not definitively pronounced a view on this matter, its jurisprudence suggests that any institutional right to freedom of religion would not extend to decisions on publicly-funded and legal health care. MAiD is a constitutionally-protected option for individuals and both courts and governments should prioritize an individual's right to access health care over any institutional considerations. Health care regulatory bodies already offer individual health care practitioners the compromise of making an effective referral to a non-objecting colleague in matters that implicate conscientious or religious objections. Institutions may be filled with people, but they are built of bricks and mortar. The institutions themselves should not take a moral stance on this complex social issue. They most certainly should not take an oppositional position to the Charter-protected rights of patients. The author concludes that provincial governments across this country must appreciate their duty to be neutral on matters of conscience and religion and take strong leadership roles in making clear to publicly-funded institutions that they must not deny medical services solely on religious or conscientious grounds.

Dans tout le Canada, des établissements de soins de santé qui fonctionnent sous l'égide de traditions religieuses refusent d'offrir l'assistance médicale à mourir au motif que cela viole leur droit à la liberté de religion et de conscience protégé par la Charte. Dans le présent article, nous analysons la jurisprudence de la Cour suprême relative à l'alinéa 2a) et concluons qu'elle ne devrait pas s'étendre à la protection des droits des établissements. Bien que la Cour ne se soit pas définitivement prononcée sur cette question, sa jurisprudence indique que le droit à la liberté de religion d'un établissement ne saurait s'étendre aux décisions relatives aux soins de santé légaux et financés par l'État. L'assistance médicale à mourir est une option protégée par la Constitution et les tribunaux comme les gouvernements devraient donner la priorité au droit d'une personne d'y accéder. Les organismes de réglementation des soins de santé offrent déjà aux praticiens le compromis de référer un patient à un collègue non objecteur dans les cas d'objections de conscience ou religieuses. Les établissements peuvent être remplis de personnes, mais ils sont construits de briques et de mortier. Les établissements eux-mêmes ne devraient pas adopter une position morale sur cette question sociale complexe. Ils ne devraient certainement pas s'opposer au respect des droits des patients protégés par la Charte. L'auteur conclut que les gouvernements provinciaux de tout le pays doivent tenir compte de leur devoir de neutralité sur les questions de conscience et de religion et assumer un rôle de leadership fort en indiquant clairement aux établissements financés par l'État qu'ils ne doivent pas refuser des services médicaux uniquement pour des raisons religieuses ou de conscience.

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Introduction

In 2015, the Supreme Court of Canada unanimously constitutionalized access to medical assistance in dying (MAiD).¹ It is not an unqualified right and the Court left it to Parliament to set out the circumstances under which a person can lawfully receive MAiD. The next year the federal government responded with legislation that decriminalized MAiD, set out the specific situations when it can be accessed and, as is consistent with the division of powers, left it to the provinces to implement regulations.² Despite judicial leadership and legislative response, MAiD remains fraught with difficulties both for the health care workers who must deliver care within a permissive regime, and for a broader Canadian public who has to adapt to a value-laden choice legally available for some of our most vulnerable citizens. There are innumerable legal, legislative, political and

1. See *Carter v Canada (AG)*, 2015 SCC 5 [Carter].

2. See Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, 1st Sess, 42nd Parl, 2016 (assented to 17 June 2016), SC 2016, c 3 [Bill C-14].

social challenges surrounding MAiD, including legal challenges to the federal legislative criteria for accessing it,³ concerns over accurate record-keeping for requests, denials in the performance of MAiD, difficulties facilitating access in remote locations, tensions within the palliative care community over how MAiD fits within that mandate, and the lingering stigma associated with the choice. All of these issues, and others, will need time and patience to sort out as we move to making MAiD accessible and acceptable.

This essay focuses on one of the most significant challenges: conscientious and religious objections to the provision of MAiD. Across Canada, publicly-funded faith-influenced⁴ institutions refuse to provide MAiD. Some individual physicians profess strong religious and conscientious objections to it.⁵ The individual and institutional resistance combines to imperil access to MAiD and to stigmatize it as the “wrong” choice. For those who fit the criteria for accessing MAiD and who want

3. Following a decision in the Quebec Superior Court in *Truchon c Procureur général du Canada*, 2019 QCCS 3792 [*Truchon*], the Federal government introduced amendments to the *Criminal Code*, RSC 1985, c C-46 [*Criminal Code*] that expanded access to MAiD; See Bill C-7, *An Act to amend the Criminal Code (medical assistance in dying)*, 1st Sess, 43rd Parl, 2020 (first reading 24 February 2020) [Bill C-7]. The most significant amendment removes the requirement that death be “reasonably foreseeable.” Further review of excluded categories is promised beginning in June 2020.

4. I am grateful to a participant at the 2019 Canadian Association of MAiD Assessors and Providers conference in Vancouver, British Columbia for suggesting this descriptor. I had been using “faith-based hospitals” but “faith-influenced” more accurately captures that the hospitals I am concerned about here are publicly-funded institutions that operate under the auspices of a religious umbrella steering group. They are therefore not directly run by a particular Church but rather are influenced in policy decisions by their directing faith-led organizations.

5. This paper focuses on religious and conscientious objection in particular. Scholars note that there are other reasons why a practitioner might not want to provide MAiD. Shaad and Shaad argue: “Some doctors might view MAiD as contrary to the internal morality of medicine. Others are palliative care specialists concerned that MAiD impedes access to palliative care services. Still others might understandably fear that it would have a corrupting influence on their own character.” See Philip Shaad & Joshua Shaad, “Institutional Non-participation in Assisted Dying: Changing the Conversation” (2019) 33:1 *Bioethics* 207 at 213. There has been considerable resistance among many members of the palliative care community to offering MAiD in hospices and palliative care institutions. In November 2019, the Canadian Hospice Palliative Care Association and the Canadian Society of Palliative Care Specialists issued a joint statement arguing that MAiD is NOT part of the palliative care “basket” nor is it an extension of palliative care: “Hospice palliative care and MAiD substantially differ in multiple areas including in philosophy, intention and approach. Hospice palliative care focuses on improving quality of life and symptom management through holistic person-centered care for those living with life threatening conditions. Hospice palliative care sees dying as a normal part of life and helps people to live and die well. Hospice palliative care does not seek to hasten death or intentionally end life. In MAiD, however, the intention is to address suffering by ending life through the administration of a lethal dose of drugs at an eligible person’s request.” See “CHPCA and CSPCP—Joint Call to Action” (2019), online (pdf): *Canadian Hospice Palliative Care Association & Canadian Society of Palliative Care Physicians* <<https://www.cspcp.ca/wp-content/uploads/2019/11/CHPCA-and-CSPCP-Statement-on-HPC-and-MAiD-Final.pdf>> [<https://perma.cc/2LY6-6EV2>]. It is beyond the scope of this paper to consider the palliative care community position, but it should be emphasized it goes beyond matters of conscience.

to exercise that choice, any denial of access is a profoundly devastating roadblock in what is already a complicated path. While there may be a need to move with some caution, and a need to be sensitive to how fundamental a shift this might seem in healthcare provision, the Supreme Court has spoken clearly. Canadians who meet the legislated criteria have a constitutional entitlement not to have unjustified barriers put in the way of access to MAiD within a publicly-funded health care system. While we might fiddle with the criteria, expanding it and clarifying it with more experience,⁶ over 7000 Canadians have already received MAiD and it is becoming a more realistic end-of-life option with each passing month.

Part I of this paper offers a brief overview of the Supreme Court of Canada's constitutionalization of access to MAiD in *Carter*. Part II offers a short summary of the Court's approach to freedom of religion as laid out in its section 2(a) jurisprudence, examining both the individual and institutional aspects of the freedom as they pertain to MAiD. Part III describes the contours of conscientious or religious objection to MAiD at the individual physician level and assesses the role it plays at the institutional level. Part III also applies the doctrinal tests developed by the Supreme Court of Canada for section 2(a) to individual and institutional objections to MAiD. Part IV considers the section 1 balancing exercise to reconcile the rights of conscientious and religious objectors with the rights of Canadians wanting access to MAiD. The paper concludes by recommending that all provincial regulatory bodies require at the least an "effective referral" model for individual conscientious or religious

6. In December 2016, the Minister of Health Jane Philpott and Minister of Justice and Attorney General of Canada Jody Wilson-Raybould asked the Council of Canadian Academies to undertake independent reviews related to medical assistance in dying: "Specifically, the CCA is tasked with examining three particularly complex types of requests for medical assistance in dying that were identified for further review and study in the legislation passed by Parliament in 2016. These cases are: requests by mature minors, advance requests, and requests where mental illness is the sole underlying medical condition." See "State of Knowledge on Medical Assistance in Dying for Mature Minors, Advance Requests, and Where a Mental Disorder is the Sole Underlying Medical Condition" (2018), online (pdf): *Council of Canadian Academies* <www.cca-reports.ca> [<https://perma.cc/43KM-ES9Q>]; "The State of Knowledge on Medical Assistance in Dying for Mature Minors" (2018), online (pdf): *Council of Canadian Academies* <www.cca-reports.ca> [<https://perma.cc/48GC-MRYQ>]; "The State of Knowledge on Advance Requests for Medical Assistance in Dying" (2018), online (pdf): *Council of Canadian Academies* <www.cca-reports.ca> [<https://perma.cc/9EFF-GG32>]; "The State of Knowledge on Medical Assistance in Dying Where a Mental Disorder is the Sole Underlying Medical Condition" (2018), online (pdf): *Council of Canadian Academies* <www.cca-reports.ca> [<https://perma.cc/LWV6-7ZJS>]. In June, 2020 a legislated review of MAiD will begin to consider all of these issues. As of October, 2018, 6749 people had accessed legalized MAiD in Canada. See "Fourth Interim Report on Medical Assistance in Dying in Canada" (April 2019), online (pdf): *Health Canada* <<https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/medical-assistance-dying-interim-report-april-2019/medical-assistance-dying-interim-report-april-2019-eng.pdf>> [<https://perma.cc/AG6A-A4TS>].

objectors. Ontario's policy, outlined below, can serve as an example, as it requires objectors to refer to a colleague in a good faith, timely way, without impeding access to any services. The paper ends with the normative assertion that objections by publicly-funded institutions should not be permitted. While not all hospitals offer all medical services, to the extent an institution is competent to offer MAiD, and routinely experiences end-of-life situations with patients, it should not be allowed to refuse MAiD on religious or conscientious grounds. Access to MAiD should be unimpeded by politics, professional regulatory regimes, and religion. We should support the early and ongoing efforts to make MAiD accessible by addressing the proper limits of freedom of conscience and religion claims in providing the service. In so doing, we can hopefully protect the people providing and accessing MAiD, accommodate those health care practitioners who object to providing MAiD, and establish proper boundaries for health care institutions.

I. *Rights in conflict: the constitutionalization of MAiD*

1. *The Carter decision*

Carter marked a dramatic moment for the Supreme Court of Canada and the country. The Court revisited its 1993 decision, *Rodriguez v British Columbia (Attorney General)*, in which a closely divided 5-4 Court concluded that criminal prohibitions on physician assisted death did not violate a person's section 7 right to life and security of the person.⁷ Some twenty years later, the Court in *Carter* found that both societal and individual norms had shifted and that our understanding of what constitutes "principles of fundamental justice" (POFJ) had evolved. Presented with a comprehensive evidentiary record and the accumulated wisdom of other countries that allow MAiD, the Supreme Court upheld the trial judge's decision that blanket criminal prohibitions on MAiD violate the section 7 rights of those with a grievous and irremediable medical condition.⁸

7. [1993] 3 SCR 519, 107 DLR (4th) 342 [*Rodriguez*]. Sue Rodriguez was the rights claimant in this case. She suffered from amyotrophic lateral sclerosis, a rapidly deteriorating physical condition that impacted every physical aspect of her body. She argued that the criminal law prohibitions on assisted suicide violated her section 7 and 15 rights. A majority of the Court disagreed. Justice Sopinka concluded that section 7 was most concerned with the value of "life" in its protection of security of the person, and that valuing life was incompatible with permitting vulnerable people to receive aid in dying. Further, there was no international consensus on permitting assisted death.

