

**Accommodation of Religious and Cultural Differences
in Medical School Training**

A Thesis Submitted to the College of
Graduate Studies and Research
In Partial Fulfillment of the Requirements
For the Degree of Master of Laws
In the College of Law
University of Saskatchewan
Saskatoon

By:

Susan L. Hayton

Permission to Use

In presenting this thesis in partial fulfillment of the requirements for the LL.M. degree from the University of Saskatchewan, College of Law, I agree that the libraries of this University may make it freely available for inspection. I further agree that permission for copying of this thesis in any manner, in whole or in part, for scholarly purposes may be granted by the professor or professors who supervised my thesis work or, in their absence, by the Dean of the College Law. It is understood that any copy or publication or use of this thesis or parts thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and to the University of Saskatchewan in any use which may be made of any material in my thesis.

Abstract

As with many other disciplines, the study of medicine is being influenced by the change in the cultural make-up of our country. On occasion, conflicts may develop between the personal beliefs of medical students and the training they must undertake in order to become competent and caring physicians. What are the implications for medical school training in terms of the increasing diversity of the individuals applying to, and being accepted into, medical schools across this country? How much should we allow the personal beliefs and values of physicians-in-training to modify the medical education experience as it currently exists? Do we need to accommodate these individual student differences (religious and cultural) when designing and modifying the medical school curriculum?

This thesis looks at the requirement for accommodation (as established in human rights legislation) and the rights of individuals entering into medical school training (as guaranteed by the *Canadian Charter of Rights and Freedoms*) and attempts to balance these individual rights against the goal of a medical school to develop a generic physician who is prepared, at completion of medical school training, to enter into many different post-graduate training programs. Medical school training involves a number of different types of learning including: knowledge acquisition, procedural competence, and the ability to interact in an intimate, yet wholly professional, manner with complete strangers. Current accreditation requirements demand that each medical student achieves a requisite level of knowledge, and the ability to perform certain physical examinations and associated procedures, by the completion of medical school training.

Three distinct examples of possible requests for accommodation are examined during this thesis in order to determine if, and when, accommodation is reasonable and achievable. Although it is possible to allow some degree of modification of the medical school training process in order to accommodate religious or cultural beliefs of particular students, this accommodation is currently not possible if bona fide educational requirements are undermined during this accommodation or if accommodation of students would require undue hardship on the part of the particular medical school, staff or other students involved in the training process.

Creating a standard process whereby students can request a modification of their involvement in the medical school curriculum (in order to accommodate religious or cultural differences) will facilitate unbiased and reasonable decision-making. This will allow students and faculty to have reasonable expectations about the ability of each individual to be successfully integrated into the medical school training program. It would also be useful and responsible to make it clear to students applying to be admitted to medical school where the limits are with respect to what degree of modification of medical school training is possible. The knowledge and clinical abilities that a student will be expected to master, within a Canadian medical school curriculum, must be consistent with the expectation of non-discrimination, as identified by provincial and national human rights legislation, and with the rights and freedoms as guaranteed by the *Canadian Charter of Rights and Freedoms*.

Acknowledgements

I would like to thank my supervisor, Barbara von Tigerstrom, for her support, patience, and encouragement during the process of researching and writing this thesis. Barbara has been extremely dedicated to the role of thesis supervisor, providing valuable advice and striving to keep me on course, throughout the term of this project.

I also wish to acknowledge and thank the members of my Advisory Committee, Brent Cotter and Ken Norman, for their interest and advice. Thank you to my external examiner, Erin Nelson, for reading and critiquing my thesis, and for giving me a lot to think about during my defence.

Thank you to my mother, Dawn Hayton, for providing an example of someone who is always interested in the world around her and who continues to want to learn about, and to embrace, new technology and new ideas.

Finally, I would like to thank my husband, Grant Stoneham, and my daughters, Emily, Frances and Kathleen, for their love and support and for allowing me time (in the midst of our busy lives) to pursue this exciting and fulfilling goal.

Table of Contents

PERMISSION TO USE.....	i
ABSTRACT	ii
ACKNOWLEDGEMENTS.....	iii
INTRODUCTION.....	1
Chapter 1: Conscientious Objection in Medical Care and Medical Education.....	7
Chapter 2: Legal Framework.....	21
2.1 Reasonable Accommodation	22
2.2 Reasonable Accommodation and Human Rights Legislation.....	24
2.2.1 Federal.....	24
2.2.2 Provincial.....	25
2.3 Addressing a Human Rights Claim.....	26
2.4 Does the <i>Canadian Charter of Rights and Freedoms</i> Apply to Universities?.....	33
2.5 Reasonable Accommodation and the Charter	39
2.5.1 Section 2(a) of the <i>Charter of Rights and Freedoms</i>	41
2.5.2 How Do the Boundaries, Established by Our Legal System and By Our Constitution, Act to Limit Freedom of Conscience?.....	53
2.5.3 Where Does “Culture” Fit Into This Picture?.....	56
2.5.4 Section 15 of the <i>Charter of Rights and Freedoms</i>	57
2.5.5 Section 7 of the <i>Charter of Rights and Freedoms</i>	65
2.5.6 Section 27 of the <i>Charter of Rights and Freedoms</i>	69

Chapter 3: Application of Legal Framework.....	71
3.1 Introduction.....	71
3.2 What is a physician and what knowledge/skills should a physician have?.....	73
3.2.1 Is there such a thing as a generic physician?.....	73
3.3 Medical School Training in Canada.....	73
3.3.1 Maintenance of Training Standards in Canada.....	73
3.4 What is a Bona Fide Occupational Requirement and what role does it play in deciding about accommodation in conscientious objection requests?.....	77
3.5 Should medical students and practicing physicians be permitted similar levels of accommodation of religious or conscience requests?.....	80
3.6 Process for determining if a request for exemption should be accommodated.....	84
3.6.1 Does the request undermine a particular educational requirement and/or is the requirement a BFOR?.....	84
3.6.2 Would accommodation of the request impose undue hardship? (3 rd arm of the Meiorin test).....	85
3.6.3 Refusal of Request for Accommodation – Challenge by Student and Potential Mechanisms for Relief.....	86
3.6.4 Examples of possible requests for accommodation.....	87
3.6.5 Relief mechanisms within the medical school and University.....	87
3.6.6 Does the request undermine a particular Educational requirement?.....	88
3.6.6(A) Student A.....	88
3.6.6(B) Student B.....	89
3.6.6(C) Student C.....	90

3.6.7	Mechanisms Beyond Medical School and University Administration.....	91
3.6.8	Applying Human Rights Legislation or <i>Charter</i> Rights to Refusal of Accommodation Requests.....	93
3.6.8(A)	Student A.....	93
3.6.8(A)1	Human Rights Legislation.....	93
3.6.8(A)1.1	Undue Hardship.....	94
3.6.8(A)2	Charter challenge.....	95
3.6.8(A)2.1	Section 2(a).....	96
3.6.8(A)2.2	Section 15.....	99
3.6.8(B)	Student B.....	102
3.6.8(B)1	Human Rights Legislation.....	102
3.6.8(B)1.1	Undue Hardship.....	102
3.6.8(B)2	<i>Charter</i> challenge.....	103
3.6.8(B)2.1	Section 2(a).....	103
3.6.8(B)2.2	Section 15.....	105
3.6.8(C)	Student C.....	106
3.6.8(C)1	Human Rights Legislation.....	106
3.6.8(C)1.1	Undue Hardship.....	106
3.6.8(C)2	<i>Charter</i> challenge.....	107
3.6.8(C)2.1	Section 2(a).....	107
3.6.8(C)2.2	Section 15.....	108
3.7	Importance of Establishing A Protocol for Managing these Requests at a medical school.....	112
3.8	Examples of Medical Schools with Conscientious Objection Request Mechanisms.....	112
3.9	Designing a Conscientious Objection Request Form.....	113

3.10 Conclusion Chapter 3.....	114
CONCLUSION	116
BIBLIOGRAPHY	119
APPENDICES	128

INTRODUCTION

Canada is a multicultural society that has been quite successful at integrating people of different cultural and religious backgrounds into its societal fabric. As Canadians, we are encouraged to respect the differences of others and to accept that there are cultural and religious beliefs of other Canadians that should be treated with respect and tolerance, even if these beliefs are significantly different from our own. Despite this historical acceptance and integration of immigrants, there has been increasing discussion, over the past number of years, about reasonable accommodation of religious and cultural beliefs within Canada, particularly within Quebec. In addition, there has been increasing awareness of the fact that one significant component of our population, our Aboriginal membership, has not received the acceptance and respect for cultural differences that we might have hoped.

Over the past half century, people have become more and more mobile and immigration to Canada has increased with our rising world population. We are seeing a greater diversity in our population in Canada compared to 50 years ago when most of our immigrant population originated from Europe. Today, most Canadian immigrants are from Asia.¹ This increasing ethnic diversity has introduced greater numbers of individuals with different cultural and religious beliefs into our population.

