Court File No. C65397

COURT OF APPEAL FOR ONTARIO

BETWEEN

CHRISTIAN MEDICAL AND DENTAL SOCIETY, THE CANADIAN FEDERATION OF CATHOLIC PHYSICIANS' SOCIETIES, CANADIAN PHYSICIANS FOR LIFE, DR. MICHELLE KORVEMAKER, DR. BETTY-ANN STORY, DR. ISABEL NUNES, DR. AGNES TANGUAY AND DR. DONATO GUGLIOTTA

Appellants

and

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Respondent

and

ATTORNEY GENERAL OF ONTARIO, B'NAI BRITH OF CANADA LEAGUE FOR HUMAN RIGHTS, VAAD HARABONIM OF TORONTO, CENTRE FOR ISRAEL AND JEWISH AFFAIRS, CANADIAN CIVIL LIBERTIES ASSOCIATION, CANADIAN HIV/AIDS LEGAL NETWORK, HIV & AIDS LEGAL CLINIC OF ONTARIO, CANADIAN PROFESSIONAL ASSOCIATION FOR TRANSGENDER HEALTH, CATHOLIC CIVIL RIGHTS LEAGUE, FAITH AND FREEDOM ALLIANCE AND PROTECTION OF CONSCIENCE PROJECT, CHRISTIAN LEGAL FELLOWSHIP, THE EVANGELICAL FELLOWSHIP OF CANADA, THE ASSEMBLY OF CATHOLIC BISHOPS OF ONTARIO, DYING WITH DIGNITY, JUSTICE CENTRE FOR CONSTITUTIONAL FREEDOMS, ONTARIO MEDICAL ASSOCIATION, and WOMEN'S LEGAL EDUCATION AND ACTION FUND INC.

Interveners

FACTUM OF THE INTERVENER, WOMEN'S LEGAL EDUCATION AND ACTION FUND INC.

November 12, 2018

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PART I: STATEMENT OF THE CASE

1. Access to reproductive health care, including contraception, abortion and assisted reproduction, is fundamental to women's equality and human dignity. The Professional Obligations and Human Rights Policy (the "Policy") of the College of Physicians and Surgeons of Ontario ("CPSO" or "College")" requires physicians who object to this care to provide their patients with an effective referral to another, non-objecting provider. In considering whether the objective of this Policy is pressing and substantial, it is crucial for the Court to understand that it protects women's right to equitable access to care, advances women's rights and freedoms and prevents harm.

2. The historical context in which women's reproductive choices have been made subject to medical control, and the ongoing physician monopoly over many medical services, makes the effective referral Policy particularly important to these objectives. Many women, particularly those facing intersecting grounds of discrimination, depend on physicians to navigate the medical system and access reproductive health care. They do not have the resources, skills, or knowledge to seek such care on their own, which is an important consideration in the minimal impairment analysis. In this context, an effective referral through their physician remains the only channel of care enabling some women to make independent moral and health decisions about their reproductive lives.

3. The importance of the Policy in protecting and promoting the fundamental rights of women also must weigh heavily in the final balancing under the s. 1 analysis. The objectives the Policy advances include affirming the rights of women, particularly the most disadvantaged women, to make choices about their bodies, to fully participate in society and to chart and the

course of their own lives. These objectives are fundamental to women's equality and should be affirmed as advancing the principles and values of a free and democratic society.

PART II: FACTS

4. The Appellants challenge the constitutionality of two policies of the CPSO. Of particular relevance to LEAF, the Professional Obligations and Human Rights Policy requires physicians who are unwilling to provide certain medical care or treatment for reasons of conscience or religion to provide, or have someone at their office provide, a patient requesting such care or treatment with an effective referral to another health care provider. The Policy also requires CPSO members to provide these services directly if necessary to prevent imminent harm.[1]

5. Among the services the Appellants object to providing a referral for are services that are particularly important to women's equality rights; specifically, they include reproductive health services such as abortion, contraception, pre-natal screening and assisted reproduction.

6. Many women face pre-existing systemic barriers to accessing reproductive health services such as contraception and abortion. These include the financial cost of contraceptive care, lack of access to sexual health education and information, lack of access to abortion facilities and the stigma associated with this care.