8. Specifically the Court concluded in *Carter*, *supra* note 1 at para 127: "The appropriate remedy is therefore a declaration that s 241(b) and s 14 of the *Criminal Code* are void insofar as they prohibit physician-assisted death for a competent adult person who (1) clearly consents to the termination of life; and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. 'Irremediable,' it should be added, does not require the patient to undertake

In particular, the Court held that the criminal law restrictions caused some people to take their lives prematurely, while still physically capable of doing so themselves, rather than wait until they were physically incapable and assistance would be unlawful. This premature implementation of the decision to die by choice as a result of the state's laws—federal *Criminal Code* prohibitions—constituted a state deprivation of life that was not in accordance with the POFJ. The provisions violated the POFJ by being overbroad.⁹ While the state may have a valid interest in protecting vulnerable individuals who could be coerced into assisted death, the blanket prohibition also captured autonomous individuals who were not vulnerable, but simply physically incapable of carrying out their death. It also captured those who had the mental and physical capacity to make the decision, but did not want to commit suicide in secret and by potentially gruesome means.¹⁰ Those who meet legislative criteria for access, the Court said, should be able to freely make this choice, facilitated by the state. The state's deprivation of life through a blanket prohibition therefore violated section 7 of the *Charter*:

The Court in *Carter* acknowledged that medical professionals—those who would be tasked with performing MAiD—would have to grapple with religious and conscientious beliefs and values around death and assisted death. Several intervenor religious organizations asked the Court to include strong protections for conscientious and religious objection in crafting a remedy.¹¹ The Court carefully noted that a declaration of invalidity of the *Criminal Code* provisions does nothing to compel physician participation. It left the question of the extent of protections for conscientious and religious rights to physician regulatory bodies and the provinces. While recognizing there are religious and conscientious implications for some, it stayed decidedly out of the fray in settling how those concerns should be addressed. The Court only observed that the *Charter* rights of physicians and patients would have to be “reconciled.”¹²

treatments that are not acceptable to the individual.”

9. *Ibid* at paras 56-58, 86-88.

10. *Ibid* at para 86.

11. The Court summarized the intervenor submissions: “The Catholic Civil Rights League, the Faith and Freedom Alliance, the Protection of Conscience Project, and the Catholic Health Alliance of Canada all expressed concern that physicians who object to medical assistance in dying on moral grounds may be obligated, based on a duty to act in their patients’ best interests, to participate in physician-assisted dying. They ask us to confirm that physicians and other health-care workers cannot be compelled to provide medical aid in dying. They would have the Court direct the legislature to provide robust protection for those who decline to support or participate in physician-assisted dying for reasons of conscience or religion” (*ibid* at para 130).

12. *Ibid* at para 132.

2. *Bill C-14*

The Federal Government responded to *Carter* with Bill C-14 “Medical Assistance in Dying.”¹³ The law received Royal Assent in June 2016 and set out the circumstances under which MAiD can be lawfully performed.¹⁴ The eligibility criteria departed from the Supreme Court’s approach in some fundamental ways. The Supreme Court declared the *Criminal Code* prohibitions void in so far as they applied to:

“a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. ‘Irremediable,’ it should be added, does not require the patient to undertake treatments that are not acceptable to the individual.”¹⁵

The federal legislation required death to be “reasonably foreseeable”¹⁶ and also required that the person be in an “advanced state of irreversible decline in capability.”¹⁷ Furthermore, the person’s condition had to be both serious and incurable.¹⁸

The government proposed the law after a period of consultation by a Special Joint Senate-House of Commons Committee that produced a report with twenty-one recommendations in February 2016.¹⁹ Among

13. Bill C-14, *supra* note 2.

14. Bill C-14 *supra* note 2 at s 241.2 (1) “A person may receive medical assistance in dying only if they meet all of the following criteria:

- (a) they are eligible—or, but for any applicable minimum period of residence or waiting period, would be eligible—for health services funded by a government in Canada;
- (b) they are at least 18 years of age and capable of making decisions with respect to their health;
- (c) they have a grievous and irremediable medical condition;
- (d) they have made a voluntary request for medical assistance in dying that, in particular, was not made as a result of external pressure; and
- (e) they give informed consent to receive medical assistance in dying after having been informed of the means that are available to relieve their suffering, including palliative care.”

15. *Carter*, *supra* note 1 at para 127.

16. But see recent proposed amendments to the *Criminal Code* that would remove this criterium, Bill C-7, *supra* note 3.

17. Bill C-14, *supra* note 2 at s 241.2 (2): “A person has a grievous and irremediable medical condition only if they meet all of the following criteria:

- (a) they have a serious and incurable illness, disease or disability;
- (b) they are in an advanced state of irreversible decline in capability;
- (c) that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
- (d) their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.”

18. *Ibid.*

19. House of Commons, *Medical Assistance in Dying: A Patient-Centred Approach: Report of the*

the recommendations are two that pertain to conscientious and religious objectors. First, recommendation 10 suggests:

“That the Government of Canada work with the provinces and territories and their medical regulatory bodies to establish a process that respects a health care practitioner’s freedom of conscience while at the same time respecting the needs of a patient who seeks medical assistance in dying. At a minimum, the objecting practitioner must provide an effective referral for the patient.”²⁰

The Committee quoted directly from *Carter* on the need to “reconcile” patient and physician rights and concluded “having health care professionals who conscientiously object to MAiD provide an effective referral for a patient who seeks MAiD is an appropriate balancing of the rights of patients and the conscience rights of physicians.”²¹

Second, recommendation 11 suggests: “[t]hat the Government of Canada work with the provinces and territories to ensure that all publicly funded health care institutions provide medical assistance in dying.”²² In laying out this recommendation the Committee noted: “[a] number of witnesses argued, and the Committee also believes, that if a health care facility is publicly funded, it must provide MAiD. The difficulty in transferring a patient from one facility to another was highlighted.”²³ Some Conservative members of the Joint Committee filed a dissenting report, disagreeing with many of the recommendations including the two on conscientious and religious objections.²⁴ The dissenting report concluded an effective referral regime went too far. It preferred that the government establish an independent agency to coordinate referrals for MAiD. Objecting physicians would be obligated to give patients the contact information for the agency, which would then connect the patient to a provider.²⁵ This model is used in Alberta and Quebec, for example.²⁶ The dissenting report also stressed that faith-influenced institutions must be exempt from the requirement to provide MAiD.²⁷ They relied on the

Special Joint Committee on Physician-Assisted Dying (February 2016) (Joint Chairs: Hon Kelvin Kenneth Ogilvie & Robert Oliphant).

20. *Ibid* at 26.

21. *Ibid*.

22. *Ibid* at 27.

23. *Ibid*.

24. *Ibid* at 51 (dissenting opinion of Members of the Conservative Party of Canada on the Joint Committee).

25. *Ibid* at 55.

26. See *Act Respecting End-of-Life Care*, CQLR c S-32.0002, ss 31, 50 [*Quebec EOL Care*]; Alberta Health Services, “Medical Assistance in Dying: Policy HCS-165-01” (2018) at 8, online (pdf): <www.albertahealthservices.ca> [https://perma.cc/SQ76-ZELD] [AHS Policy].

27. House of Commons, *supra* note 19 at 55.

Supreme Court's observation in *Loyola* that, "individual and collective aspects of freedom of religion and conscience guaranteed under the *Charter* are 'indissolubly intertwined.'"²⁸

The federal legislation crafted in part from these recommendations includes only this statement in its preamble: "[w]hereas everyone has freedom of conscience and religion under section 2 of the *Canadian Charter of Rights and Freedoms*..."²⁹ MAiD is therefore legally available in Canada for certain individuals who meet the criteria and want to exercise the choice. Provincial responsibility for the delivery of healthcare has produced a patchwork of options to accommodate religious and conscientious objectors. In Manitoba, for example, objecting physicians are permitted to refuse to refer a patient to a non-objecting colleague, but are required to provide patients with an informational resource.³⁰ In Alberta and Quebec, a "self-referral" model prevails where patients can contact a centralized referral service if their own physician refuses.³¹ Ontario has the most robust system, requiring an "effective referral."³² Across the country, faith-influenced institutions, loosely organized under umbrella organizations, collectively refuse to provide MAiD. Some jurisdictions have more faith-influenced institutions than others. In Newfoundland, for example, there are none.³³ Much of Alberta, on the other hand, is serviced by faith-influenced institutions.³⁴ All of this regional disparity means that ease of access to MAiD depends on where you live. This is eerily familiar for those who champion reproductive rights, as the Supreme Court decision in *R v Morgentaler* struck down *Criminal Code* prohibitions on abortion in part because of unequal access to the service across the country.³⁵ In

28. *Ibid.*, citing *Loyola High School v Quebec (Attorney General)*, 2015 SCC 121 at para 94 [*Loyola*].

29. Bill C-14, *supra* note 2.

30. "Standards of Practice of Medicine" (2019) at 99, online (pdf): *College of Physicians & Surgeons of Manitoba* <<http://cpsm.mb.ca/>> [<https://perma.cc/Q2QT-AW3Q>] [CPSM Standard]; See also, "Policy: Medical Assistance in Dying" (2017) at 3.16, 4.1, online (pdf): *Winnipeg Regional Health Authority* <www.wrha.mb.ca/MAiD> [<https://perma.cc/S2WY-Q7NF>].

31. See *Quebec EOL Care*, *supra* note 26 at ss 31, 51; AHS Policy, *supra* note 26 at 8.

32. "Medical Assistance in Dying" (2018) at 5, online (pdf): *College of Physicians & Surgeons of Ontario* <www.cpso.on.ca/> [<https://perma.cc/V58D-6S39>] [CPSO Policy].

33. "Room to Grow: About Our Health Care System" (2019), online: *Practice Newfoundland and Labrador* <www.practicenl.ca/> [<https://perma.cc/6XW5-GRKG>].

34. See "Hospitals and Health Centres" (2019), online: *Covenant Health* <www.covenanthealth.ca/> [<https://perma.cc/7HE7-48F8>]. See also "Mission" (2019), online: *Covenant Health* <www.covenanthealth.ca/> [<https://perma.cc/RH4W-KABK>].

35. [1988] 1 SCR 30, 44 DLR (4th) 385. In concluding that the administrative structure for granting permission for abortion set out in the *Criminal Code* did not comport with the principles of fundamental justice, then Chief Justice Dickson argued: "Consider then the case of a pregnant married woman who wishes to apply for a therapeutic abortion certificate because she fears that her psychological health would be impaired seriously if she carried the foetus to term. The uncontroverted evidence reveals that there are many areas in Canada where such a woman would simply not have access to a therapeutic

Morgentaler, the Court concluded that a federal *Criminal Code* defence had to be uniformly available to all who could avail themselves of it, regardless of their location in Canada. The MAiD exceptions to the ban on assisting a suicide operate in a similar way as the abortion permission system worked. It is therefore legally problematic if access to MAiD differs dramatically across the country.