¹Elizabeth Riddell-Dixon, "Assessing the Impact of Recent Immigration Trends on Canadian Foreign Policy" in David Carment & David Bercuson, eds., *The World in Canada: Diaspora, Demography, and Domestic Politics* (McGill: Queen's University Press, 2008) at 31.

In recent years, there has been increased discussion and anxiety within other democratic nations, particularly European nations, about the challenges raised by immigration. Anxiety with respect to immigration has also become evident in Quebec society, most significantly over the past ten years. The resulting discourse led to formation of the *Consultation Commission on Accommodation Practices Related to Cultural Differences (Bouchard-Taylor Report)*² in 2007 with a mandate to look at the reality and perceptions of immigration in Quebec and to make recommendations regarding the best approach to take when attempting to integrate new immigrants into Quebec society. Although these suggestions were directed primarily at Quebec society, the concept of reasonable accommodation, supported by modern democratic viewpoints, and constitutional underpinnings such as the *Canadian Charter of Rights and Freedoms*³, allow many of these suggestions to be translated to the rest of Canada in terms of providing a framework on which policy positions can be built.

Discussion about reasonable accommodation in Canada has been spurred on by recent concerns in Quebec, and a number of European nations, but it has equal relevance to challenges associated with ongoing alterations within Canadian society, within immigrant and non-immigrant populations, and within the Aboriginal population in Canada.

Clashes between laws of general application and minority religious practices are likely to escalate in the future as a result of broad factors such as the growth of the administrative state, the development of technologies that may aid the state in

² Gérard Bouchard and Charles Taylor, BUILDING THE FUTURE, A Time for Reconciliation, online: <http://www.accommodements.qc.ca/documentation/rapports/rapport-final-integral-en.pdf>.

³ Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [Charter].

addressing security concerns, the rise of immigration from communities with different conceptions of the significance of seemingly neutral requirements, and the greater secularization of Canadian society as a whole.⁴

How do we respectfully support the right for groups and individuals to practice their religious and cultural beliefs, but continue to educate varying professionals in a manner consistent with Canadian values and constitutional requirements?

As with many other disciplines, the study of medicine is being influenced by the change in the cultural make-up of our country. On occasion, conflicts may develop between the personal beliefs of medical students and the training they must undertake in order to become competent and caring physicians. What are the implications for medical school training in terms of the increasing diversity of the individuals applying to, and being accepted into, medical schools across this country? How much should we allow the personal beliefs and values of physicians-in-training to modify the medical education experience as it currently exists? Do we need to accommodate these individual student differences (religious and cultural) when designing and modifying the medical school curriculum? Do we need to accept conscientious objection by medical students with respect to involvement in certain types of medical teaching sessions, contact with patients and performance or observation of particular medical procedures? If we are open to adjustment of the medical curriculum in these ways, then when should these accommodations occur and how do we make the decision to allow for these modifications? How might accommodation change the finished product (physician,

⁴ Sara Weinrib, "An Exemption for Sincere Believers: The Challenge of *Alberta v. Hutterian Brethren of Wilson Colony*" (2011) 56(3) McGill LJ 719.

ready to practice medicine) and are these changes consistent with quality medical care for Canada's patient population?

Conscientious Refusal

The notion of conscientious objection, as claimed by physicians, has been studied and written about fairly extensively over the past half century. This concept is, intrinsically, a somewhat difficult one to accept, considering the fact that physicians are often imagined to be self-less individuals who are involved in medical care for the benefit of their patients and who are expected to divorce their personal feelings, and moral or religious beliefs, from the concept of best medical practice for the individuals hoping to benefit from their care. One such perspective is found in the following statement:

A doctors' conscience has little place in the delivery of modern medical care. What should be provided to patients is defined by the law and consideration of the just distribution of finite medical resources, which requires a reasonable conception of the patient's good and the patient's informed desires. If people are not prepared to offer legally permitted, efficient, and beneficial care to a patient because it conflicts with their values, they should not be doctors. Doctors should not offer partial medical services or partially discharge their obligations to care for their patients.⁵

There has been much less written about the concept of conscientious objection as it applies to students training in the profession. When do students develop this self-less perspective that is expected of them when they become practicing physicians? Is this perspective of the self-less physician realistic, and what do medical students make of the perspective, held by many non-physicians in society, that physicians should not allow

⁵ Julian Savulescu, "Conscientious Objection in Medicine" (2006) 332 BMJ 294 [*Savulescu*].

their personal biases to influence patients' access to appropriate and legal medical care in our society?

Recent survey data gathered from British medical students reveal widespread acceptance of conscientious objection in medicine, despite the existence of strict policies in the UK that discourage conscientious refusals by students to aspects of their medical training.⁶

From this study, and case reports found in the literature, it appears that many medical students believe that they have a right to refuse to provide certain types of medical care that is otherwise legal, and often publicly funded, if it is in conflict with their own personal religious, cultural or ethical beliefs. How do these beliefs mesh with physicians' codes of ethics, legislation to protect patients' rights to medical care, and the public's expectation of altruistic behaviour from physicians who are trusted to care for their health? More specifically, how should medical schools deal with requests for exemption from certain medical procedures, or medical education sessions, based on conscientious objection to participation? In order to determine the answer to these questions one would need to establish: who and what we are training in the medical education process; what the end product should look like; whether or not it is possible to accommodate certain requests and still create the end product we are looking for; and what role the physician should be expected to play in our modern western world where individual rights are often thought to be sacrosanct.

Each society needs to decide what type of "creature" they are creating when they train a student to become a practicing physician. The route that is taken will, in turn,

⁶ Robert F. Card, "Is there no alternative? Conscientious objection by medical students" (2011) *J Med Ethics* [Card].

determine the ability of that particular physician to practice in certain countries, and within certain areas of those countries. This paper will not attempt to make a final determination of what standard teachings and experiences are required in order to create the ideal physician. Even this will vary from country to country and culture to culture. Instead, I will attempt to demonstrate how some accommodation of cultural and religious differences might be permitted within the Canadian medical school curriculum, where boundaries might reasonably be drawn, what legal and human rights challenges might be raised by thwarted students, and how those challenges might be answered within the Canadian and International context.

Chapter 1: Conscientious Objection in Medical Care and Medical Education

The term “conscientious objection” originally referred primarily to the circumstance in which an individual recused himself from military involvement because of an ethical, moral or religious opposition to some aspect of war. The process of excusing one’s self from certain activities for religious or conscience reasons has gradually become more prevalent in all areas of life. This is certainly the case when it comes to health care provision. “The last half of the twentieth century has seen the concept of conscientious objection move from a military context into other areas at the interface of public and private life, notably becoming a fixture in the medical landscape.”⁷

Physicians have always introduced their personal biases into the patient care scenario, either through the implementation of societal and religious norms or, more recently, by way of arguing their rights to personal moral integrity with respect to their actions.⁸ The original Hippocratic Oath⁹ contains a statement proclaiming that a physician will not facilitate an abortion and that he will practice medicine according to “divine law”. In western society, the direct relationship between the legal-administrative structure of our communities and the religious beliefs of the members of those communities has gradually become less connected, in part because of the growth of scientific understanding during the past 100 years. “As the 20th century progressed, the

⁷ Nathaniel J. Brown, *Conscientious objection in medicine: An hypothesis towards a federated solution*, (ProQuest, UMI Dissertation Publishing, 2011).

⁸ Farr A. Curlin, “Religion, Conscience, and Controversial Clinical Practices” (2007) 356(6) NEJM 593 [Curlin].

⁹ *Hippocratic Oath*, History of Medicine Division, National Library of Medicine, National Institutes of Health, online: http://www.nlm.nih.gov/hmd/greek/greek_oath.html.

association of medical work with a religion eroded; the laboratory bench replaced the church pew as the symbolic locus of legitimacy and authority for health-care professionals (HCPs).”¹⁰

During the first part of the 20th century, religion as a guiding force was gradually replaced by the scientific method, but a “physician knows best” perspective, in association with a still poorly educated general public, meant that patriarchy in the physician-patient relationship persisted. It is only in the past quarter century, as society began to acknowledge the importance of individual patient’s rights, and patients became better educated, that patient autonomy has gradually begun to supersede physicians’ perspectives on what is considered best medical treatment. “Once willing to endorse medical paternalism, constitutional and common law jurisprudence now embraces patients’ rights to informed consent, bodily autonomy, and self-determination.”¹¹ More and more guidelines have been established to try to prevent physicians from allowing their own moral and ethical biases to intrude upon the physician-patient relationship. The *Physician’s Oath*,¹² established by the World Medical Association, is an example of one such guideline. Medical regulatory or licensing bodies have also established many of these rules, often in the form of codes of ethics.^{13 14 15} These recommendations tend to

¹⁰ Joel Frader and Charles L. Bosk, “The Personal is Political, the Professional is Not: Conscientious Objection to Obtaining/Providing/Acting on Genetic Information” (2009) 151C American Journal of Medical Genetics Part C (Seminars in Medical Genetics) 62 [*Frader and Bosk*].