> Jennifer Hulme, et al, "Barriers and Facilitators to Family Planning Access in Canada" (2015) 10 Healthcare Policy 3, Affidavit of Dr. Sheila Dunn, (file 499/16), sworn Oct 19, 2016, Exhibit Book Vol 2, Tab 27, ("Dunn Affidavit") Exhibit D, p 4256-4260 and p 4146, ¶21; Affidavit of Barbara Bean, (file 499/16), sworn Oct 18, 2916, Exhibit Book Vol 2, Tab 30, ("Bean Affidavit") pp 4440-4442, ¶¶8-11.

7. Without a referral from their primary care provider, many women, particularly

[1] While the Appellants challenge this part of the Policy, the focus of their argument is on the effective referral. As such, LEAF is not addressing this element of the Policy in this factum.

marginalized women, lack the knowledge, skills, or resources to seek out and obtain reproductive health services independently. When women are unable to access these services it results in adverse outcomes, including unwanted pregnancy, psychological stress, increased risk of patient morbidity, or being unable to access the care required altogether.

> Dunn Affidavit, p 4140-4142, ¶¶15(a)-(d); Affidavit of Dr. Jeffrey Turnbull, (file 499/16), sworn Oct 19, 2016, Exhibit Book Vol 2, Tab 25, ("Turnbull Affidavit") pp 4039-4041, ¶28; Dunn Affidavit, pp 4148-4150, ¶24.

PART III: ISSUES AND THE LAW

8. LEAF submits that, should the Court find that the Policy violates s. 2(a) or s. 15 of the *Charter,* the Court should give significant weight to women's equality rights of access to health care in the s. 1 analysis. Specifically:

a) In considering whether the objective of the Policy is pressing and substantial, it is crucial for the Court to consider women's right to equitable access to health care and the rights' advancing objective of promoting access to reproductive health services; and

b) The objective of preserving women's fundamental rights plays an important role in the proportionality analysis. In considering whether the Policy impairs the Appellants' rights "as little as possible," it is crucial to acknowledge that for at least some women, particularly those who are most marginalized, an effective referral is the only way they can meaningfully access reproductive health care and therefore, reproductive choice. In balancing the salutary and deleterious effects of the Policy, the importance of the Policy for women's equality and fundamental freedoms should weigh heavily in the balance.

A. The Importance of Women's Rights in the Pressing and Substantial Objective

9. The Policy is intended to protect the rights, autonomy and dignity of all patients, including by ensuring that patients receive equal access to health services. Equitable access to health care advances the CPSO's public interest mandate and is a sufficiently important objective to justify an interference with competing rights. This objective is particularly crucial to women as some of the services the Appellants object to providing referrals for are specifically required by women and, as set out above, are already difficult for many women to access. The Policy promotes women's equal access to health care, protected by s. 15 of the *Charter*, by reducing the barriers women face in accessing the particular kinds of care that they require.

> College of Physicians and Surgeons of Ontario, "Professional Obligations and Human Rights, Policy Statement #2-15", approved by Council September 2008; updated March 2015, at 1, *Regulated Health Professions Act*, SO 1991, c 18, s 3(2), *Law Society of British Columbia v Trinity Western University*, 2018 SCC 32 at ¶96; *R v Spratt*, 2008 BCCA 340 at ¶71; *R v Lewis*, (1996) 24 BCLR (3d) 247 (BC SC) at ¶101; *Eldridge v British Columbia,* [1997] 3 SCR 624 at paras 78, 80.

10. Access to reproductive health services is profoundly important for women's equality. Women's social, economic and political equality is intimately tied to their access to reproductive services. Unwanted pregnancy can disrupt women's lives in a myriad of ways – interfering with women's ability to work, pursue education, or engage in political life, and carries significant, long term financial consequences. The Policy ensures that women are not disproportionately exposed to these risks as a consequence of their physician's religious convictions.

> Daphne Gilbert, "Let They Conscience Be Thy Guide (but Not My Guide): Physicians and the Duty to Refer" (2017) 10 McGill JL & Health 47 at 69-71.

11. Further, the Policy protects women from physical and psychological harm. Without a referral, some women will not be able to access an abortion for reasons unrelated to their own priorities and aspirations, which is a "profound interference with a woman's body and thus an

infringement of security of the person." Further, delays in obtaining abortion increase its associated risks, including the risks of mortality and psychological trauma. Depriving women of the choice of whether or not to become pregnant itself may pose a significant risk of bodily harm.