II. Section 2(a) and freedom of religion under the Charter

1. Individual freedom of religion

The Supreme Court decision in *Multani v Commission Scolaire Marguerite-Bourgeoys* outlines the Court's approach to section 2(a) in the most common kind of challenge.³⁶ The decision represented a classic freedom of religion dilemma. A school board had a rule prohibiting bringing weapons to school. This was a rule of "general applicability"—it applied to all students, faculty, and guests coming on to school grounds. Weapons were prohibited to all. The rights claimant was a young student and member of the Sikh faith who wanted permission to wear a ceremonial dagger (known as a kirpan) to school. He sincerely believed his faith required wearing a kirpan at all times. He wanted an exception to the general rule—an accommodation for his religious beliefs. As a compromise, the claimant offered to ensure that the kirpan was sealed and sewn up in his clothing. He could still satisfy the tenets of his faith but the school board's "no weapons" policy would be respected in its intent, as the kirpan would be inaccessible as a "weapon." He argued that the state's objective of public safety would still be achieved with this compromise. The school board disagreed.

Justice Charron wrote the majority decision. She began with an analytical argument about the interaction between sections 2(a) and 1 of the *Charter*. The Court's freedom of religion jurisprudence had yet to make clear whether section 2(a) protected an almost absolute right that could only be limited through an *Oakes* analysis at section 1. She acknowledged that this was not a settled question, and that the parties themselves could

abortion. She may live in an area where no hospital has four doctors; no therapeutic abortion committee can be created. Equally, she may live in a place where the treatment functions of the nearby hospitals do not satisfy the definition of "accredited hospital" in s. 251(6). Or she may live in a province where the provincial government has imposed such stringent requirements on hospitals seeking to create therapeutic abortion committees that no hospital can qualify. Alternatively, our hypothetical woman may confront a therapeutic abortion committee in her local hospital which defines "health" in purely physical terms or which refuses to countenance abortions for married women. In each of these cases, it is the administrative structures and procedures established by s. 251 itself that would in practice prevent the woman from gaining the benefit of the defence held out to her in s. 251(4)" (*ibid* at 70).

36. 2006 SCC 6 [*Multani*].

not agree on the proper approach. The rights claimant (Multani) argued that an absolute ban on the wearing of a kirpan was a clear violation of section 2(a) that must be justified under section 1. The Attorney General of Quebec as intervenor conceded there was an infringement of religious liberty in prohibiting the carrying of a kirpan. The Attorney General of Quebec argued that freedom of religion can be limited within section 2(a) itself: it is not an almost absolute right. The school board argued that freedom of religion was not infringed because the right guaranteed by section 2(a) “must be limited by imperatives of public order, safety, and health, as well as by the rights and freedoms of others.”³⁷ Justice Charron acknowledged: “[t]his Court has clearly recognized that freedom of religion can be limited when a person’s freedom to act in accordance with his or her beliefs may cause harm to or interfere with the rights of others”³⁸ She also pointed out that the Court in other *Charter* contexts has stressed the advantages of reconciling competing rights under section 1. To illustrate this preference, she quoted from *B(R) v Children’s Aid Society of Metropolitan Toronto*, “it appears sounder to leave to the state the burden of justifying the restrictions it has chosen. Any ambiguity or hesitation should be resolved in favour of individual rights.”³⁹ She noted that *Multani* did not involve the reconciliation of two constitutional rights and therefore a balancing under section 1 was more appropriate to the context.

It is significant that Justice Charron’s preference for balancing under section 1 was much dependent on the specific situation Multani captured, that is the balancing of an individual right against a state policy that the state should bear the burden of justifying. There was no other rights holder with a strong interest in the outcome of this case. While other students and staff at the school have an interest in a safe environment, this can be characterized as a generalized or diffuse interest without a specific constitutional framework to bring it to the fore. This represents a different scenario than a contest between two identifiable and obvious competing rights holders, as evidenced in the context of MAiD. Whether it would require a different methodology for resolving claims or not, a MAiD case would present a challenge to the classic case law.

In finding a violation of section 2(a) in *Multani*, Justice Charron summarized the test as follows: the claimant must demonstrate (1) that he or she sincerely believes in a practice or belief that has a nexus with religion, and (2) that the impugned conduct of a third party interferes, in

37. *Ibid* at para 25.

38. *Ibid* at para 26.

39. *Ibid*, citing [1995] 1 SCR 315 at paras 109-110, 122 DLR (4th) 1, Justice La Forest.

a manner that is non-trivial or not insubstantial, with his or her ability to act in accordance with that practice or belief.⁴⁰ This remains the governing approach to section 2(a) in the classic freedom of religion contest. In another significant decision on section 2(a), *Alberta v Hutterian Brethren of Wilson Colony*, then Chief Justice McLachlin, who wrote the majority reasons, began her judgment with a brief outline of what is meant by the phrase “more than trivial or insubstantial” in step one of the *Multani* test.⁴¹ At issue was a provincial law requiring photos on all driver’s licences. The Hutterite claimants argued it violated their freedom of religion to require photos, as their belief system prohibits the capturing of an individual’s image. Chief Justice McLachlin elaborated that in order for a violation of section 2(a) to be made out, “it would need to be shown that the claimants’ ‘religious beliefs or conduct might reasonably or actually be threatened’ by the universal photo requirement....*Evidence of a state-imposed cost or burden would not suffice*; there would need to be evidence that such a burden was ‘capable of interfering with religious belief or practice.’”⁴² This line of argument might become relevant in addressing the extent of any burden imposed by legislative requirements around MAiD. For example, the compromise of requiring an objecting physician to offer an effective referral to a non-objecting colleague might well be described as a “trivial” or insubstantial infringement of religious freedom; it might be a state-imposed cost or burden, but not one that interferes with religious belief or practice.⁴³ MAiD cases could offer the Court an opportunity to consider the boundaries of section 2(a) protection itself, before the state becomes involved in justifying limits under section 1.

2. *Institutional freedom of religion: faith-influenced institutions and MAiD*

In *Loyola*, the Court addressed the communal aspect of religious beliefs. It held that religious communities are protected by section 2(a), but the majority left open the question of whether a religious corporate entity could claim protection.⁴⁴ At issue in the case was a challenge from a private

40. *Multani*, *supra* note 36 at para 34.

41. 2009 SCC 37 at para 32 [*Hutterian Brethren*]. For a discussion on the need to clarify the non-trivial/not insubstantial language in step one of the *Multani* test, see Howard Kislowicz, “*Loyola High School v Attorney General of Quebec*: On Non-Triviality and the Charter Value of Religious Freedom” (2015) 71:13 SCLR 331.

42. *Hutterian Brethren*, *supra* note 41 at para 34 [emphasis added].

43. See discussion at note 71.

44. For a cogent analysis of the difference between the community and corporate aspect of communal protection, see JK Donlevy, Kevin P Feehan & Peter Bowal, “A Community’s Right to Freedom of Religion: *Loyola High School v Quebec*” in Dwight Newman, ed, *Religious Freedom and Communities* (Toronto: LexisNexis, 2015).

Catholic boys' school to a Quebec provincial curriculum requirement that mandates the teaching of world religions from a neutral and objective perspective. Pursuant to section 22 of the legislation, the Minister of Education can grant an exemption from the program requirements if the proposed alternative program is deemed to be "equivalent."⁴⁵ A majority of the seven-member bench held that it was unnecessary to decide whether institutions are protected by section 2(a) of the *Charter* as Loyola was entitled to administrative review of the Minister's decision not to grant an exemption in this case. The Minister is *Charter*-bound to exercise her discretion in a manner that "respects the values underlying the grant of her decision-making authority, including the *Charter*-protected religious freedom of the members of the Loyola community who seek to offer and wish to receive a Catholic education."⁴⁶ In urging the Minister to embrace *Charter* values, Justice Abella writing for the four-judge plurality noted: "[r]eligious freedom must therefore be understood in the context of a secular, multicultural and democratic society with a strong interest in protecting dignity and diversity, promoting equality, and ensuring the vitality of a common belief in human rights."⁴⁷ Religious freedom is therefore not absolute and unqualified from a *Charter* perspective. It is influenced and perhaps even defined by its interplay with other *Charter* values. In this case, the Court held that the Minister did not give adequate consideration to freedom of religion. The matter was remitted back for her reconsideration.

Then Chief Justice McLachlin and Justice Moldaver, on behalf of the remaining three judges, held in obiter that section 2(a) could extend to protecting institutional freedom of religion claims. They argued this was a necessary corollary to the individual and collective nature of religious expression. Many individuals express their sincerely held beliefs through their religious institutions: "[t]he individual and collective aspects of freedom of religion are indissolubly intertwined. The freedom of religion of individuals cannot flourish without freedom of religion for the organizations through which those individuals express their religious practices and through which they transmit their faith."⁴⁸ Obviously, context is key, and religious institutions are not entitled to the protection in all situations and for all purposes. This group of three judges fashioned a test for determining when section 2(a) can extend to an institutional claim:

45. *Loyola*, *supra* note 28 at para 1.

46. *Ibid* at para 34.

47. *Ibid* at para 47.

48. *Ibid* at para 94.

“On the submissions before us, and given the collective aspect of religious freedom long established in our jurisprudence, *we conclude that an organization meets the requirements for s. 2(a) protection if (1) it is constituted primarily for religious purposes, and (2) its operation accords with these religious purposes.*”⁴⁹

The judges left open the scope of this protection as meriting clarification in future cases. It was clear to them that regardless of the parameters, Loyola would fit the test: “[i]t is a non-profit religious corporation constituted for the purpose of offering a Jesuit education to children within Quebec’s Catholic religious community. It has operated for over a century in accordance with this religious educational purpose.”⁵⁰

Notably, in applying the test it fashioned for institutional protection, the minority deviated somewhat from the strictness of its own language. In application, it treated the two requirements (constitution and operation) as an “or” proposition, not an “and.” While the test requires an organization be “constituted primarily for religious purposes,” in considering the facts of this case, the minority only asked: “[i]s Loyola’s claimed belief that it must teach ethics and its own religion from the Catholic perspective *consistent with its organizational purpose and operation?*”⁵¹ In concluding it was, the minority stated that “Loyola’s belief in its religious obligation to teach Catholicism and ethics from a Catholic perspective *is consistent with its organizational purpose and operation.*”⁵² This emphasis on “consistency” with purpose is not the same as requiring an organization to be “constituted primarily for the purpose” in order to qualify for protection under section 2(a). If consistency with purpose is all that is required, it may be easier for an institution to argue its refusal to allow MAiD is legitimate. One could argue that a faith-influenced institution operates consistently if it defines its purpose as offering faith-influenced care. In other words, the way the minority applied its own test seems to allow more space for institutions to self-describe or self-define. The way the test is worded in the abstract suggests a more neutral or objective approach to assessing an institution’s purpose. For faith-influenced institutions, it is easier to satisfy a test for section 2(a) protection that does not require the institution to show it was constituted primarily for the purpose of providing faith-influenced care. It is also easier for the institution to self-define as operating within a faith tradition, as opposed to satisfying an objective assessment.

49. *Ibid* at para 100 [emphasis added].

50. *Ibid* at 101.

51. *Ibid* at 140 [emphasis added].

52. *Ibid* at 143 [emphasis added].

Loyola therefore offers the Court's first pass at the institutional question. Neither set of reasons suggests that a religious institution is entitled to section 2(a) protection in all contexts. The minority opens the door under restricted circumstances, though the contours of the boundaries of protection are uncertain. The majority leaves the question open, but suggests that religious freedom must be assessed in the context of other *Charter* values. If the majority view prevails, provinces would have an obligation to consider *Charter* values in any limits imposed or negotiated with institutions in the delivery of health services. In considering its role, governments would be guided by the Supreme Court's decision in *Mouvement laïque québécois v Saguenay (City)* on the state's duty of religious neutrality.⁵³

3. *State neutrality on religious matters*

The conflict in *Saguenay* arose after the Mayor of the city refused to stop opening council meetings with a public prayer and remove religious symbolism that adorned the chambers. A citizen who regularly attended meetings complained of a violation of his rights under sections 3 and 10 the Quebec *Charter of Human Rights and Freedoms*. Section 3 provides: "[e]very person is the possessor of the fundamental freedoms, including freedom of conscience, freedom of religion, freedom of opinion, freedom of expression, freedom of peaceful assembly and freedom of association."⁵⁴ Section 10 states: "[e]very person has a right to full and equal recognition and exercise of his human rights and freedoms, without distinction, exclusion or preference based on...religion. Discrimination exists where such a distinction, exclusion or preference has the effect of nullifying or impairing such right."⁵⁵ The Court described section 2(a) of the Canadian *Charter* as a companion to these rights and concluded that because of their similarity, the analyses should inform each other.⁵⁶ While there is no express duty for the state to remain neutral on matters of religion, such an obligation has evolved in both jurisprudence and scholarly analysis.⁵⁷ The Court concluded:

"When all is said and done, the state's duty to protect every person's freedom of conscience and religion means that it may not use its powers

53. 2015 SCC 16 [*Saguenay*].