¹¹ Elizabeth Sepper, “Taking Conscience Seriously” (2012) 98 Virginia Law Review 1501 [*Sepper*] at 1507.

¹² The World Medical Association, Declaration of Geneva – Physician’s Oath (1948), online: <http://www.mma.org.my/Portals/0/Declaration%20of%20Geneva.pdf>.

¹³ Canadian Medical Association (2004) *Code of Ethics*, “Responsibilities to the Patient”, online: <http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>. (see Appendix)

reinforce the established legal concept that the physician owes a duty of care to the patient.¹⁶ This duty is a fiduciary duty¹⁷ and, as such, the physician is expected to place the well being of the patient above other considerations.

Attempts to ensure patients' rights, and patient autonomy, have resulted in significant resistance from some medical practitioners in western society, particularly from those individuals who are members of religious communities with doctrines that oppose certain types of medical practice.¹⁸ This phenomenon has been most significant in the United States.

Physicians, nurses, and pharmacists are increasingly claiming a right to the autonomy not only to refuse to provide services they find objectionable, but even to refuse to refer patients to another provider and, more recently, to inform them of the existence of legal options for care.¹⁹

The U.S. government and most state legislatures have introduced legislation designed to protect physicians, and other health care workers, from prosecution if they choose not to participate in certain aspects of patient care due to perceived conflicts with individual religious or ethical ideology.²⁰

¹⁴ British Columbia Medical Association (1996) *Code of Ethics*, "Responsibilities to the Patient", online: <https://www.bcma.org/about-bcma/code-ethics>.

¹⁵ *Health Professions Act*, RSA 2000, c H-7, s. 25 (2-4).

¹⁶ *Norberg v. Wynrib*, [1992] 2 S.C.R. 226.

¹⁷ *McInerney v. MacDonald*, [1992] 2 SCR 138.

¹⁸ *Curlin*, *supra* note 8.

¹⁹ R. Alta Charo, "The Celestial Fire of Conscience – Refusing to Deliver Medical Care" (2005) 352(24) *NEJM* 2471 [*Charo*] at 2471.

²⁰ Samuel B. Casey, GENERAL COUNSEL & EXECUTIVE VICE PRESIDENT

Legislation in almost every state – known as “conscience clauses” – ensures that employers accommodate refusal and that refusing doctors and nurses face no adverse professional discipline and liability for contravening acceptable medical standards.²¹

Many of these conscience clauses were passed fairly shortly after *Roe v. Wade*²² and almost all of them refer to abortion as one procedure that physicians should be able to opt out of without sanction.²³ The *Coats Amendment*²⁴ and the *Church Amendment*²⁵ are examples of this legislative attempt to protect physicians. They were specifically designed to prevent any group receiving government funding from discriminating against an individual on the basis of their unwillingness to participate in any facet of abortion accessibility.^{26 27} Some legislation even permits physicians to avoid notifying patients about particular treatment options, or to refuse to refer patients for certain types of care.²⁸

ADVOCATES INTERNATIONAL, “The Health Care Right of Conscience” May 2009, online: http://www.iirf.eu/fileadmin/user_upload/PDFs/ConscienceHC.pdf at 4.

²¹ *Sepper, supra* note 11 at 1503.

²² *Roe v. Wade*, 410 U.S. 113.

²³ Andis Robeznieks, “Battle of the conscience clause: When practitioners say no - When do medical professionals have the right to opt out of treating patients?”, online: <http://www.ama-assn.org/amednews/2005/04/11/prsa0411.htm>.

²⁴ 42 USC § 238n(c)(2) (1996).

²⁵ 42 USC § 300a-7(e) (1973).

²⁶ The Coats Amendment prohibits the federal government as well as state and local governments that receive federal funds from discriminating against any “participant in a program of training in the health professions” who refuses abortion training - Mark R. Wicclair, “Conscience-Based Exemptions for Medical Students” (2010) 19 *Cambridge Quarterly of Healthcare Ethics* 38 at 44.

²⁷ A section of the Church Amendment states that no “entity” that receives certain federal funds “may deny admission or otherwise discriminate against any applicant...because of the applicant’s reluctance, or willingness, to counsel, suggest, recommend, assist, or in any way participate in the performance of abortions or sterilizations contrary to or consistent with the applicant’s religious beliefs or moral convictions” - Mark R. Wicclair, “Conscience-Based Exemptions for Medical Students” (2010) 19 *Cambridge Quarterly of Healthcare Ethics* 38 at 44-45.

²⁸ See, e.g., 745 Ill. Comp. Stat. 70/4-5 (2010); Miss. Code Ann. § 41-107-5 (2009); Wash. Rev. Code § 48.43.065 (2)(a)(2008). The Illinois statute reads, No physician or health care personnel shall be civilly or criminally liable...by reason of his or her refusal to

The claim of conscientious objection by medical practitioners arises from a belief in individual autonomy for all concerned, including the medical personnel who care for patients. This is a relatively new concept. Historically it was thought that physicians would act selflessly in the best interests of their patients – even if that “best interest” was a standard decided upon by the physician.²⁹ Many medical organizations and legal bodies in the western world now give credence to the concept of conscientious objection for physicians and other medical personnel, but they almost always limit this accommodation to the non-emergent situation.³⁰ A physician’s duty to provide medical care in the emergency situation has consistently been demonstrated by the courts.^{31 32} A number of organizations also stress that physicians should notify their patients (at the beginning of the doctor-patient relationship, if possible) if they have an objection to certain medical treatments so that patients are not surprised by this perspective in the

perform, assist, counsel, suggest, recommend, refer or participate in any way in any particular form of health care service which is contrary to the conscience of such physician or health care personnel.
745 Ill. Comp. stat. 70/4 Health care is defined as
[A]ny phase of patient care, including but not limited to, testing; diagnosis; prognosis; ancillary research; instructions; family planning, counselling, referrals, or any other advice in connection with the use or procurement of contraceptives and sterilization or abortion procedures; medication; or surgery or other care or treatment rendered by a physician or physicians, nurses, paraprofessionals or health care facility, intended for the physical, emotional, and mental well-being of persons...(as taken from *Elizabeth Sepper, “Taking Conscience Seriously” (2012) 98 Virginia Law Review 1501*).

²⁹ Roger Collier, “Professionalism: the historical contract” (2012) 184(11) CMAJ 1233.

³⁰ Principle VI of the AMA’s Principles of Medical Ethics states: “A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.” This Principle appears to grant physicians considerable latitude in deciding whether or not to enter into a new patient-physician relationship. However, this Principle includes a fundamental exception: from an ethical standpoint, physicians are not free to refuse to provide services to patients in need of emergency care.

³¹ Anne F. Walker, “The legal duty of physicians and hospitals to provide emergency care” (2002) 166(4) CMAJ 465 [*Walker*].

³² *Egedebo v. Windermere District Hospital Association* (1993) 78 B.C.L.R.

midst of an urgent or emergent medical situation.³³ They advance the thesis that “practitioners who would place their own spiritual or other interests above their patients’ healthcare interests have a conflict of interest, which is unethical if not appropriately declared.”³⁴ Some (but not all) of the policy statements allowing conscientious objection by physicians state the expectation that physicians will refer patients on to another physician who will take over care in a situation where the primary physician is unwilling to act.³⁵ “The reconciliation of patients’ rights to care and providers’ rights of conscientious objection is in the duty of objectors in good faith to refer their patients to reasonably accessible providers who are known not to object.”³⁶

There is no specific legislative requirement in Canada for physicians to notify patients of potential conflicts of interest, or for them to facilitate patient access to another physician in the event of a conflict. The Canadian Medical Association *Code of Ethics*³⁷ encourages proper patient disposition in such a situation, but does not attempt to mandate it.³⁸ Physicians are told to notify patients of conflicts of interest that might arise within the physician-patient relationship and to “resolve them in the best interest of patients.”³⁹

³³ “Ethical guidelines on conscientious objection: FIGO Committee for the Ethical Aspects of Human Reproduction and Women’s Health”, FIGO Committee Report, (2006) 92 International Journal of Gynecology and Obstetrics 333.

³⁴ Bernard M. Dickens, “Legal Protection and Limits of Conscientious Objection: When Conscientious Objection is Unethical” (2009) 28 Med Law 337 [*Dickens*].

³⁵ G.I. Serour, “Ethical guidelines on conscientious objection: FIGO Committee for the Ethical Aspects of Human Reproduction and Women’s Health”, FIGO Committee Report, (2006) 92 International Journal of Gynecology and Obstetrics 333.