> *R v Morgentaler*, [1988] 1 SCR 30 at 56-60, per Dickson CJ and Lamer J, concurring; Dunn Affidavit, p 4149, para 24(c).

12. The Policy also promotes women's ability to make personal decisions that are of fundamental importance to their bodies, lives and well-being. In *Morgentaler*, Justice Wilson rightly understood women's freedom to decide whether and when to reproduce as fundamental to women's individual liberty, human dignity, self-respect and essential humanity. The Policy facilitates women's capacity to exercise this freedom and chart the course of their own lives. Moreover, it promotes women's conscientious and religious freedom by enabling women to make their own choices, free from the compulsion to act in a manner dictated by another's religion.

> *R v Morgentaler*, *supra*, at 163 – 172, *R v Big M Drug Mart,* [1985] 1 SCR 295 at 349-350

13. It should be uncontroversial that promoting women's equality rights and preventing harm are pressing and substantial objectives; indeed, "equality, human rights and democracy — are values the state always has a legitimate interest in promoting and protecting." In LEAF's submission, these objectives must be specifically attended to in the remainder of the s. 1 analysis.

> *Loyola High School v Quebec (Attorney General)*, 2015 SCC 12 at ¶47.

B. Proportionality

(i) Minimal Impairment: Effective Referral Only Channel for Some Women to Access Care

14. The requirement to provide an effective referral is the only means by which the Policy's

objectives can be accomplished, particularly for the most marginalized women and, as detailed below, in light of the control the state has provided to the medical profession over women's reproductive autonomy.

15. Policy or legislation will fail the minimal impairment test only if the legislator "fails to explain why a significantly less intrusive and equally effective measure was not chosen." A contextual factor that must be considered in determining whether a less intrusive measure would be equally effective is the vulnerability of the group the legislation seeks to protect. The court should be careful not to undermine legislators' attempts to give a voice to the vulnerable, nor require them to use the "least ambitious means to protect vulnerable groups".

> *RJR MacDonald Inc v Canada (Attorney General)*, [1995] 3 SCR 199 at ¶160; *Irwin Toy v Quebec*, [1989] 1 SCR 927 at 993 and 999, *Thompson Newspapers Co v Attorney General*, [1998] 1 SCR 877 at ¶90 and 112; *R v Mills*, [1999] 3 SCR 668 at 58.

16. In this case, the historic inequality women face in the medical system has shaped their vulnerability and provides insight into the appropriate steps to protect and promote their fundamental rights. Reproductive health care, fundamental to women's equality, has been heavily restricted historically for reasons "inextricably bound up with theological doctrine." Following partial decriminalization, reproductive health services were medicalized – that is, assigned to the exclusive purview of doctors – in part to maintain control over women's reproductive choices. As a result, women were made dependent on physician approval in order to access reproductive services. The consequences were particularly severe for marginalized women, for example, Indigenous women or women with disabilities, who were often granted abortions by physicians only on condition of consent to sterilization.

> Shelley Gavigan, "The Criminal Sanction as it Relates to Human Reproduction: The Genesis of the Statutory Prohibition of Abortion" (1984) 5 J Legal Hist 20 at 20; Medicalization has been defined as "reducing political, personal and social issues to medical problems thereby giving scientific experts the power to `solve' them within the constraints of medical practice.": Jana Sawicki, *Disciplining Foucault: Feminist, Power and the Body* (London: Routledge, 1991) at 119. Joanna Erdman, "Constitutionalizing Abortion Rights in Canada" (2017) 49 Ottawa Law Rev 1 at 232-233. The medicalization of assisted reproduction also allows medical practitioners to enforce normative views about family formation: Royal Commission on New Reproductive Technologies, "Infertility Treatments: Assisted Reproduction" in *Proceed with care: final report of the Royal Commission on New Reproductive Technologies* (Ottawa: Ministry of Government Services Canada, 1993) at 430, 454-457.

17. In this historical context, women seeking reproductive health services, particularly marginalized women, should be understood as a vulnerable group in need of comprehensive protection for their rights. Greater accommodation for "conscientious objections" will disproportionately impact women, whose decisions are already inordinately subject to medical control. This may be particularly damaging for women who have other identity-markers the physicians object to, such as queer or unmarried women. In considering alternatives, this Court should not endorse a model that perpetuates women's vulnerability in relation to the medical establishment. Indeed, the *Charter* should not be used "as an instrument of better situated individuals to roll back legislation which has as its object the improvement of the condition of less advantaged persons."