54. *Charter of Human Rights and Freedoms*, CQLR, c C-12, s 3.

55. *Ibid* at s 10.

56. *Saguenay*, *supra* note 53 at para 67.

57. *Ibid* at paras 71, 73, citing *Congrégation des témoins de Jéhovah de St-Jérôme-Lafontaine v Lafontaine (Village)*, 2004 SCC 48 at paras 66-67, Justice LeBel; Richard Moon, "Freedom of Religion Under the Charter of Rights: the Limit of State Neutrality" (2012) 45:2 UBC L Rev 497 at 507.

in such a way as to promote the participation of certain believers or non-believers in public life to the detriment of others. It is prohibited from adhering to one religion to the exclusion of all others.”⁵⁸

Of particular significance for our purposes is the way the Court framed its approach to claims that the state has violated its duty to remain neutral. It held: “[i]n a case like this one in which a complaint of discrimination based on religion concerns a state practice, the alleged breach of the duty of neutrality must be established by proving that the state is professing, adopting or favouring one belief to the exclusion of all others...and that the exclusion has resulted in interference with the complainant’s freedom of conscience and religion.”⁵⁹ The Supreme Court has already determined that hospitals are “government actors” and therefore subject to the *Charter* when delivering provincially-regulated medical services. In *Eldridge v British Columbia (Attorney General)*, Justice LaForest held:

“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, upon defining its objective as guaranteeing access to a range of medical services, cannot evade its obligations under...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*.”⁶⁰

If hospitals are state agents as described in *Eldridge*, then an institutional decision not to provide MAiD can be characterized as a “government” decision. When that decision is made because of religious or conscientious reasons, and when the institution is claiming *Charter* protections for freedom of religion, this is a government position. *Saguenay* suggests this should not be permitted. A province that supports a faith-influenced institution that refuses to provide MAiD is arguably “adopting” or “favouring” the faith of the institution’s founders or Board of Directors to the exclusion of others. This constitutes a violation of the conscientious or religious rights of taxpayers who do not share the institution’s faith,

58. *Saguenay*, *supra* note 53 at para 76.

59. *Ibid* at para 83.

60. [1997] 3 SCR 624 at para 51, 151 DLR (4th) 577 [*Eldridge*]. *Eldridge* was distinguished from the context of *Stoffman v Vancouver General Hospital*, [1990] 3 SCR 483, 76 DLR (4th) 700 [*Stoffman*] where the Court held that a hospital’s governing Board of Directors was not subject to the *Charter* as a government entity when making decisions that do not implicate government policy. *Stoffman* concerned a challenge to mandatory retirement rules in the Board’s granting of hospital privileges. See Martha Jackman, “The Application of the Canadian Charter in the Health Law Context” (2001) 9:2 Health L Rev 22 at 24 for an analysis of why *Eldridge* means that the *Charter* applies to hospitals, physicians and other health care providers who act as agents for the state in delivering publicly-funded health care.

and cannot access a legal medical service in that institution. This is an interpretation of *Saguenay* that offers the broadest protection for a secular health care policy decision model. It is not however, the only way to look at the neutrality dilemma.

Richard Moon distinguishes between religious *values*, which may be supported by the state, and religious *practices* that demand neutrality.⁶¹ He argues that the state must remain neutral towards only religious belief systems that address spiritual or worldly matters and that are confined to the sphere of private life (like for example the proper forms of worship).⁶² On the other hand, where religious values are implicated in “worldly concerns or civic issues,” these must be debated on their merits, “on their conception of human good or public welfare.”⁶³ *Saguenay* and state neutrality under this divided view represents a more challenging way to approach the limits of faith in institutional health care. A faith-influenced institution could argue that MAiD is a “public welfare issue” around which there is legitimate and evident debate. The decision to decriminalize MAiD and its highly regulated delivery, reinforce that it is at least in part a political matter. A faith-influenced institution might be able to successfully argue in court that it represents not only the practices of religious communities that do not support MAiD, but also acts as a space where the debate over spiritual values can accommodate different viewpoints.

Ultimately, the concern over state neutrality leans towards the view that institutions that receive significant public funding not be governed by religious practices. As Moon argues, “[a] religious belief should not play a role in political decision-making if the action it calls for is spiritual in character (relating simply to spiritual concerns, or involving the worshipping or honouring of God).”⁶⁴ An institutional refusal to allow MAiD because the particular faith does not believe in it, sounds more like “worship” than politically legitimate debate over values and ethics.

III. *Application of jurisprudence to MAiD*

1. *Freedom of religion and the practice of medicine*

There has already been an unsuccessful court challenge to an effective referral requirement that considers the *Charter* rights of physicians and engages the issue of reconciling competing rights.⁶⁵ Five individual

61. Moon, *supra* note 57.

62. *Ibid* at 524.

63. *Ibid*.

64. *Ibid* at 520.

65. See *Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario*, 2019 ONCA 393 [CMDSC v CPSO].

physicians and several physician advocacy organizations challenged two policies of the College of Physicians and Surgeons of Ontario (the College) that require physicians with conscientious or religious objections to providing care make an effective referral to a non-objecting colleague. In Ontario, the College has opted for an “effective referral” regime to accommodate individual conscientious or religious objections to providing a service.⁶⁶ Policy 2-15 states:

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 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.⁶⁷

Policy 2-15 covers broad human rights and non-discrimination obligations, and was incorporated with identical wording into specific guidance on MAiD in Policy 4-16. The College sees an effective referral regime as the appropriate compromise between patient entitlement to legal medical services and the protection and support of physicians who have religious or conscience objections to the service:

In order to uphold patient autonomy and facilitate the decision-making process, physicians must provide the patient with information about all options for care that may be available or appropriate to meet the patient’s clinical needs, concerns, and/or wishes. *Physicians must not withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs.*

Where a physician declines to provide medical assistance in dying for reasons of conscience or religion, the physician must not abandon the patient. An effective referral must be provided. *An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, nurse practitioner or agency. The referral must be made in a timely manner to allow the patient to access medical assistance in dying. Patients must not be exposed to adverse clinical outcomes due to delayed referrals.*⁶⁸

66. For an analysis of the College’s policy in the context of reproductive services, see Daphne Gilbert, “Let Thy Conscience Be Thy Guide (but not *My* Guide): Physicians and the Duty to Refer” (2017) 10:2 McGill JL & Health 47.

67. *CMDSC v CPSO*, *supra* note 65 at para 18, citing the College of Physicians and Surgeons of Ontario, “Policy 2-15: Professional Obligations and Human Rights” (2015).

68. *CMDSC v CPSO*, *supra* note 65 at para 23, citing the College of Physicians and Surgeons of Ontario, “Policy 4-16: Medical Assistance in Dying” (2015) [emphasis added].

What is the freedom of religion argument for physicians to an effective referral regime? The main way that objections to referral are described is as a “complicity” offence.⁶⁹ Those who have strong conscientious and religious objections to performing a service (MAiD, abortion, providing contraception, etc) argue that referring a patient to another non-objecting physician still implicates the objector in that service. Objectors believe there is something “wrong” or “sinful” in the service and therefore refuse to be complicit in its delivery. The College expressly rejects a broad definition of “providing a service” and by implication dismisses the legitimacy of complicity-based objections to effective referral requirements. The MAiD policy includes this final caveat: “*the College does not consider providing the patient with an ‘effective referral’ as ‘assisting’ in providing medical assistance in dying.*”⁷⁰

The applicants argued the policy violated both sections 2(a) and 15 of the *Charter*. They lost at first instance on the basis that while the policy is a violation of freedom of religion, it is justified under section 1 of the *Charter*. The Divisional Court did not consider freedom of conscience and dismissed entirely the section 15 claim.⁷¹ The Ontario Court of Appeal agreed with the “thorough and cogent analysis” of the Court below and dismissed the appeal.⁷²

69. See Amy J Sepinwall, “Conscience and Complicity: Assessing Pleas for Religious Exemptions in Hobby Lobby’s Wake” (2015) 82:4 U Chicago L Rev 1897. See also Douglas NeJaime & Reva Siegel, “Conscience Wars in Transnational Perspective: Religious Liberty, Third-Party Harm, and Pluralism” in Susanna Mancini & Michel Rosenfeld, eds, *The Conscience Wars: Rethinking the Balance between Religion, Identity, and Equality* (United States: Cambridge University Press, 2018) 187 at 219. The authors conclude: “In seeking exemptions from laws that religious claimants assert make them complicit in sins of their fellow citizens, religious claimants may speak as a minority and yet assert what have long been the norms of the majority against those whose rights the law has only recently and fragily come to protect. Under these circumstances, limiting accommodation in ways that respect the convictions of the believer and one’s fellow citizens is the most pluralism-promoting path.” NeJaime and Siegel were writing in the context of complicity wars in what they term the “culture wars” over LGBTQ and abortion rights. Given how recently Canada legalized MAiD, it could well be argued to be a fragile “right.”

70. *CMDSC v CPSO*, *supra* note 65 at para 23, citing CPSO Policy, *supra* note 32 [emphasis added].

71. *The Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario*, 2018 ONSC 579. After noting (at para 117) that the parties devoted little attention to their section 15(1) claim during the hearing, the Divisional Court held there was no equality violation for three reasons. First (at para 129), the effective referral policy is an attempt to take the specific concerns of the objectors into account; second (at para 130), the policy has an ameliorative effect for vulnerable groups seeking medical services; and third, the Court concluded (at para 131), “The burdens imposed on objecting physicians, for whom the options for compliance with the effective referral requirements of the Policies are not satisfactory, pertain ultimately to the nature of their practice of medicine. It is important in this context to note that there is no constitutionally protected right to practice medicine as discussed further below.” The Court of Appeal agreed with the Divisional Court’s reasoning noting that while the appellants renewed their section 15(1) objections in their facts, it was not raised in oral argument (*CMDSC v CPSO*, *supra* note 65 at para 90).

72. *CMDSC v CPSO*, *supra* note 65 at para 8.

In determining that an effective referral policy violates section 2(a), the Court disagreed with the College's position that any interference with freedom of religion is trivial or insubstantial. Justice Strathy, for the Court, noted:

While it is true that s.2(a) is internally limited, that not all religious conduct is protected by the *Charter*, and that context is important in considering whether interference with religious freedom is "trivial or insubstantial", the specific contextual features identified by the College are more relevant to the proportionality analysis under s.1.⁷³

The Court agreed that some of the individual appellants are not free to practice medicine in accordance with their religious beliefs because of the effective referral requirement, and that the specific context of their self-regulated profession is better addressed under minimal impairment and in the final balancing under section 1.⁷⁴ This reasoning suggests that courts are wary of engaging in a robust analysis under section 2(a) as to the scope and limits of freedom of religion, preferring to consider only whether the belief is sincere before moving on to section 1. Given the evidential burden that would be placed on challengers to refute an allegation that a breach of rights was only "trivial or insubstantial," shifting the analysis to section 1 makes sense in cases where it is clear there is at least some evident encumbrance on religious freedom.