³⁶ *Dickens, supra* note 34.

³⁷ CMA Code of Ethics, online: <http://policybase.cma.ca/PolicyPDF/PD04-06.pdf>.

³⁸ Jocelyn Downie and Carla Nassar, “Barriers to Access to Abortion Through a Legal Lens” (2007) 15 Health L. J. 143 at 16-17.

³⁹ CMA Code of Ethics, online: <http://policybase.cma.ca/PolicyPDF/PD04-06.pdf> at sections 11/12.

The College of Physicians and Surgeons of Ontario expects physicians to notify patients if there are any procedures or treatments that the physician would not be willing to provide because of his or her religious or moral beliefs. An OMA Policy Statement also declares that “physicians must not withhold information about the existence of a procedure or treatment because providing that procedure or giving advice about it conflicts with their religious or moral beliefs.”⁴⁰ The Ontario College of Physicians and Surgeons does not specifically require physicians to refer their patients to another physician who would be willing to offer the service to the patient that the current physician is not able to provide based on religious or moral concerns. A recent revision of the *Guideline: Unplanned Pregnancy* from the College of Physicians and Surgeons of Saskatchewan states that “any physician who is unable to be involved in the further care and management of any patient when termination of the pregnancy might be contemplated should inform the patient and make an expeditious referral to another available physician.”⁴¹

The specific requirements of organizations that regulate physician behaviour and licensure across Canada therefore seem to vary with respect to whether or not they require physicians to arrange for alternate care for patients in situations where the physician is opposed to a particular type of care for religious or moral reasons. This inconsistency makes it difficult for patients to be able to depend with certainty on the continuity of care that they may receive from their physicians when requiring certain types of treatment or treatment advice. This lack of consistency is a concern of members

⁴⁰ Policy Statement #5-08, Physicians and the Ontario *Human Rights Code*, online: http://www.cpso.on.ca/uploadedFiles/downloads/epsodocuments/policies/policies/human_rights.pdf.

⁴¹ *Guideline: Unplanned Pregnancy*, College of Physicians and Surgeons of Saskatchewan, online: https://one45.usask.ca/webeval/admin/files/learning_objs/learning_object11149.pdf.

of the National Abortion Federation who write that

If doctors do not wish to refer women for and inform women about their comprehensive medical options, including abortion care, then they should not participate in the public system. Refusing to refer women for abortion care could result in delays that could force women to have later abortions at an increased risk to their health.⁴²

Acceptance of the concept of some degree of conscientious objection by physicians is now fairly widespread, although there are strong opponents of this concept⁴³, and others who would push for broader rights of refusal to provide treatment in situations that physicians find morally troubling. In the United States, “conservative advocates have been working at both the state and the federal levels in their campaign to enact laws to expand the scope of refusal policies.”⁴⁴ Some state legislatures have moved even further in an attempt to protect the rights of physicians to practice based on conscientious beliefs, and to limit patient access to legally available care if that care would conflict with the physician’s personal mores.⁴⁵ These more recent legislative advancements seem to directly undermine the idea of the altruistic and caring physician.⁴⁶ “Legislation currently being passed in some states and considered in others protects the

⁴² “Has Your Physician Refused to Provide a Referral for Abortion Care?” A Patient’s Guide to Action – National Abortion Federation, online: http://www.prochoice.org/pubs_research/publications/downloads/canada/patientguide.pdf.

⁴³ *Savulescu, supra* note 5.

⁴⁴ Adam Sonfield, “New Refusal Clauses Shatter Balance Between Provider ‘Conscience,’ Patient Needs”, (2004) 7(3) *The Guttmacher Report on Public Policy*, online: <http://www.guttmacher.org/pubs/tgr/07/3/gr070301.html>.

⁴⁵ Mississippi Senate Bill 2619, Health Care Rights of Conscience Act (2004), online: <http://billstatus.ls.state.ms.us/documents/2004/html/sb/2600-2699/sb2619sg.htm>.

⁴⁶ B. Jessie Hill. “Legislative Restrictions on Abortion: More anti-abortion legislation was passed in the United States in 2011 than in any other year since 1973” (2012) 14(2) *Virtual Mentor* 133.

right of conscientious objectors not only to practice their own religious faith but also to impose their objections on those of different conscience.”⁴⁷

International policies that refer to these issues address patient rights, as well as rights of physicians and other health care providers, in terms of the rights of autonomous individuals. The UN International Covenant on Civil and Political Rights (ICCPR), which came into force in 1976, provides in Article 18(1) that:

Everyone shall have the right to freedom of thought, conscience and religion...[and] to manifest his religion or belief in worship, observance, practice and teaching.⁴⁸

This statement has been used to support the idea that individual health workers can refuse to provide certain types of health care to patients if the treatment or intervention does not meet with their own religious or ethical views. However, the right to refusal outlined by this covenant is not absolute. Article 18(3) of the Covenant limits conscientious objection where it may intrude upon the health, safety and rights of others in society. “Freedom to manifest one’s religion or beliefs may be subject only to such limitations as...are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.”⁴⁹

⁴⁷ Rebecca J. Cook and Bernard M. Dickens, “The Growing Abuse of Conscientious Objection” (2006) 8(5) *Virtual Mentor* 337 [Cook and Dickens] at 338.

⁴⁸ *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, UNTS171 (entered into force 23 March 1976) at Article 18(1).

⁴⁹ *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, UNTS171 (entered into force 23 March 1976) at Article 18(3).

The World Medical Association Declaration of Geneva (Physician's Oath) states that the physician will always put the needs of his or her patient ahead of any other concerns, including considerations of "religion, nationality, race, party politics or social standing."⁵⁰ This perspective is undermined by state legislatures that pass legislation divesting physicians of any responsibility for patient care, even in emergency situations, if that care conflicts with deeply held religious or moral beliefs of the physician. As one can see, the idea of a physician as an autonomous individual who can withdraw from patient care, even in an emergency situation, is being embraced more frequently in western society, particularly in the United States.

The "duty to care" in the physician-patient relationship, particularly in the emergent situation, is fairly well described in the literature and in national and international jurisprudence. There has been significantly less discussion with respect to the responsibilities owed to a patient by a student who is studying to become a practicing physician.⁵¹ Students do not bear ultimate responsibility for care of the patient and, instead, their main goals and responsibilities are to themselves and to the physicians they will ultimately become. A recent survey⁵² gathered information from British medical students, asking them about their beliefs with respect to conscientious objection to medical procedures and whether or not they believed that it was acceptable for students to refuse to participate in certain aspects of medical training because of particular religious

⁵⁰ The World Medical Association Declaration of Geneva (1948) Physician's Oath, online: <http://www.cirp.org/library/ethics/geneva/>.

⁵¹ *Card*, *supra* note 6.

⁵² S.L. Strickland, "Conscientious Objection In Medical Students: A Questionnaire Survey" (2012) 38(1) J Med Ethics 22 [*Strickland*].

beliefs or beliefs of conscience. “Nearly half of the students in this survey stated that they believed in the right of doctors to conscientiously object to any procedure.”⁵³ The United Kingdom has fairly strict policies that limit the ability of medical students to avoid certain types of medical training because of conscientious objection.⁵⁴ Despite this, many students seem to believe that conscientious objection is a reasonable stand to take as a medical student or practicing physician. In the United States, the American Medical Association’s Conscience Clause allows students to be exempted from certain medical training and/or involvement in certain medical procedures if the educational component of the training or procedure can be acquired by the students in some other manner.⁵⁵

Should there be a distinction between conscientious objection for practicing physicians and conscientious objection for medical students? Are the roles different enough that there should be a distinction between how conscientious objection is viewed between these two groups? Practicing physicians are licensed to look after patients and have a certain responsibility to ensure care is provided for their patients, particularly in emergency situations where, it may be argued, the urgency of patient care outweighs any moral or ethical concerns that a physician might have with respect to a certain medical procedure or activity. Medical students, on the other hand, are seldom the sole individuals responsible for a patient’s well being and it may be more permissible to allow students to act based on conscientious beliefs without affecting overall patient care. Then

⁵³ *Ibid.*

⁵⁴ “Good Medical Practice – explanatory guidance”, General Medical Council – Undergraduate Board, April 2012, online: http://www.gmc-uk.org/5_Good_Medical_Practice_explanatory_guidance.pdf_48639321.pdf.