> See *R v Lewis*, *supra*, at ¶130; Transcript of cross-examination of Dr. Michelle Korvemaker, Exhibit Book Vol 6, Tab 89, Pp 9959-9961, Qs 90-101; *R v Edwards Books and Art*, [1986] 2 SCR 713 at 779.

18. Any alternative that provides less protection for women's rights would perpetuate physicians' moral control over women's lives. While this is problematic for all women, it is particularly damaging for those experiencing intersecting grounds of discrimination. For many marginalized women, an effective referral is the only channel of care by which they will access

reproductive health services. For example, women in rural communities may be unable to effect a "self-referral" because they do not have other access points through which to enter the system. Newcomers to Canada may be unaware of what other access points exist due to language barriers and a lack of familiarity with the Canadian health care system.

> Affidavit of Dr. Danielle Martin, (file 499/16), sworn Oct 14, 2016, Exhibit Book Vol 2, Tab 23 ("Martin Affidavit"), pp 3928-3929, para 19; Dunn Affidavit, pp 4140-4141, para 15(a)-(b) and 4147, ¶22; Turnbull Affidavit, pp 4039-4041, ¶¶ 28(e).

19. Others, such as young women and girls, may lack the skills or capacity to find alternate sources of care. An adolescent girl who approaches one physician for contraception or abortion and is denied a referral may not have the capacity, resources or information to take further steps on her own. Homeless women, women with addictions and women with mental illness often experience sporadic access to health care; without a referral they will likely have difficulty locating another physician, making an appointment and obtaining appropriate care.

> Turnbull Affidavit, pp 4039-4041, ¶¶28(a)-(d).

20. For women who are able to effect a self-referral, those who have less knowledge about the health care system or who have to travel to access alternate care providers will inevitably experience delays in treatment. An effective referral is therefore a key mechanism through which these women can access reproductive health care and autonomy.

21. Furthermore, reproductive health care, particularly contraception and abortion, is highly stigmatized. A physician refusing a referral for reproductive health services can increase and perpetuate the shame and stigma associated with such services, which may cause some women to delay or avoid seeking abortion care from another provider. The continued stigma attached to reproductive services maintains physicians' capacity to exert moral coercion over women's

decisions, particularly those women who are most vulnerable to such control. In this context, an effective referral plays an important role in facilitating women's reproductive autonomy.

Dunn Affidavit, pp 4146-4147, ¶21; Bean Affidavit, pp 4440-4442, ¶¶8-11.

22. While, in LEAF's submission, the requirement to provide an effective referral would be necessary in any regulatory environment, it is particularly crucial in the current system in which physicians hold a monopoly over health care services. Women depend on physicians – the gatekeepers to medical services – to navigate the health care system. This makes it all the more essential that physicians be required to respect women's rights and choices. Anything less than an effective referral would maintain physicians' ability to control women's choices for moral reasons, particularly marginalized women, and would thereby perpetuate women's disadvantage and inequality.

Martin Affidavit, p 3927, para 15, p 3929-3930, ¶¶21-22.

(ii) Protection of Women's Rights Weighs Heavily in the Final Balancing

23. Finally, the salutary effects of the Policy in protecting and advancing women's constitutional rights must weigh heavily in the balancing exercise. The objectives the Policy advances include nothing short of safeguarding women's dignity, equality and human rights.

24. The Supreme Court of Canada has found repeatedly that the protection of equality and dignity for marginalized groups justifies interferences with competing rights. In *TWU*, the Court held that, where the exercise of religious freedom would harm LGBTQ people and exclude them from the legal profession, a limitation on that religious right was justified. Indeed, minor limits on religious freedom are "often unavoidable in a multicultural and democratic society."

Law Society of British Columbia v Trinity Western University, *supra*, at ¶100; *R v Keegstra*, [1990] 3 SCR 697.

25. In this case, the Policy preserves the rights of women, particularly the most disadvantaged women, to make choices about their bodies and the course of their lives. It preserves their right to participate fully in society. Moreover, this objective occurs in a context characterized by women's historic disadvantage, where reproductive services have been criminalized, medicalized and stigmatized, to the detriment of women's substantive equality. It also occurs in a context in which physicians owe a fiduciary duty to act in their patients' best interest, a duty that is of magnified importance to the most vulnerable women.