Justice Strathy next considered section 1 arguments, concluding that the pressing and substantial objective of the policy is, as argued by the College and found by the Divisional Court, "the facilitation of equitable [patient] access to [health care] services."⁷⁵ In the reasons that follow, the Court relied to a substantial degree on the submissions of the intervenors, and in particular LEAF, Dying with Dignity Canada and the Canadian HIV/AIDS Legal Network. The work of the intervenors was evident in the Court's focus on the equality interests of particularly vulnerable patients who may be even more reliant than others on an effective referral model.⁷⁶ A policy of effective referral is rationally connected to facilitating equitable access to services as a matter of "logic and common sense."⁷⁷

With respect to minimal impairment, the Court contextualized the claim in two significant ways. First, it located the role of the appellant

73. *Ibid* at para 77.

74. *Ibid*. The Court concluded that the evidentiary record was insufficient to support an analysis of freedom of conscience and that it was inappropriate to explore the contours of that clause in a case with robust evidence (*ibid* at para 85).

75. *Ibid* at para 101.

76. *Ibid* at para 107.

77. *Ibid* at para 113.

physicians as “gatekeepers” and a “key point of access” to the services in question for a majority of patients.⁷⁸ Given how difficult it can be to find a family physician in Canada, and since for most patients, their family doctor is key to navigating a complex system of specialists and follow-up treatment, effective referral policies protect patients who depend on their family doctor for coordination of care and initial counselling and information provision. The second important context was the nature of the services to which the appellants objected. In addition to MAiD, the appellants objected to providing effective referrals for other services including, “abortion, contraception (including emergency contraception, tubal ligation, and vasectomies), infertility treatment for heterosexual and homosexual patients, prescription of erectile dysfunction medication, [and] gender re-assignment surgery”⁷⁹ The Court accepted that these issues are difficult for patients to raise and discuss, and noted that it “is impossible to conceive of more private, emotional or challenging issues for any patient.”⁸⁰ Abortion and MAiD in particular, “carry the stigmatizing legacy of several centuries of criminalization grounded in religious and secular morality.”⁸¹ The combination of stigma and the vulnerability of patients in need of the services⁸² heightens the importance of the family physician’s gatekeeper role. Given that context, the effective referral policy was minimally impairing.

The appellants advocated for a “self-referral model” as less-impairing than an effective referral policy.⁸³ They argued that having a centralized government agency with lists of MAiD providers would allow patients to make direct contact for a referral, without the objecting physician acting as a go-between. The only obligation on a physician would be to provide the phone number or website for the agency. The Court of Appeal agreed with the court below that a self-referral model entails a real risk that vulnerable patients will have delayed or no access to the requested

78. *Ibid* at paras 118, 124.

79. *Ibid* at para 121.

80. *Ibid*.

81. *Ibid* at para 123.

82. While all patients are vulnerable in the balance of power with their physician, the Court emphasizes the particular vulnerability of certain groups including, “patients with financial, social, educational or emotional challenges; patients who are old, young, poor or addicted to drugs; patients with mental health challenges or physical or intellectual disabilities; patients facing economic, linguistic, cultural or geographic barriers; and patients who do not have the skills, abilities or resources to navigate their own way through a vast and complicated health care system” (*ibid* at para 121). Clearly this represents a large fraction of many family medicine practices.

83. *Ibid* at paras 126-127. Self-referral might include a public information line with information or a coordination service or registry.

medical services.⁸⁴ It pointed out that the fundamental weakness in the appellant's proposed alternatives to effective referral was the same as identified by the majority of the Supreme Court of Canada in *Hutterian Brethren*, that is "the alternatives proposed by the appellants and some of the intervenors are directed to minimizing the burden of the Policies on objecting physicians, not to advancing the goal of equitable access to abortion, MAiD, contraception and sexual and reproductive health care."⁸⁵ In analysing the salutary and deleterious effects of the policy, the Court found "much assistance" in the arguments of Dying with Dignity Canada, which emphasized that "patients should not bear the burden of managing the consequences of physicians' religious objections."⁸⁶ Interestingly, the Court noted that this compromise of effective referral is not optimal for patients, who lose the support and personalized care of their primary physician at a time of great vulnerability and stress.⁸⁷ No party to the case argued that objectors should not be accommodated in any way, so it is of note that the Court acknowledged that even an effective referral model constitutes a harm to some patients.⁸⁸

The CPSO decision represents a victory for patient interests. The unanimous decision, written by Justice Strathy, is well-reasoned and follows an equally strong Divisional Court judgment. It should bolster similar policies in provinces that use the language of "effective transfer of care"⁸⁹ and it serves as a compelling basis for challenging policies like that of Manitoba which expressly permit physicians not to refer patients.⁹⁰ It is helpful that the Court concentrated its analysis on equality of access to the services in question, and its reference to stigma and vulnerability are

84. *Ibid* at para 128.

85. *Ibid* at para 157.

86. *Ibid* at para 185.

87. *Ibid* at para 187.

88. In the United Kingdom, the decision on whether to accommodate religious or conscience beliefs is guided by the "Liberal Model of Conscientious Exemptions." This model has three defining criteria

- A. The liberal state should generally refrain from passing moral judgement on the content of the beliefs which give rise to a claim for conscientious exemption;
- B. The liberal state should neither privilege nor disadvantage religious beliefs over non-religious ones when considering whether to grant a conscientious exemption; and
- C. The liberal state should grant conscientious exemptions to claimants who sincerely hold a religious or non-religious conscientious objection which would not disproportionately impact on the rights of others or the public interest.

Point "C" and the reference to "disproportionate impact" is evocative of our section 1 analysis and reinforces that a patient's interest in access to MAiD must be taken into account in balancing religious or conscience rights. See John Adenitire, "Conscientious Exemptions in a Liberal State" in John Adenitire, ed, *Religious Beliefs and Conscientious Exemptions in a Liberal State* (Hart Publishing: Oxford, 2019) 247.

89. See e.g. CPSO Policy, *supra* note 32 at 5.

90. CPSM Standard, *supra* note 30.

helpful to the symbolic arguments in favour of effective referral. While Strathy JA focused on the practical consequences of delayed or no access, his argument is equally applicable to the less tangible consequences of broad religious or conscientious objector protections. Physicians occupy a privileged space in a relationship with patients, with considerably more power and specialized knowledge. For many patients, a physician's objection to providing legally-available services will be experienced as judgment for requesting that service. To allow a physician to opt out of caring for a vulnerable patient may mean that the patient does not feel justified in wanting the particular service, may be ashamed of having made the request in the first place, and may have heightened shame at having to ask again. The symbolic statement of moral and/or ethical disapproval is made explicit and stands as a strong disincentive for pursuing a course of treatment.

The *CPSO* decision may also be helpful in the broader context of refusals to provide care by faith-influenced institutions.⁹¹ While the case centered on individual physicians and the accommodations accorded to them, much of the language and reasoning is equally applicable in an institutional context. It is also true that an effective referral model for individual physicians is meaningless for hospitalized patients in faith-influenced institutions that refuse to allow MAiD to be performed by any physician on the premises.

2. *Faith-influenced institutions and refusal to treat*

If the case were litigated, publicly-funded Catholic or other faith-influenced institutions would be unlikely to meet the minority decision which set out the *Loyola* test for institutional section 2(a) protection.⁹² Their mandate as health care providers would likely not satisfy either step. A hospital is not constituted "primarily for religious purposes." The mission statements of Catholic hospitals do not suggest otherwise. For example, St. Michael's Hospital in Toronto describes itself this way:

91. Since the decision in *CMDSC v CPSO*, *supra* note 65, members of Ontario's Progressive Conservative party have voiced their support for legislating measures to protect the conscience rights of Ontario's healthcare providers, though the government has yet to provide details on the content or timeline of such measures. See Victoria Gibson, "Ontario PC Members Rubber Stamp Call for Conscience Rights Legislation as New Federal MAiD Bill Rolls Out," *iPolitics* (26 February 2020), online: <ipolitics.ca> [https://perma.cc/YRK8-2KEU].

92. As set out in text accompanying *supra* note 28. That test requires that to claim institutional 2(a) protection an organization must show that (1) it is constituted primarily for religious purposes, and (2) its operation accords with these religious purposes. This assumes the entire Court adopted the views of the *Loyola* minority. Of course, it could fashion a different test.

St. Michael's Hospital is a Catholic teaching and research hospital founded by the Sisters of St. Joseph in 1892 to care for the sick and poor of Toronto's inner city....As downtown Toronto's adult trauma centre, the hospital is a hub for neurosurgery, complex cardiac and cardiovascular care, diabetes and osteoporosis care, minimally invasive surgery and care of the homeless and disadvantaged. St. Michael's is also one of the province's major sites of care for critically ill patients.⁹³

Other than identifying itself as a Catholic institution, its mission statement contains only this reference to any spiritual mission: “[p]roviding exemplary physical, emotional and spiritual care for each of our patients and their families.”⁹⁴ Similarly, the Bruyère Centre in Ottawa has this Mission Statement:

We excel in the provision of evidence based health care and services for the vulnerable and medically complex, with a focus on persons who require sub-acute, geriatric or palliative care. Inspired by our founder, Mother Élisabeth Bruyère, we are a Catholic health care organization that optimizes the quality of life of people within the diverse community we serve in French and English. We do this through our commitment to excellence, education, research and innovation, regional partnerships, and bringing care closer to home.⁹⁵

93. “Who we Are” (2019), online: *St. Michael's Hospital* <www.stmichaelshospital.com> [<https://perma.cc/K76U-WRB7>].

94. “Strategic Plan 2015-18” (2015) at 7, online (pdf): *St. Michael's Hospital Academic Family Health Team and Department of Family and Community Medicine* <www.stmichaelshospital.com> [<https://perma.cc/4H8K-RYA6>]. The full mission statement is:

“St. Michael's Hospital is a Catholic academic health care provider, fully affiliated with the University of Toronto and committed to innovative patient care, teaching and research. Established in 1892 by the Sisters of St. Joseph to care for the sick and poor, St. Michael's Hospital remains dedicated to treating all with respect, compassion and dignity.

At St. Michael's Hospital, we recognize the value of every person and are guided by our commitment to excellence and leadership. We demonstrate this by:

- Providing exemplary physical, emotional and spiritual care for each of our patients and their families
- Balancing the continued commitment to the care of the poor and those most in need with the provision of highly specialized services to a broader community.
- Building a work environment where each person is valued, respected and has an opportunity for personal and professional growth
- Advancing excellence in health services education
- Fostering a culture of discovery in all of our activities and supporting exemplary health sciences research
- Strengthening our relationships with universities, colleges, other hospitals, agencies and our community
- Demonstrating social responsibility through the just use of our resources

The commitment of our staff, physicians, volunteers, students, community partners and friends to our mission permits us to maintain a quality of presence and tradition of caring—the hallmarks of St. Michael's” (*ibid*).

95. “Mission, Vision and Values” (2019), online: *Bruyère* <www.bruyere.org> [<https://perma.cc/QM3C-3TRZ>].