⁵⁵ American Medical Association Policy H-295.896 Conscience Clause, online: <http://www.consciencelaws.org/background/policy/associations-006.aspx>.

again, we must remember that these students are going to become practicing physicians who are, potentially, not able to refuse to provide care in certain circumstances. This is an important consideration to keep in mind when allowing students to avoid certain types of medical procedures or training sessions. It can be argued that the alternative training measures, if delivered, must ensure that training physicians are receiving adequate education and experience to permit them to practice medicine safely if urgent or emergent situations require it in the future.⁵⁶ This will certainly be possible for certain areas of medical training, but may not be as reasonable an option in other situations. “There are cases where one must perform the ‘objectionable’ activity itself in order to learn the necessary content and underlying principles.”⁵⁷

Medical students eventually move into different areas of training and must choose what discipline they want to pursue when it comes to post-graduate education (residency training). Certain disciplines train students in areas that are much more likely to challenge them in terms of their moral and religious beliefs. This is particularly the case in the discipline of Obstetrics and Gynecology. Some writers have suggested that students should not choose to train in areas that are incompatible with their religious or ethical beliefs.⁵⁸

Conscientious objection makes sense with conscription, but it is worrisome when professionals who freely chose their field parse care and withhold information that patients need. As the gatekeepers to medicine, physicians and other health care

⁵⁶ Policy re “Religious Observance” and “Opting Out of Educational Experiences Due to Conscientious Objections, 2009” University of Rochester School of Medicine and Dentistry, online: <http://www.urmc.rochester.edu/education/md/documents/student-handbook.pdf> at pp. 29-30.

⁵⁷ *Card*, *supra* note 6.

⁵⁸ Ariel Williams, “Conscientious Objection: A Medical Student Perspective” (2009) 11(9) *Virtual Mentor* 686 [*Williams*].

providers have an obligation to choose specialties that are not moral minefields for them.⁵⁹

There are a number of reasons for and against allowing conscience-based exemptions from medical procedures or educational sessions for medical students. It has been argued that it is important to encourage medical students to remain ethical and thoughtful in their approach to management of medical problems and care of patients, and that refusal of conscience-based requests for exemptions would encourage ethical insensitivity in students.⁶⁰ Refusal to grant conscience-based exemptions may lessen the diversity of the student population within a medical school because individuals with a religious or cultural background who are opposed to certain aspects of western culture (for example - same sex relationships or the use of contraception) will not be able to meet the requirements of a western medical education and still maintain the tenets of their religion. Nonetheless, there are certain competing interests that need to be addressed when contemplating whether or not to allow someone to opt-out of aspects of medical training based on religious or ethical concerns. “Relevant considerations include: (1) established core educational requirements, (2) local core curricula, (3) non-discrimination, (4) impact on patients, and (5) impact on students, residents and supervisors.”⁶¹

⁵⁹ Julie D. Cantor, “Conscientious Objection Gone Awry – Restoring Selfless Professionalism in Medicine” (2009) 360(15) NEJM 1484 [*Cantor*] at 1485.

⁶⁰ Wicclair, Mark R. *Conscientious Objection in Health Care: An Ethical Analysis* (Cambridge, UK: Cambridge University Press, 2011) [*Wicclair*] at 201.

⁶¹ *Wicclair, supra* note 60 at 201.

While examining the issue of conscientious objection and medical school training, this thesis will focus on several areas where conscientious objection may arise. Two of these areas of controversy are fairly well recognized in our society: objection to abortion/contraception; and, request for exemption from certain duties in order to carry out religious observances. This discussion will also consider the possibility that at some future date a Canadian medical student will refuse to perform an examination on someone of the opposite sex as part of his or her training process. This may currently be an unfamiliar scenario in Canada, but it is one that has been encountered in the United Kingdom⁶² and it may arise in medical schools in Canada as patterns of immigration change and more students of non-European backgrounds begin to train as physicians in this country. These examples will be used to explore the approaches that medical schools should take when deciding whether or not to grant exemptions on accommodation grounds. The following chapter will outline the relevant legal framework.

⁶² D. Foggo, A. Taher, “Muslim medical students get picky”, The Times Online. 2007, online: www.timesonline.co.uk/tol/news/uk/health/article2603966.ece.

Chapter 2: Legal Framework

Medical education generally follows a very structured program, based on the goal of teaching human anatomy, physiology, normal function, disease states and the management and/or treatment of disease. Students admitted into this curriculum have, heretofore, been expected to proceed through the training process, mastering all areas of training and knowledge acquisition before exiting from the program as trained physicians. Recent changes in the population mix within medical school classes have challenged ideas about what constitutes an absolute in medical school training, and where programs may be modified in order to allow individuals from different religious and cultural backgrounds to receive medical training, while still remaining true to their religious or cultural roots.

Medical students have occasionally requested exemption from certain components of medical school training for religious or conscience reasons,⁶³ and this process may occur more frequently in the future. What mechanisms could be used by a medical student to challenge a refusal to allow that student to opt out of some aspect of medical training because of a religious or conscientious objection? This chapter will describe the framework that could be used to develop a mechanism by which both a medical student and a college of medicine training program could reach an agreement about how to deal with requests for differential treatment within the medical school paradigm. In order to develop this mechanism, I will identify the rationale behind the concept of reasonable accommodation, and the methods that a student might follow to achieve their goal if a

⁶³ *Card, supra* note 6.

request for accommodation is denied. Potential legal mechanisms available to the student would fall within the ambit of human rights legislation or under the guidelines of the *Canadian Charter of Rights and Freedoms*. Appraisal of these legal mechanisms could ultimately lead to a technique of guiding policies for medical schools that are trying to establish fair and reproducible means of accommodating differences.

2.1 Reasonable Accommodation

Reasonable accommodation is a method of dealing with requests for differential treatment and is a common component of human rights legislation. Reasonable accommodation refers to the act of accommodating differences between groups of people within the fabric of our society. The requirement for reasonable accommodation assumes that there is behaviour that is different than, or infringes upon, the belief system, or cultural norms of another segment of society. Discussion of reasonable accommodation attempts to discern when, and why, one would allow for these differences to exist, rather than forcing outliers to meet accepted societal norms through legislative directive, or through challenge via the courts. This is often seen from the perspective of the “dominant” group that is having their norm “challenged” by the atypical behaviour or differential request.

The concept of reasonable accommodation was first introduced in the *United States Civil Rights Act*⁶⁴ of 1968.⁶⁵ This Act mandated that religious practices be accommodated in the work force “unless an accommodation would cause undue hardship

⁶⁴ Indian Civil Rights Act of 1968, Pub.L. 90-284, 82 Stat. 73, enacted April 11, 1968. (within Title 25, sections 1301 to 1303 of the United States Code)

⁶⁵ The Concept of Reasonable Accommodation in Selected National Disability Legislation, UN Enable A/AC.265/2006/CRP.1, online: <http://www.un.org/esa/socdev/enable/rights/ahc7bkgrndra.htm> [UN Enable].

on the employer's business.”⁶⁶ This accommodation is defined, and limited, by legal requirements, both common law and statutory, but is also shaped by societal mores and by the particular ideology within the society itself. “Reasonable accommodation is a legal notion. This notion stems from jurisprudence in the realm of labour and indicates a form of relaxation aimed at combating discrimination caused by the strict application of a norm, which, in certain of its effects, infringes on a citizen's right to equality.”⁶⁷ One cannot legally allow a behaviour that is proscribed by law, but beyond that, behaviour is permitted, or is subject to sanction, by groups or individuals based on differing views as to where a line should be drawn between permitting an activity or behaviour, versus disallowing it.

Reasonable accommodation of religious practice, that infringes, or has the potential to infringe, on others' space in society, is decided upon and informed by the religious and cultural beliefs of the people assessing the behaviour. It is limited by the *extent* to which it infringes upon individual or group rights and goals, as well as the discomfort it may create in groups or individuals affected by the behaviour. It is also limited by legal precepts that outline restrictions to certain types of manifestations of religious belief. Freedom of conscience would, theoretically, be limited by similar societal mores and legal rules that bar certain manifestations of religious belief (e.g.

⁶⁶ The Concept of Reasonable Accommodation in Selected National Disability Legislation, UN Enable A/AC.265/2006/CRP.1, online: <http://www.un.org/esa/socdev/enable/rights/ahc7bkgrndra.htm> [UN Enable].

⁶⁷ Gérard Bouchard and Charles Taylor, BUILDING THE FUTURE A Time for Reconciliation, Abridged Report, online: <http://red.pucp.edu.pe/wp-content/uploads/biblioteca/buildingthefutureGerardBouchardycharlestaylor.pdf>.

discrimination against women or homosexuals), but the boundaries associated with freedom of conscience are still not very well defined by our Canadian legal system.

2.2 Reasonable Accommodation and Human Rights Legislation

What are the limits of reasonable accommodation and how are they determined in Canadian society? Ensuring the provision of reasonable accommodation is an important part of Federal and Provincial human rights legislation.

2.2.1 Federal

“The duty to accommodate arises from two federal statutes: the *Canadian Human Rights Act* and the *Employment Equity Act*.”⁶⁸ The duty to accommodate refers to the obligation of an employer, service provider, or union to take steps to eliminate disadvantage to employees, prospective employees or clients resulting from a rule, practice, or physical barrier that has or may have an adverse impact on individuals or groups protected under the *Canadian Human Rights Act*, or identified as a designated group under the *Employment Equity Act*.⁶⁹ Human rights commissions deal primarily with complaints of discrimination. Some prohibited grounds of discrimination are listed in section 3 of the *Canadian Human Rights Act*.