26. The Policy marks a step towards reversing the historic, entrenched inequality that characterizes women's access to reproductive services. Meanwhile, it only requires physicians to act within the core principles of their existing professional obligations. The Policy's objectives in protecting and promoting the rights of women should weigh heavily in the final balancing. Indeed, promoting equality is an undertaking essential to any free and democratic society.

R v Keegstra, supra, at ¶75.

IV – ORDER REQUESTED

27. LEAF seeks no costs, and requests that none be awarded against it. LEAF takes no position on the ultimate disposition of the appeal.

ALL OF WHICH IS RESPECTFULLY SUBMITTED, November 12, 2018

Karen Segal FOR

Shaun O'Brien

Karen Segal

Karen Segal

SCHEDULE "A"

LIST OF AUTHORITIES

Case Law

1. *Law Society of British Columbia v Trinity Western University,* 2018 SCC 32
2. *R v Spratt,* 2008 BCCA 340
3. *R v Lewis,* (1996) 24 BCLR (3d) 247 (BC SC)
4. *Eldridge v British Columbia,* [1997] 3 SCR 624
5. *R v Morgentaler,* [1988] 1 SCR 30
6. *R v Big M Drug Mart,* [1985] 1 SCR 295
7. *Loyola High School v Quebec (Attorney General)*, 2015 SCC 12
8. *RJR MacDonald Inc v Canada (Attorney General),* [1995] 3 SCR 199
9. *Irwin Toy v Quebec,* [1989] 1 SCR 927
10. *Thompson Newspapers Co v Attorney General,* [1998] 1 SCR 877
11. *R v Mills*, [1999] 3 SCR 668
12. *R v Edwards Books and Art,* [1986] 2 SCR 713
13. *R v Keegstra,* [1990] 3 SCR 697

Secondary Sources

14. College of Physicians and Surgeons of Ontario, "Professional Obligations and Human Rights, Policy Statement #2-15", approved by Council September 2008; updated March 2015
15. Daphne Gilbert, "Let They Conscience Be Thy Guide (but Not My Guide): Physicians and the Duty to Refer" (2017) 10 McGill JL & Health 47
16. Shelley Gavigan, "The Criminal Sanction as it Relates to Human Reproduction: The Genesis of the Statutory Prohibition of Abortion" (1984) 5 J Legal Hist 20

18. Jana Sawicki, *Disciplining Foucault: Feminist, Power and the Body* (London: Routledge, 1991)

19. Joanna Erdman, "Constitutionalizing Abortion Rights in Canada" (2017) 49 Ottawa Law Rev 1

20. Royal Commission on New Reproductive Technologies, "Infertility Treatments: Assisted Reproduction" in *Proceed with care: final report of the Royal Commission on New Reproductive Technologies* (Ottawa: Ministry of Government Services Canada, 1993)

SCHEDULE "B"

TEXT OF STATUTES, REGULATIONS & BY - LAWS

1. *Regulated Health Professions Act,* SO 1991, c 18

Duty of Minister

3 It is the duty of the Minister to ensure that the health professions are regulated and co-ordinated in the public interest, that appropriate standards of practice are developed and maintained and that individuals have access to services provided by the health professions of their choice and that they are treated with sensitivity and respect in their dealings with health professionals, the Colleges and the Board. 1991, c. 18, s. 3.

2. ***CONSTITUTION ACT, 1982***

PART I

CANADIAN CHARTER OF RIGHTS AND FREEDOMS

Whereas Canada is founded upon principles that recognize the supremacy of God and the rule of law:

Guarantee of Rights and Freedoms

Rights and freedoms in Canada

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

Equality Rights

Equality before and under law and equal protection and benefit of law

15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Affirmative action programs

(2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability. (84)

THE CHRISTIAN MEDICAL AND DENTAL SOCIETY OF CANADA, THE CANADIAN FEDERATION OF CATHOLIC PHYSICIANS' SOCIETIES, CANADIAN PHYSICIANS FOR LIFE, DR. MICHELLE KORVEMAKER, DR. BETTY-ANN STORY, DR. ISABEL NUNES, DR. AGNES TANGUAY and DR. DONATO GUGLIOTTA

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