These two institutions are reflective of Catholic hospitals across the country. While situated in a historic attachment to Catholic founders, and linked as a network of “Catholic health care providers” under various umbrella organizations,⁹⁶ Catholic hospitals provide care within a national health care strategy governed by the *Canada Health Act*.⁹⁷ In *Loyola*, the four-person plurality judgment did not decide whether institutions could claim section 2(a) protection but, as quoted above, Justice Abella more broadly understood religious freedom as contextual and as co-existing with equality rights and human rights, in a secular society.⁹⁸ The reasons why the minority found it an obvious case for *Loyola* was that its primary mission was to live out the reasons for its foundation: to offer private Catholic education to boys. The curriculum was designed to pass on the teaching of Catholicism (hence its successful *Charter* challenge to the Minister’s decision on enforcing a “neutral” provincial curriculum). Faith-influenced institutions no doubt share a common historic commitment to serving impoverished and vulnerable communities, but the *Loyola* court’s reasoning that religious communities sometimes require institutions or collectives to bring faith alive does not fit with the broad, inclusive, scientific and public nature of government-regulated health care. Catholic hospitals are not organized to give Catholics a community or collective opportunity to live out their spiritual needs, and they do not primarily fulfill that purpose as medical institutions. Esau describes the reason why *Loyola* is deserving of community religious protection as stemming from this view of the educational impact of private religious schools:

“Education at religious schools is not about taking a number of defined courses and getting a degree, but is rather about a transformative journey, where the extra-curriculum is as important at the curriculum, and where the experience is relational. The student is not alone on a path, but rather is part of a community travelling the path together.”⁹⁹

These considerations are not as strong (or arguably present at all) in faith-influenced institutions. While such an institution might argue that for terminally-ill patients, the journey to death in hospital is transformative, the lack of spiritual uniformity in staff, the fact that many patients do not choose what hospital they end up in, and the fact that patient choice might

96. See e.g. “About CHSO,” online: *Catholic Health Sponsors of Ontario* <<http://chco.ca>> [<https://perma.cc/E9ZQ-DZC4>]; “About Us” (2009), online: *Catholic Health Alliance of Canada* <www.chac.ca> [<https://perma.cc/8UWR-9HXB>].

97. RSC 1985, c C-6.

98. *Loyola*, *supra* note 28 at para 47.

99. Alvin Esau, “Collective Freedom of Religion” in Dwight Newman, ed, *Religious Freedom and Communities* (Toronto: LexisNexis, 2015) 77 at 85.

be more influenced by where their physician has privileges, all suggest that hospitals operate quite differently from schools.

Further, it is likely a court would find that hospitals do not operate sufficiently in accordance with religious purposes, as required by the second step of the minority's *Loyola* test. It is incontrovertible that faith-influenced institutions continue a legacy of care for the sick and the poor that stretches back for centuries. St. Michael's offers this "Affirmation Statement" of its inclusivity:

To acknowledge the needs of the communities we serve, St. Michael's reiterates our longstanding commitment to affirm and protect the right to accessible, inclusive, secure, and respectful health care for all patients, including people living with HIV/AIDS, lesbians and gay men, their partners and families, the poor, the homeless, persons with disabilities and people with mental illnesses. It is the mission and tradition of St. Michael's to provide compassionate care in a welcoming environment, embracing all races, cultures, classes, beliefs, ages, genders and sexual orientations.¹⁰⁰

This Affirmation Statement echoes back to the religious foundation of hospitals as ministries to the poor and vulnerable, a powerful and laudable history for Catholic institutions.

Despite this legacy, it is difficult to reconcile this Affirmation Statement with an argument that the hospital is operating in accordance with a religious *purpose*. The roots of care may well be informed by a religious tradition, but the purpose of a hospital in a modern health-care context is guided by scientific research, professional norms, non-discrimination, economics, and broad public policy goals. Compassion, spiritual support, and care for the vulnerable and sick are a significant part of what a faith-influenced hospital strives to deliver, but its purpose is more strongly aligned with that of secular hospitals—to provide the most advanced, efficient, cutting-edge treatment with professionalism, science and ethical health policy at the centre.

On the other hand, there is no doubt that Catholicism holds the sanctity of life as a foundational spiritual belief. Faith-influenced hospitals may argue that this basic premise is at the core of their ethos on best practices in providing medical care. The sanctity of life could be an operating or guiding principle of how health care is organized and delivered in these institutions. If the minority test fashioned in *Loyola* is taken up by a future court decision, and if the Court relies on an interpretation of the

100. "Affirmation Statement" (2019), online: *St. Michael's Hospital* <www.stmichaelshospital.com> [<https://perma.cc/822N-G5PJ>].

test that focuses on how consistently an institution operates within its stated purpose, faith-influenced hospitals may be legally strengthened in their insistence to a right to deny MAiD on their premises for religious or conscientious reasons.

In the *Carter* hearing before the Supreme Court, some religious intervenors put forward a variant of this position. The Catholic Health Alliance of Canada (the Alliance) argued:

“Faith-based health-care institutions are, by their very nature, religious. They are confessional. They are founded on religious principles by religious individuals, leaders, organizations or orders for expressly religious purposes. Faith-based health-care institutions, such as those represented by the Alliance, are extensions of the Church and manifestations of a religious community.”¹⁰¹

The Alliance further argued that there is no difference between the Catholic institution and the individuals who serve in it.¹⁰² It is clear from the intervenor facta in *Carter* on this point that Catholic hospital bodies anticipated a future need to take an institutional stand on the issue. Resolving the question might require the Supreme Court to take a firm position on whether and when institutions can claim a section 2(a) right. It would also have to decide whether a faith-influenced hospital is, as Loyola College was, operating within a primarily religious purpose.¹⁰³

3. *Reconciling competing rights*

In order to assess the scope of impact of an objecting physician and/or institution, one must envision a hypothetical challenge. How will this issue get to court to be resolved on a judicial level? There are two likely scenarios. The first sees an objecting physician bringing a *Charter* challenge to effective referral obligations promulgated by a provincial regulatory authority, as has already happened in Ontario in the unsuccessful bid to overturn a College of Physicians and Surgeons policy requiring an effective referral.¹⁰³ This kind of challenge by a physician involves a proactive freedom of religion claim, with the responding regulatory authority justifying the government position as a reasonable limit. Patients are third parties with no formal role in the legal process.

Another way this issue could get to court would be by way of a patient admitted to a faith-influenced institution and then forced into a transfer because of a refusal to perform MAiD. This kind of challenge brings

101. *Carter*, *supra* note 1 (Factum of the Catholic Health Alliance at para 27), online: <www.scc-csc.ca> [<https://perma.cc/XTN6-SJX7>].

102. *Ibid* at para 26.

103. *CMDSC v CPSO*, *supra* note 65.

patient interests front and centre as the institution would be defending on the grounds of religious freedom. This would raise an interesting dilemma for a provincial government. In the provision of medical services, hospitals are considered government entities, as they deliver a publicly-funded service.¹⁰⁴ The government therefore would need to take a position on whether it supports a faith-influenced institution's religious freedom in refusing to provide MAiD. If it did not support the institution's view on this, it could intervene in the court challenge, but would need to indicate its preferred remedy. As a party or intervenor, the government would be limited by the dictates of state neutrality as set out in *Saguenay*, which is outlined above.¹⁰⁵ This kind of case has yet to materialize.

Either scenario asks courts to grapple with the reconciliation of competing *Charter* rights. Patients have section 7, section 15 and section 2(a) rights to legally-available and appropriate medical treatment. Security of the person encompasses not only bodily integrity but also protects patients from undue state-imposed psychological stress. The denial of treatment that is clinically warranted undoubtedly qualifies as a violation of security of the person. Section 15 dictates that patients not face discrimination based on their disability, which could extend to a denial of MAiD on moral or ethical grounds leaving a person with a disability with no choice but to continue suffering. Finally, as Justice Wilson noted in *Morgentaler*, patients have section 2(a) freedom of conscience rights when it comes to making decisions of profound and private importance. The choice to die has to be one of the most profound decisions of one's life. It is for the patient's conscience to dictate the choice, not the physician's. And yet, the practice of medicine puts physicians in difficult positions when patients want to pursue options that a physician thinks are immoral or unethical. We expect medical professionals to act with professionalism and compassion, and some physicians strongly believe that these qualities include practicing according to a set of religious or conscientious beliefs or values. The reconciliation of patient and physician rights is no easy task.

The Supreme Court's leading case on the reconciliation of competing *Charter* rights is *R v NS*¹⁰⁶ which considered when, if ever, a witness must remove a niqab when testifying. The Court characterized the issue as requiring an assessment of two competing *Charter* rights: section 2(a) freedom of religion (for the witness) and the right to make full answer

104. *Eldridge*, *supra* note 60 at para 51.

105. *Saguenay*, *supra* note 53.

106. 2012 SCC 72 [NS].

and defence (for the accused), protected by sections 7 and 11(d).¹⁰⁷ The majority noted, “our 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.”¹⁰⁸ In justifying a contextual approach instead of a strict rule, the majority argued “[t]he need to accommodate and balance sincerely held religious beliefs against other interests is deeply entrenched in Canadian law. For over half a century this tradition has served us well. To depart from it would set the law down a new road, with unknown twists and turns.”¹⁰⁹ In *NS*, accommodation of religious rights led to the requirement of a hearing in every case on whether the salutary effects of making a witness remove a niqab outweigh the deleterious effects. The reasoning of the majority emphasized the historic and present-day importance of religion and the primacy of accommodation. The case suggests that a failure to accommodate religion in the face of a competing *Charter* claim will only be countenanced if there is no compromise position. Freedom of religion is not to be easily sacrificed, even where there are vital interests in the balance.

In the context of MAiD, the *NS* framework requires legislators and courts to give real effect to conscientious objection. It also provides some guidance in fulfilling this deceptively simple statement in *Carter*: “we underline that the *Charter* rights of patients and physicians will need to be reconciled.”¹¹⁰ In lay terms, the dictionary definition of “reconcile” offers: “to make consistent or congruous.”¹¹¹ Synonyms include conciliate, conform, coordinate, harmonize.¹¹² The key in other words is the balancing of two interests to come to a mutual solution. Full access to MAiD (for those who qualify) must co-exist with the rights of physicians who do not want to participate in the process. Provincial regulatory bodies, the Colleges, have all endeavoured to strike the appropriate balance, as discussed above. The more difficult compromise centers on institutional objections which operate more like bans than accommodation. It is beyond the purview of the legal analysis offered here to engage with the complex ethical literature on MAiD. It is notable however that scholars in that field

107. *Ibid* at para 7.

108. *Ibid* at para 52. The majority relied on the precedent case *Dagenais v Canadian Broadcasting Corp*, [1994] 3 SCR 835, 120 DLR (4th) 12, further refined in *R v Mentuck*, 2001 SCC 76.

109. *NS supra* note 106 at para 54.

110. *Carter, supra* note 1 at para 132.

111. “Reconcile” (2019), online: *Merriam-Webster* <www.merriam-webster.com> [<https://perma.cc/PFP4-D9BW>].

112. “Thesaurus: Reconcile” (2019), online: *Merriam-Webster* <www.merriam-webster.com> [<https://perma.cc/GUZ5-P789>].

argue much more work should be done to consider what an appropriate response might be to conscientious or religious objectors:

An important feature of ethical reasoning is to make explicit absolute moral duties that are mutually exclusive through consideration of all the values, rights, and duties involved in an ethical decision. From our analysis it appears that there are at least two conflicting duties for any conscientious objector to MAID: 1) the duty to respect the patient's right to life, liberty and security of the person, and 2) the freedom of religion or conscience. The moral difficulty is that simply asserting a conscientious objection to MAID does not automatically justify the normative conclusion that this conscientious objection should be respected. The assertion of a conscientious objection is simply the acknowledgement that there are conflicting duties.¹¹³

The Supreme Court decision in *Law Society of British Columbia v Trinity Western University* offers additional helpful guidance in assessing whether an institution might be able to claim freedom of conscience and religion rights.¹¹⁴ Trinity Western University (TWU) is an evangelical Christian post-secondary institution that wants to open a law school. As a condition of admission, it requires its students and faculty to adhere to a religiously-based code of conduct, the Community Covenant Agreement (Covenant), which prohibits “sexual intimacy that violates the sacredness of marriage between a man and a woman.”¹¹⁵ The Covenant would prohibit same sex intimacy and sex outside of marriage throughout the three years of law school, even when students are off-campus in the privacy of their own homes. The professional regulator in British Columbia voted not to accredit TWU as an approved law school because of the Covenant. The university responded with a challenge to this decision as a violation of its section 2(a) rights.¹¹⁶

In assessing the section 2(a) claim, the Court found it unnecessary to consider whether TWU possesses an institutional right to *Charter*

113. Timothy Christie, John Sloan, Dylan Dahlgren & Fred Koning, “Medical Assistance in Dying in Canada: An Ethical Analysis of Conscientious and Religious Objections” (2016) 5 *Bioéthique* Online 1 at 6. The authors conclude: “Given this ethical dilemma, professional organizations like the Catholic Health Association, the Canadian Medical Association, and the Federal, Provincial, Territorial, Expert Group on Physician Assisted Dying should complete their work. To date, they have simply articulated one side of the argument, deriving a normative conclusion without any normative justification. Furthermore, they have proposed a pragmatic solution that attempts to generate a “win-win” situation for everyone. Unfortunately, the result of this pragmatism is that the ethical dilemma remains unanalyzed” (*ibid* at 9).