3(1) For all purposes of this Act, the prohibited grounds of discrimination are race, national or ethnic origin, colour, religion, age, sex, sexual orientation, marital status, family status, disability and conviction for an offence for which a pardon has been granted or in respect of which a record suspension has been ordered.⁷⁰

⁶⁸ Canadian Human Rights Commission, online: http://www.chrc-ccdp.ca/discrimination/apfa_uppt/page1-eng.aspx.

⁶⁹ *Ibid.*

⁷⁰ *Canadian Human Rights Act* (R.S.C., 1985, c. H-6), s. 3.

Discriminatory practices that distinguish between individuals based on these prohibited grounds of discrimination are dealt with in sections 5 and 10 of the *Canadian Human Rights Act*.⁷¹ In particular, section 10 serves to prevent discrimination that would affect training or apprenticeship and, therefore, limit access to future employment.

10. It is a discriminatory practice for an employer, employee organization or employer organization
(b) to enter into an agreement affecting recruitment, referral, hiring, promotion, training, apprenticeship, transfer or any other matter relating to employment or prospective employment that deprives or tends to deprive an individual or class of individuals of any employment opportunities on a prohibited ground of discrimination.⁷²

2.2.2 Provincial

Provincial human rights codes stipulate similar guidelines and rules to those established within the *Canadian Human Rights Act*. Education is a provincial responsibility and any human rights complaint initiated by a medical student would likely be dealt with through provincial human rights legislation. Section 13(1) of the Manitoba Human Rights Code, for example, states that

No person shall discriminate with respect to any service, accommodation, facility, good, right, licence, benefit, program or privilege available or accessible to the public or to a section of the public, unless bona fide and reasonable cause exists for the discrimination.⁷³

Statements such as this within Provincial human rights may be important with respect to

⁷¹ *Canadian Human Rights Act* (R.S.C., 1985, c. H-6), s. 5, s. 10.

⁷² *Ibid.*, s. 10.

⁷³ *The Human Rights Code*, CCSM c H175, s. 13(1).

the ability of a College of Medicine to “discriminate” if “bona fide and reasonable cause” exist(s). Section 14(2)(c) of the Manitoba Human Rights Code identifies that the code applies to any aspect of an employment or occupation, including “training, advancement or promotion”.⁷⁴ The *Saskatchewan Human Rights Code*⁷⁵ contains a bill of rights that includes freedom of conscience and freedom of religion for all citizens of the province.

4 Every person and every class of persons shall enjoy the right to freedom of conscience, opinion and belief and freedom of religious association, teaching, practice and worship.⁷⁶

The Saskatchewan Human Rights Code also specifically addresses the right to education saying that

13(1) Every person and every class of persons shall enjoy the right to education in any school, college, university or other institution or place of learning, vocational training or apprenticeship without discrimination on the basis of a prohibited ground other than age.⁷⁷

2.3 Addressing a Human Rights Claim

The framework for proving a human rights claim (proving a *prima facie* complaint) involves the process of establishing that the individual or individuals involved have been subject to treatment with respect to a prohibited ground of the code and that the burden associated with that treatment falls within a sphere of activity covered by the code. A prohibited ground might include race or religion, and a protected sphere of

⁷⁴ *The Human Rights Code*, CCSM c H175, s. 14(2)(c).

⁷⁵ *Saskatchewan Human Rights Code*, SS 1979, c S-24.1.

⁷⁶ *Ibid.*, s. 4.

⁷⁷ *Saskatchewan Human Rights Code*, SS 1979, c S-24.1, s. 13(1).

activity could include such things as access to employment, health or education. A complainant can also claim discrimination based on adverse effects – wherein a rule or procedure that treats everyone alike (a “neutral rule”) results in differential treatment to one group of people in comparison to another. Once a complainant is able to demonstrate inequitable treatment with respect to a prohibited ground, and within a recognized sphere of activity, *prima facie* discrimination is held to have occurred unless the respondent negates, rebuts or justifies this differential treatment. If discrimination is established, the burden of proof lies on the respondent to show why this discriminatory rule or process should be allowed.⁷⁸ A human rights tribunal would need to determine if there is “real” discrimination occurring that warrants liability on behalf of the respondent, if no reasonable explanation for this differential treatment can be advanced.

All of the normative questions that finally determine liability occur at this stage. Did the respondent have some “good” reason for the requirement imposed? What counts as a good reason? What would be the consequences for the operation of its enterprise of having to dispense with or change the requirement? Is it asking too much to make the respondent go this far in order to avoid the differential effect imposed by its practice or policy?⁷⁹

When looking at human rights legislation, in terms of the declaration expected from the respondent in order to legitimize this differential treatment or discriminatory result, answers to several questions must be provided. Is there evidence that this rule or practice is necessary for successful function of the particular business or enterprise? Did the respondent act in honesty and good faith in implementing this differential rule? Is it

⁷⁸ *Kelly v. University of British Columbia* (No. 3) (2012), CHRR Doc. 12-0032, 2012 BCHRT 32 at para. 451.

⁷⁹ Denise Réaume, “Defending the Human Rights Codes from the Charter” (2012) 9 J.L. & Equality 67 at para. 11.

impossible to accommodate the complainant without creating undue hardship on the respondent or undermining the purpose and/or function of the enterprise?⁸⁰ If these questions demonstrate an honest rationale behind the rule, then discrimination may not be identified.

Germane to this process, the *Meiorin*⁸¹ case involved a female firefighter who lost her job because she did not meet the fitness requirements established by the government of British Columbia. In addition to addressing the specifics of this particular case, the Court in the *Meiorin* case attempted to develop a consistent method of identifying and proving discrimination, regardless of the sphere of activity within which the complainant was participating. The *Meiorin Test* serves to evaluate a standard that is developed as a requirement for employment within a particular work place.

An employer may justify the impugned standard by establishing on the balance of probabilities:

- (1) that the employer adopted the standard for a purpose rationally connected to the performance of the job;
- (2) that the employer adopted the particular standard in an honest and good faith belief that it was necessary to the fulfilment of that legitimate work-related purpose; and
- (3) that the standard is reasonably necessary to the accomplishment of that legitimate work-related purpose. To show that the standard is reasonably necessary, it must be demonstrated that it is impossible to accommodate individual employees sharing the characteristics of the claimant without imposing undue hardship upon the employer.⁸²

⁸⁰ *British Columbia (Public Service Employee Relations Commission) v. British Columbia Government Service Employees' Union* 1999 SCC 48, [1999] 3 S.C.R. 3. [*Meiorin*].

⁸¹ *Ibid.*

⁸² *Meiorin*, *supra* note 80 at para. 54.

If an individual requests differential treatment, but this request is refused by an employer, then a human rights challenge might look to the *Meiorin Test* to determine if refusal to accommodate this request is reasonable. In *British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights)*⁸³, Justice McLachlin determined that the *Meiorin Test* applies to all situations of discrimination where accommodation may be possible. The *Meiorin Test* requires those governed by human rights legislation to accommodate the characteristics of affected groups when demanding particular standards, or show why accommodation is not possible. Once a plaintiff establishes that a standard is *prima facie* discriminatory, the onus shifts to the defendant to prove, on a balance of probabilities, that the discriminatory standard is a *bona fide* occupational requirement or that there is a *bona fide* and reasonable justification for maintaining the impugned standard.⁸⁴

Bona fide occupational requirement (BFOR) is a term that applies in human rights law and refers to a work requirement that has been established and is thought to be necessary for a job to be performed properly or efficiently. The concept of a BFOR was discussed in detail by the Supreme Court of Canada in *Canadian National Railway Co. v. Canada (Human Rights Comm.) and Bhinder (1985)*.⁸⁵ The majority in that case determined that a work rule or requirement that is based on a genuine BFOR should be upheld, even if it appears to discriminate against certain factions of society. This

⁸³ *British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights)*, [1999] 3 S.C.R. 868.

⁸⁴ *Ibid.*

⁸⁵ *Canadian National Railway Co. v. Canada (Human Rights Comm.) and Bhinder (1985)*, 7 C.H.R.R. D/3093 (S.C.C.) [*Bhinder*].

decision was thought to be consistent with statements found within the *Canadian Human Rights Code* (previously section 14(a)).