114. 2018 SCC 32 [*TWU*].

115. *Trinity Western University v The Law Society of Upper Canada*, 2016 ONCA 518 at para 23 [*TWU v LSUC*].

116. *Trinity Western University v Law Society of British Columbia*, 2015 BCSC 2326 at para 1.

protection.¹¹⁷ The majority offered this observation as to the scope of protection offered by the *Charter*: “[f]or many religions, community is critical to manifesting faith. Whether through communal worship, religious education, or good works, the community is often the public face of religion. In other words, it is how the religion engages with the world.”¹¹⁸ Notably however, the majority concluded:

While acknowledging this communal aspect, I underscore that religious freedom is premised on the personal volition of individual believers. Although religious communities may adopt their own rules and membership requirements, the foundation of the community remains the voluntary choice of individual believers to join together on the basis of their common faith. Therefore, in the context of this appeal, I would decline to find that TWU, as an institution, possesses rights under s. 2(a). I note that, even if TWU did possess such rights, these would not extend beyond those held by the individual members of the faith community.¹¹⁹

There are two important aspects to this conclusion in assessing whether section 2(a) protects institutional rights. First, the majority is careful to specify that its conclusion is made “in the context of this appeal.” This leaves open the question of whether a different set of facts might warrant a broader institutional rights approach.

Second, the majority suggests that even institutional rights would not extend “beyond those held by the individual members of the faith community.”¹²⁰ Both Loyola and TWU are educational institutions with a mission to serve students who choose those schools in part because of their shared religious convictions. Both schools incorporate religious teachings

117. *TWU*, *supra* note 114 at para 61.

118. *Ibid* at para 217.

119. *Ibid* at para 219. The dissenting judgments had this to say about institutional *Charter* protections: “While it may not be necessary to determine whether TWU, *qua* institution, enjoys a right to religious freedom in its own right for the purposes of this appeal...in our view, ensuring full protection for the ‘constitutionally protected communal aspects of...religious beliefs and practice’ requires more than simply aggregating individual rights claims under the amorphous umbrella of an institution’s ‘community’....That being said, for the purposes of this appeal we adopt the majority’s description of the rights-holder as the ‘TWU community’” (*ibid* at para 315).

120. *Ibid* at para 219. The majority’s comment seems to reject the “moral-association” account of institutional conscience. In her paper, “Identifying the Institutional Religious Freedom Claimant” (2018) 95:3 *Can Bar Rev* 707, Kathryn Chan canvasses two competing accounts of institutional conscience that could justify extending 2(a) freedom to institutions. The first, “mission-operation theory,” understands an institution as having a conscience that is expressed through its mission and structure. The second, “moral-association theory” sees institutions as the means through which individuals express their moral convictions. Without endorsing the approach, Chen concludes that the “moral-association” theory provides a stronger basis for a constitutional claim, noting that the *Loyola* decision seems to reveal the SCC’s preference for a “mission-operation” theory. For further discussion on conceptions of corporations and institutional freedom of religion claims, see Howard Kislowicz, “Business Corporations as Religious Freedom Claimants in Canada” (2017) 51:2-3 *RJT* 337.

as a core component of the design of curriculum, the admission of students, and the overall educational mission. In considering a challenge to MAiD, hospitals do not share the same kind of cohesive, religiously-based mission as private educational institutions. They are not made up of a uniform staff, nor do they serve a primarily religious constituency. Patients do not necessarily (and perhaps even rarely) choose their hospital based on its religious affiliations. The difference between a private school and a public hospital might be stark enough to warrant a different conclusion as to whether section 2(a) protection extends to hospitals, even if the Supreme Court conclusively decides that in some situations institutions can claim freedom of religion.

On the other hand, the dissenting judgment in *TWU* may be influential if a case arises that squarely addresses institutional rights. The dissent noted the difficulty in adjudicating cases involving competing rights and was critical of the framework established by Justice Abella's decision in *Loyola*.¹²¹ The dissent argued that conflicting rights cases are challenging because "the stakes for parties are sometimes not fully appreciable by those who do not share their experiences."¹²² The dissent was particularly concerned about a framework that suggested that *Charter* values have an as important, even equal, position to *Charter* rights in analysis. The dissent argued: "[w]e are in agreement with the Chief Justice and our colleague Rowe J. that *Charter* values do not receive independent protection under the *Charter*. In our view, and for several reasons, resorting to *Charter* values as a counterweight to constitutionalized and judicially defined *Charter* rights is a highly questionable practice."¹²³ To the extent that a case on faith-influenced hospitals is framed as a contest between an institutional freedom of religion right versus *Charter* values around equality of access to publicly-funded care, it could be that a Court is more sympathetic to a specific rights claim. It would be important then for challengers to argue that there are specific *Charter* rights in opposition to any claimed by faith-influenced institutions. Patients and their physicians have *Charter* conscience rights for example, to determine the path of care with legally available options. Patients have equality rights not to be discriminated against on the basis of their own religious or conscientious beliefs that permit MAiD.

Loyola and *TWU* offer important yet ambiguous guidance to provinces as they grapple with what advice and/or direction to give faith-influenced

121. *TWU*, *supra* note 114 at para 266.

122. *Ibid* at para 264.

123. *Ibid* at para 307.

institutions on the issue of MAiD. While it may be a fair compromise for a professional regulatory body to allow individual physicians to offer an effective referral (rather than compel performance) for services they object to on a conscience or religious basis, this is an inadequate accommodation for a hospital. Many faith-influenced institutions now take the position that they will transfer care to secular institutions for patients needing information about MAiD. In Ottawa, for example, the Bruyère Centre represents the largest palliative care provider in the city.¹²⁴ Its refusal to allow MAiD to be performed on premises requires patients to leave the institution to find new places in which to die. Patients may also deny themselves access to crucial palliative care for fear of being trapped in an institution that will not perform MAiD, if their situation worsens or becomes intolerable. These are cruel choices for patients constitutionally entitled to access this medical service. It is one thing for patients (and their families) to adapt to a new non-objecting physician. It is another thing entirely to have to move institutions, encounter an entirely new staff, and possibly end up further from support systems and family members. Some patients will find the transfer physically challenging or impossible.¹²⁵

Further, given that staff at faith-influenced institutions like Bruyère are not necessarily Catholic, or not necessarily objecting to MAiD, it is arguably an infringement on their medical judgment and sense of ethics and conscience to deny them the opportunity to provide a service they may have a profound sense is appropriate and clinically warranted in the circumstances. It is true that not all hospitals perform all procedures. Specialized centres are common in larger cities and doctors with particular talents may attract patients who travel for difficult procedures. MAiD is not clinically difficult and it is not expensive.¹²⁶ It is hard to conceive of a hospital that is not clinically competent to provide MAiD. In any event, the argument that hospitals should be allowed to specialize is one grounded in efficiency and competence, and the same rationales do not apply to a refusal to provide services for religious or conscientious reasons.¹²⁷ It

124. Elizabeth Payne, "Ottawa's Biggest Palliative Care Hospital says it Won't Offer Assisted Dying," *Ottawa Citizen* (29 February 2016), online: <www.ottawacitizen.com> [<https://perma.cc/E2A9-L6KA>].

125. See e.g. Tom Blackwell, "B.C. Man Faced Excruciating Transfer After Catholic Hospital Refused Assisted Death Request," *National Post* (27 September 2016), online: <www.nationalpost.com> [<https://perma.cc/DE36-V9TA>]; Chris Purdy, "Patient has Assisted-Death Assessment on Sidewalk Outside Catholic Hospital in Edmonton," *The Globe and Mail* (23 October 2018), online: <www.theglobeandmail.com> [<https://perma.cc/H59Y-V7VS>].

126. See Aaron J Trachtenberg & Braden Manns, "Cost Analysis of Medical Assistance in Dying in Canada" (2017) 189:3 CMAJ E101 at E103. The authors found the cost of the medications administered during MAiD to be as little as \$25.40.

127. Shaad and Shaad, *supra* note 5 at 214, argue that there are legitimate non-conscience reasons

would be a novel but interesting claim for a non-objecting physician with privileges at a faith-influenced institution to argue a violation of section 2(a) *Charter* rights for an inability to follow his or her conscience in the practice of medicine. A claimant could reasonably articulate a sincere belief that patients should be allowed the autonomy and dignity of a death of their own choosing. This has been argued in the United Kingdom in scholarly writing on the impact of the *Carter* decision for MAiD and the European Convention on Human Rights (ECHR). Adenitire argues that section 9 of the ECHR (which protects freedom of conscience and religion) might offer protection against criminal prosecution for an assisted death as, “[i]n fact, it is entirely plausible that a doctor may provide assistance in dying to a non-related person, not for personal gain, and out of a conscientious conviction that assisted dying is not only morally permissible but, in some tragic cases and when explicitly requested, morally required.”¹²⁸ Since MAiD is legal in Canada, a doctor who believes a patient to qualify, and facing that choice from the patient, suffers a non-trivial harm to his or her own conscience in having to deny that choice.¹²⁹ A physician in a faith-influenced institution could be entitled to protection as a conscientious provider.

IV. *Equality and freedom of religion: protecting the vulnerable*

In any discussion of either individual or institutional freedom of religion rights and MAiD, the equality rights of patients should also be considered. The equality claims of physicians in the *CPSO* case were raised but not seriously addressed in argument, and were unsuccessful at both levels

for an institution not to offer MAiD: “First, institutional non-participation is an issue of institutional self-governance, not conscience. Second, there are many reasons unrelated to conscience for which a health centre may legitimately decide to not offer a particular procedure. Institutional non-participation isn’t primarily, let alone exclusively, about conscience. We already recognize institutional self-governance in part—as when we say the government should fund, but not dictate, scientific research at universities—but we could do so more fully by recognizing an institutional right of non-participation for health centres.” I have no quarrel with their second observation but maintain that in most if not all faith-influenced institutions, MAiD is within the competence of staff. An argument that an institution is incapable of offering MAiD is very different from arguing it is unwilling.

128. John Adenitire, “A Conscience-Based Human Right to be ‘Doctor Death’” (2016) 4 Public L 613 at 617.

129. In an example from North Bay, Ontario, a four-doctor team of MAiD providers sent a letter to the Nippising Serenity Hospice denouncing the publically-funded hospice’s refusal to allow MAiD in the facility. The doctors wrote “We absolutely disagree with you that MAiD ‘is not one of the tools in the palliative care basket.’ It is in fact a tool—a very special, humane tool that thousands of Canadians have accessed and the Canadian government, under law, has permitted. . . . The four of us pride ourselves on being compassionate physicians that understand, respect, and try our absolute professional and personal best to provide compassionate end of life care to our own and other physicians’ patients in our community.” See Chris Dawson “Local Doctors Question Hospice’s Stance on Assisted Death,” *BayToday* (29 January 2020), online: <baytoday.ca> [perma.cc/TT57-6HMY].

of court.¹³⁰ At the Supreme Court, section 15 did not play a significant part in the Court's decision in *TWU*, though both the Law Society and some intervenors argued that a decision to accredit the proposed law school would have significant ramifications for LGBTQ students. At the Ontario Court of Appeal in *TWU*, Justice MacPherson made two valuable observations on how to approach the balancing of *Charter* interests that might be useful in the MAiD context. He pointed out that the *Charter* analysis should take a different approach when religious freedom impacts the equality rights of others, and he noted that a degree of interference with religious freedom may be necessary in the public interest to promote equality.¹³¹ The dissent at the Supreme Court of Canada was critical of this approach and argued: “[w]hat *is* troubling, however, is the imposition of judicially preferred ‘values’ to limit constitutionally protected rights, including the right to hold other values.”¹³² The fact that the dissenting judges described constitutional equality rights only as values in juxtaposition to freedom of religion and conscience is concerning. As argued above, the traditional approach to section 2(a) claims may need to be rethought when the clear interests of a third-party are at stake. In the MAiD context, the rights of the patient stand in sharp contrast to the rights of a physician and/or institution in a freedom of conscience and religion claim. The equality rights of patients are not just values to be sacrificed to conscience and religious rights.

The trial judge in the *Carter* case found a violation of section 15 in the criminal prohibitions on assisted death.¹³³ Justice Lynn Smith concluded that the *Criminal Code* provisions discriminated on the enumerated section 15 ground of disability. They imposed a “more burdensome” effect on those with physical disabilities which led to a loss of capacity, whose only option for suicide was to refuse food and water.¹³⁴ Non-disabled people could choose less painful and stark options. She concluded: “[the *Criminal Code* provision] perpetuates and worsens a disadvantage experienced by persons with disabilities. The dignity of choice should be afforded to Canadians equally, but the law as it stands does not do so with respect to this ultimately personal and fundamental choice.”¹³⁵ She poignantly describes the impact of the equality violation:

130. *CMDSC v CPSO*, *supra* note 65 at paras 5, 94.

131. *TWU v LSUC*, *supra* note 115 at paras 100, 142.

132. *TWU* *supra* note 114 at para 308.

133. *Carter v Canada*, 2012 BCSC 886.

134. *Ibid* at para 1077.

135. *Ibid* at para 1161.

The effect of the distinction is felt particularly acutely by a subset of persons with physical disabilities...persons who are grievously and irremediably ill and physically disabled or will soon become so, are mentally competent, have full cognitive capacity, and wish to have a measure of control over their circumstances at the end of their lives. They may not wish to experience prolonged pain. They may wish to avoid the anxiety that comes with fear that future pain will become unbearable at a time when they are helpless. They may not wish to undergo palliative sedation without hydration or nutrition for reasons including concern for their families, fear for themselves or reaction against the total loss of independence at the end of their lives.¹³⁶

The Supreme Court of Canada decided the *Carter* case on section 7 grounds and so declined to address the equality violation as it was unnecessary to the resolution. In the *Rodriguez* decision, then Chief Justice Lamer was the only judge to consider section 15, and like Justice Smith at trial in *Carter* years later, he found a violation. It is a strong argument that there are equality issues at stake for patients denied access to MAiD. The Supreme Court may well have to address more specifically the section 15 equality impact of denying or limiting access to MAiD. The consultations to expand access to new categories (e.g. where mental illness is the sole underlying condition, mature minors, advance request etc.) will raise new and important equality concerns.¹³⁷

In considering whether to expand access to MAiD—including by requiring effective referral models and denying institutions the right to refuse to provide the service—the Court should be sensitive to the material, symbolic and dignitary harms implicated by a denial of access. The material or practical harms of a refusal to effectively refer (or of a regulatory regime that does not require effective referral) is that a patient is left without clear information and options-counselling and access. Physicians who object to discussing MAiD on conscientious or religious grounds, and who are not obligated to facilitate that discussion with a colleague, leave a vulnerable, fragile patient, and their no doubt distraught family, without adequate information as to the legal services available to end suffering. A patient may well opt not to access MAiD. The patient, fully informed, may decide on palliative options for pain management. However, a cancer patient in treatment whose trusted oncologist will not

136. *Ibid* at para 1159.

137. In 2019, the Superior Court of Québec found that requirement under s 241.2(2)(d) of the *Criminal Code* that an individual's natural death has become reasonably foreseeable violates s 7 of the *Charter* and cannot be justified under s 1 (see *Truchon*, *supra* note 3). In response to *Truchon*, the federal government introduced Bill C-7 which seeks to expand access to MAiD by removing the requirement that natural death has become reasonably foreseeable and by allowing individuals to sign advanced directives prior to becoming incapable. See *An Act to amend the Criminal Code (medical assistance in dying)*, 1st Sess, 43rd Parl, 2020 (first reading 24 February 2020).

facilitate information provision on MAiD, or a frail resident of a senior's home whose in-house physician will not engage in the conversation or pave the way for it, leave patients with a severe material harm to their security of the person and life.

There are also serious dignitary harms in not requiring an effective referral protocol.¹³⁸ The clear message is that there is something wrong with the decision to die by choice. There is no doubt that a religious leader could offer counsel and advice that in the Catholic faith, for example, suicide is a sin. Religious leaders would certainly be free to counsel parishioners against this choice. Physicians in Canada are secular professionals. Their personal opinions as to what is the best option for themselves (or perhaps their own family members who ask for familial, not professional counsel) are irrelevant to a medical judgment. A generous view might allow that, for an objecting physician, medical judgment as to MAiD (or abortion or contraception) is impossible to separate from the serious religious or conscientious view that those services are incompatible with medicine. That is a strong justification for non-compellability. (As a practical matter, other than in urgent circumstances, it is likely few patients would want an objecting physician to provide the service.) The same considerations are not as implicated in effective referral models. Yet a physician's judgement at a time of great vulnerability, and around decisions that even when freely arrived at and autonomously chosen are still difficult and profound decisions, carries great dignitary harm to the patients. For some patients, MAiD (and abortion) are inevitable choices, borne of egregious circumstances that few would "choose" to be in. An autonomous choice to access the service is not the same as a celebration of the decision. Permitting physicians not to refer to non-objecting colleagues, for the provision of accurate and compassionate information and options, leaves patients feeling ignorant, stigmatized and possibly ashamed. As Justice Strathy concluded in the *CPSO* case, this dignitary harm raises serious equality issues for patients, and led his Court to find that effective referral is a minimally impairing limit on freedom of religion.

138. As NeJaime & Siegel argue, *supra* note 69 at 201, "Conscience-based refusals can obstruct access to services and to information about alternative providers, and they can inflict dignitary harm, as one citizen seeks an exemption from a legal duty to serve another on the ground that she believes her fellow citizen is sinning. For these reasons, we believe that conscience objections by those acting in professional roles should only be accommodated when the institution in which they are situated mitigates the material and dignitary effects on third parties. Accommodation regimes must be designed in such a way as to shield other citizens from the deprivations and denigrations that refusals can inflict. In settings where there is no feasible way of organizing a regime that can accomplish this, we are deeply skeptical of accommodation."

Conclusion

MAiD offers the Supreme Court and legal academics a thought-provoking dilemma in the reconciliation of *Charter* rights. It is, however, so much more than a constitutional quandary. The decision to end one's life is arguably the most profound decision any individual can make. The solemnity and power of that was recognized in *Carter*. The Court rose to the occasion in a decision that affirmed the core rights of the sick and dying to make choices for themselves. These decisions may be incredibly difficult, painful, and personal to the individual making them, and the families supporting that person. It is not a personal decision for the infrastructure tasked with helping the sick and dying. Institutions may be filled with people, but they are built of bricks and mortar. The institutions themselves should not take a moral stance on this complex social issue. They most certainly should not take an oppositional position to the *Charter*-protected rights of patients. Ideally, provincial governments across this country will appreciate their duty to be neutral on matters of conscience and religion and take strong leadership roles in making clear to publicly-funded institutions that they must not deny medical services solely on religious or conscientious grounds.¹³⁹ Faith-influenced institutions have long skirted their obligations in the reproductive context, but that void is more easily filled by clinics. For patients who cannot receive MAiD in their own homes, institutions are needed to deliver it.

For individual physicians, the personal and often painful task of practicing medicine in keeping with one's values and beliefs is more nuanced than the institutional position. It is unfair, and perhaps impossible to expect an individual physician to practice medicine in a way that

139. There are at least two examples where provinces intervened in favour of patient access. First, in Antigonish, Nova Scotia, the Nova Scotia Health Authority ordered St. Martha's Hospital to provide MAiD on site. It was able to do so in part because it owns the facility, though St. Martha's is operating as a faith-influenced institution. MAiD is available at St. Martha's in a designated space within the institution. See: Ross Lord & Alexander Quon, "NSHA Quietly Changes Medically Assisted Dying Policy at Catholic Hospital," *Global News* (18 September 2019), online: <<https://globalnews.ca/news/5917973/nova-scotia-health-authority-st-marthas-regional-hospital-assisted-dying/>> [<https://perma.cc/GCF5-Q5N8>]. In Victoria, British Columbia the government took a strong stand against a faith-influenced hospice that refused to provide MAiD: "Health Minister Adrian Dix...instructed Fraser Health to stop paying \$1.5 million annually to the Delta Hospice Society within the next year because it is violating federal law and B.C. government policy that requires medically assisted dying be made allowed at non-denominational facilities that receive more than half their funding from the province." See: Rob Shaw, "Ladner Hospice to Lose B.C. Funding for Banning Medically Assisted Dying," *Vancouver Sun* (26 February 2020), online: <<https://vancouversun.com/news/local-news/ladner-hospice-loses-provincial-funding-over-refusal-to-comply-with-maid/>> [<https://perma.cc/6JQN-4JGN>] and see Agnieszka Ruck, "B.C. Delta Hospice Losing Funds Over Assisted Suicide," *the Catholic Register* (27 February 2020), online: <catholicregister.org> [perma.cc/UG5Q-BFXL].

profoundly negates his or her own beliefs as to care. In the context of reproductive services like abortion or contraception, it is advisable that physicians choose practice areas that avoid the conflict.¹⁴⁰ MAiD presents a more complicated set of circumstances. Many physicians, in diverse practice areas, could be confronted with a patient who wants and is eligible for MAiD. If we expand the criteria for access, it will be impossible for many physicians to avoid dealing with the issue by simply choosing a less-fraught practice area. Effective referral is the best compromise to reconcile rights. Policies like those in Ontario must prevail to protect patient rights. The extent of complicity forced upon objecting physicians is a reasonable way to address conflicting rights. It presents an additional burden to patients as it forces them to consult a non-objecting physician. Still, both sides get some relief.

It is unfortunate that MAiD may well end up back in the courts to work out these conflicts. The Ontario Court of Appeal decision in the *CPSO* case may offer some leverage in achieving stronger protections for patients in other provinces. It is a well-reasoned and unanimous decision, with compelling arguments as to the need for an effective referral model. Hopefully other provincial regulatory bodies will voluntarily adopt that model, rather than re-litigate the issue. It would be preferable for both governments and regulatory bodies to take strong leadership roles in advising institutions and physicians as to the proper limits of their ability to act in a religiously-motivated way in the secular provision of health care. Hopefully we do not need another Sue Rodriguez or Lee Carter or Gloria Taylor, Nicole Gladu, Jean Truchon, Julia Lamb to make clear what is at stake for those most vulnerable members of our society.

140. And at the very least, in Ontario they must make an effective referral to a non-objecting colleague. See *CMDSC v CPSO*, *supra* note 65 and see Gilbert, *supra* note 66.