15. (1) It is not a discriminatory practice if
(a) any refusal, exclusion, expulsion, suspension, limitation, specification or preference in relation to any employment is established by an employer to be based on a bonafide occupational requirement.⁸⁶

“A working condition does not lose its character as a bona fide occupational requirement because it may be discriminatory. Rather, as a bona fide occupational requirement, it may permit consequential discrimination, if any.”⁸⁷ It appears from this case that there are bona fide occupational requirements that are considered non-negotiable, even if no consideration of undue hardship is made in the context of the request advanced. This viewpoint was challenged by Dickson C.J. who would have allowed the appeal, determining that a BFOR did not exist unless undue hardship was proven.

The words "occupational requirement" refer to a requirement manifestly related to the occupation as a whole. The qualifying words "bona fide" require an employer to justify the imposition of an occupational requirement on a particular individual when such imposition has discriminatory effects on the individual. A requirement which is prima facie discriminatory against an individual, even if occupational, is not bona fide for the purposes of s. 14(a) if its application to the individual is not reasonably necessary in the sense that undue hardship would result on the part of the employer if an exception or substitution were to be allowed on the part of the individual affected.⁸⁸

The method of determining whether or not something is a BFOR was revisited in the *Meiorin* case (*British Columbia (Public Service Employee Relations Commission) v.*

⁸⁶ *Canadian Human Rights Act* (R.S.C., 1985, c. H-6), s. 15(1)(a).

⁸⁷ *Bhinder*, *supra* note 85.

⁸⁸ *Bhinder*, *supra* note 85.

BCGSEU (1999 35 C.H.R.R. D/257 (S.C.C.)) and specific criteria were outlined that included the necessity of proving undue hardship in the final step of the analysis.⁸⁹

Undue hardship is a somewhat vague concept and has a subjective quality to it. When accommodation of an employee would result in undue hardship to the employer, then the requirement that is being challenged is likely a BFOR. When something is definitely a BFOR, undue hardship would, as a matter of course, result from removing it from the employment situation. These two components provide checks and balances against the advancement of discriminatory decision-making.

A recent Supreme Court of Canada case looked to human rights legislation in determining that a student was discriminated against when a particular special education program was cancelled, and that the discriminatory action was not justifiable. *Moore v. B.C.*⁹⁰ was heard, on appeal⁹¹ from the British Columbia Court of Appeal, on March 22, 2012. This case involved a claim of lack of substantive equality for children with learning disabilities (in this case – dyslexia) with respect to their access to public school education within the province of British Columbia. The BC Human Rights Tribunal found that discrimination had occurred when the School District cut funding to services for learning disabled students, thereby undermining these students’ access to public

⁸⁹ A three-step test should be adopted for determining whether an employer has established, on a balance of probabilities, that a prima facie discriminatory standard is a bona fide occupational requirement (BFOR). First, the employer must show that it adopted the standard for a purpose rationally connected to the performance of the job. The focus at the first step is not on the validity of the particular standard, but rather on the validity of its general purpose. Second, the employer must establish that it adopted the particular standard in an honest and good faith belief that it was necessary to the fulfilment of that legitimate work-related purpose. Third, the employer must establish that the standard is reasonably necessary to the accomplishment of that legitimate work-related purpose. To show that the standard is reasonably necessary, it must be demonstrated that it is impossible to accommodate individual employees sharing the characteristics of the claimant without imposing undue hardship upon the employer.

⁹⁰ *Moore v. British Columbia (Education)*, 2012 SCC 61.

⁹¹ *British Columbia (Ministry of Education) v. Moore*, 2010 BCCA 478.

education services. The case was heard by the BC Supreme Court, which overturned the decision of the tribunal. It was then referred on to the BCCA and 2 of 3 judges dismissed the appeal. A third judge dissented and her written reasons focused on a section 15 analysis of the case and the need to ensure that reasonable accommodation had occurred. The Moores were given leave to appeal the case to the SCC and the appeal was heard on March 22nd, 2012. The appeal was allowed. The Court determined that Jeffrey Moore was discriminated against when his special education program was cancelled due to financial constraints. The Court agreed with the Tribunal finding that

the District faced financial difficulties during the relevant period. Yet it also found that cuts were disproportionately made to special needs programs.... More significantly, the Tribunal found that the District undertook *no* assessment, financial or otherwise, of what alternatives were or could be reasonably available to accommodate special needs students if the Diagnostic Centre were closed. The failure to consider financial alternatives completely undermined the District's argument that it was justified in providing *no* meaningful access to an education for J because it had no choice. In order to decide that it had no other choice, it had at least to consider what those other choices were.⁹²

In other words, the Court determined that the District did not make a meaningful attempt at accommodation of the Moores' requests. "Accommodation is necessarily a fact-driven inquiry. Among the relevant factors adjudicators will consider are the costs associated with the possible method of accommodation and safety issues."⁹³

Human rights legislation provides one avenue for pursuing complaints about perceived discrimination in a medical school situation and its application to these issues will be examined in Chapter 3. Another option that a medical student might choose

⁹² *Moore v. British Columbia (Education)*, 2012 SCC 61.

⁹³ Heather M. MacNaughton and Jessica Connell, "A Delicate Balance: The Challenges Faced By Our Democratic Institutions in Reconciling the Competing Rights and Interests of a Diverse Population" (2011) 44 UBC L Rev 149 at para 19.

would be to challenge a decision not to accommodate a request for differential treatment by launching a legal challenge using the *Charter of Rights and Freedoms*. How would the *Charter* apply in situations where there has been a request by medical students for accommodation of specific religious, cultural or conscience-based beliefs? Could a refusal to accommodate such a request result in a *Charter* challenge by the student? Does the *Canadian Charter of Rights and Freedoms* even apply to universities?

2.4 Does the *Canadian Charter of Rights and Freedoms* Apply to Universities?

Section 32(1)⁹⁴ of the *Charter* describes what rules and regulations are subject to this component of the constitution.⁹⁵ A literal reading of section 32(1) finds that the reach of the *Charter* is limited to legislation crafted by the government of each province and by the Parliament of Canada. This concept seems fairly straightforward but is less conclusive than one might initially suppose. In *Dolphin Delivery*,⁹⁶ the Court attempted to place some boundaries on the reach of the *Charter*, based specifically on a reading of section 32(1). Over time, the Court has broadened the potential application of the *Charter*, allowing that it pertains to a number of cases in which the arm of the government is seen to be controlling aspects of the private sphere. The *Charter* has been

⁹⁴ *Charter*, *supra* note 3 at section 32(1).

⁹⁵ 32. (1) This Charter applies

a) to the Parliament and government of Canada in respect of all matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest Territories; and
b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province.

⁹⁶ *RWDSU v. Dolphin Delivery Ltd.*, [1986] 2 S.C.R. 573 [*Dolphin Delivery*].

found to apply to "many forms of delegated legislation, regulations, orders in council, possibly municipal by-laws, and by-laws and regulations of other creatures of Parliament and the Legislatures."⁹⁷ More recent judgments of the Supreme Court of Canada have determined that "the *Charter* may apply to the actions of a delegated decision maker acting pursuant to statutory authority."⁹⁸ Strictly private actors are not subject to *Charter* scrutiny, but bodies performing governmental work may be subject to assessment under the *Charter*. "Also included are those Crown corporations and public agencies that are outside the formal departmental structure, but which, by virtue of ministerial control or express statutory stipulation, are deemed to be "agents" of the Crown."⁹⁹

In *McKinney v. University of Guelph*¹⁰⁰ Chief Justice Dickson and Justices La Forest and Gonthier determine that a university is not subject to the *Charter*, stating that "the fact that an entity is a creature of statute and has been given the legal attributes of a natural person is not sufficient to make its actions subject to the *Charter*."¹⁰¹ The Court does, however, leave the door open to the possibility that particular entities that are not obviously governmental bodies might be subject to the *Charter* if they meet certain criteria.

I would favour an approach that asks the following questions about entities that are not self-evidently part of the legislative, executive or administrative branches of government:

⁹⁷ *Ibid.*

⁹⁸ *Pridgen v. University of Calgary*, 2010 ABQB 644 [*Pridgen*] at para. 34.

⁹⁹ Peter Hogg, *Constitutional Law of Canada*, Student Edition. (Toronto: Carswell, 2008) at pp. 784-5.

¹⁰⁰ *McKinney v. University of Guelph*, [1990] 3 S.C.R. 229 [*McKinney*].

¹⁰¹ *McKinney*, *supra* note 100.

1. Does the legislative, executive or administrative branch of government exercise general control over the entity in question?
 2. Does the entity perform a traditional government function or a function which in more modern times is recognized as a responsibility of the state?
 3. Is the entity one that acts pursuant to statutory authority specifically granted to it to enable it to further an objective that government seeks to promote in the broader public interest?
- Each of these questions is meant to identify aspects of government in its contemporary context. An affirmative answer to one or more of these questions would, to my mind, be a strong indicator that one is dealing with an entity that forms part of government. ¹⁰²

Further broadening of the perspective that the *Charter* applies only to governmental legislation and activity is found in *Eldridge v. British Columbia (Attorney General)*.¹⁰³ In this case a hospital failed to provide sign language interpretation for deaf patients. The patients argued that lack of this service infringed their ability to receive adequate medical care as they were unable to communicate effectively with their physicians and with other health care practitioners. Justice La Forest for the Supreme Court determined that the *Charter* applies to a hospital that is carrying out government policy with respect to health service implementation. In *Eldridge*, the Court found that there were two ways in which the *Charter* may apply to specific legislation. First, legislation may be unconstitutional because it violates a *Charter* right.

Secondly, the *Charter* may be infringed, not by the legislation itself, but by the actions of a delegated decision-maker in applying it. In such cases, the legislation remains valid, but a remedy for the unconstitutional action may be sought pursuant to s. 24(1) of the *Charter*.¹⁰⁴

¹⁰² *Ibid.*

¹⁰³ *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624 [*Eldridge*].

¹⁰⁴ *Eldridge*, *supra* note 103 at para. 20.

La Forest also states “there is no doubt...that the *Charter* also applies to action taken under statutory authority.”¹⁰⁵ That does not mean that every body created by the government is subject to *Charter* review. Corporations may be created by statute but then function autonomously, without government interference. Depending upon the particular circumstance, and the meaning of “government” as defined under section 32¹⁰⁶, some of these statutory entities may need to function within *Charter* guidelines.

“A private entity may be subject to the *Charter* in respect of certain inherently governmental actions... The rationale for this principle is readily apparent. Just as governments are not permitted to escape *Charter* scrutiny by entering into commercial contracts or other "private" arrangements, they should not be allowed to evade their constitutional responsibilities by delegating the implementation of their policies and programs to private entities.”¹⁰⁷

Therefore, a private entity that is carrying out a public purpose is not necessarily subject to *Charter* review. “In order for the *Charter* to apply to a private entity, it must be found to be implementing a specific governmental policy or program.”¹⁰⁸

In *R. v. Whatcott*,¹⁰⁹ the appellant was charged with littering contrary to a bylaw that had been enacted by the University of Regina, pursuant to a statute that allowed the University of Regina to pass bylaws governing traffic and parking issues on university grounds. “The Court found that while the University of Regina was independent from government, it attracted *Charter* scrutiny in the performance of certain governmental

¹⁰⁵ *Ibid.*, at para. 21.

¹⁰⁶ Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, section 32.

¹⁰⁷ *Eldridge*, *supra* note 103 at para. 42.

¹⁰⁸ *Eldridge*, *supra* note 103.

¹⁰⁹ *R. v. Whatcott*, 2002 SKQB 399, 225 Sask. R. 205 [*Whatcott*].

activities.”¹¹⁰ “By enacting the bylaws the University is essentially carrying out the purposes of ss. 90.1 to 90.3 of the *Act*. It is engaged in governmental action which may bring an individual before the courts in the same manner as a Federal, Provincial or municipal law.”¹¹¹

In *Pridgen v. University of Calgary*¹¹², a case involving two students who were disciplined for non-academic misconduct by the university, the Court determined that the University of Calgary was not a part of the government per se, but that the actions taken by it were in relation to implementation of a government program (*Post-Secondary Learning Act* (PSL)) and, therefore, that this activity was subject to assessment under the *Charter*.

I find that the University is tasked with implementing a specific government policy for the provision of accessible post secondary education to the public in Alberta, thus bringing the facts of this case into line with *Eldridge*. The structure of the *PSL Act* reveals that in providing post-secondary education, universities in Alberta carry out a specific government objective.¹¹³

The judge found that the program, as well as actions specifically related to that program, such as discipline of students, fit within a statutory framework, created by government.

I find that the nature of the activity being undertaken by the University here, imposing disciplinary sanctions, fits more comfortably within the analytical framework of statutory compulsion. The issue is whether in disciplining students pursuant to authority granted under the *PSL Act*, the University must be *Charter* compliant. The statutory authority includes the power to impose serious sanctions

¹¹⁰ *Pridgen*, *supra* note 98 at para. 55.

¹¹¹ *Whatcott*, *supra* note 109 at para. 44.

¹¹² *Pridgen*, *supra* note 98.

¹¹³ *Pridgen*, *supra* note 98.

that go beyond the authority held by private individuals or organizations. Those sanctions include the power to fine, the power to suspend a student's right to attend the university, and the power to expel students from the university: *PSL Act*, section 31. Accordingly, *Charter* protection for students' fundamental freedoms, including freedom of expression, applies in these circumstances. This goes to the fundamental purpose of the *Charter* as noted by Wilson J. at 222 of her dissent in *McKinney*, where she stated that those who enacted the *Charter* "were concerned to provide some protection for individual freedom and personal autonomy in the face of government's expanding role".¹¹⁴

In this Court of Appeal decision, Justice Paperny moved more definitely toward determining that universities are governmental bodies, dependent upon government funding and integral to societal function. She interpreted *McKinney* as leaving the door open to the possibility that aspects of university function may be subject to *Charter* review, depending upon what government role the university has adopted. She upheld the Court of Queen's Bench decision in support of the perspective that the disciplinary proceedings carried out by the University of Calgary were subject to *Charter* review.

The importance of this case, as it relates to the subject matter of this thesis, is critical. What recourse would a student have if he or she were to request exemption from specific aspects of medical training, either within the confines of medical training, or as a request in anticipation of being accepted into a College of Medicine? Justice Paperny's writings seem to directly address this issue, stating that decisions made by a university body that might serve to inhibit a student from graduating from a professional college, should be a public concern and open to assessment.

Access to post-secondary education is a pressing public concern. The sanctions available to the Review Committee here, which include denial of access to public post-secondary education for the affected students, can have consequences as serious for one's ability to practice in one's chosen field as the actions of a

¹¹⁴ *Pridgen v. University of Calgary*, 2012 ABCA 139 [*Pridgen CA*] at para. 105.

professional regulator. In the case of many professional schools, such as medicine, dentistry or law, the university acts as gatekeeper to the profession as much as any regulatory body.¹¹⁵

From the *Pridgen* case, particularly the decision from the Court of Appeal in Alberta, it appears that more and more aspects of university function may be subject to *Charter* review – at least until this perspective is addressed by the Supreme Court of Canada.

The recent decision by the Supreme Court of Canada in *Doré*¹¹⁶ suggests that an administrative body (such as an appeals board of a university), exercising power under a statute, would be required to make decisions through application of administrative law rules (rather than an *Oakes* type of analysis) using the standard of review of reasonableness to take *Charter* values into account. The decision would need to balance the proportionality of various rights, attempting to determine “has the decision-maker disproportionately, and therefore unreasonably, limited a *Charter* right.”¹¹⁷ However, it is likely that the *Charter* would still be applied in the usual fashion when there is a challenge to a specific **policy** created by a body like a university or medical school.

2.5 Reasonable Accommodation and the *Charter*

Components of the *Charter* that are most relevant to this discussion include sections 2(a), 15 and, to a lesser degree, section 7. How have the relevant components of the *Charter of Rights and Freedoms* been used to deal with discrimination or differential

¹¹⁵ *Pridgen CA*, *supra* note 114 at para. 109.

¹¹⁶ *Doré v. Barreau du Québec*, 2012 SCC 12, [2012] 1 S.C.R. 395 [*Doré*].

¹¹⁷ *Ibid.*

treatment? Informing this discussion is the 2009 SCC case *Alberta v. Hutterian Brethren of Wilson Colony* in which McLachlin C.J. states that

Minimal impairment and reasonable accommodation are conceptually distinct. Reasonable accommodation is a concept drawn from human rights statutes and jurisprudence. It envisions a dynamic process whereby the parties — most commonly an employer and employee — adjust the terms of their relationship in conformity with the requirements of human rights legislation, up to the point at which accommodation would mean undue hardship for the accommodating party.¹¹⁸

She writes that there is a distinction that exists between the attempt to accommodate the rights of an individual, and the need for Parliament to design laws for the betterment of society. She argues that the constitutionality of a law (as determined by a *Charter* analysis) should be assessed via a section 1 analysis that takes into account the law's effect on society as a whole.

The broader societal context in which the law operates must inform the s. 1 justification analysis. A law's constitutionality under s. 1 of the Charter is determined, not by whether it is responsive to the unique needs of every individual claimant, but rather by whether its infringement of Charter rights is directed at an important objective and is proportionate in its overall impact. While the law's impact on the individual claimants is undoubtedly a significant factor for the court to consider in determining whether the infringement is justified, the court's ultimate perspective is societal. The question the court must answer is whether the Charter infringement is justifiable in a free and democratic society, not whether a more advantageous arrangement for a particular claimant could be envisioned.¹¹⁹

And further,

¹¹⁸ *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37, [2009] 2 S.C.R. 567, para. 68 [*Wilson Colony*].

¹¹⁹ *Wilson Colony*, *supra* note 118 at para. 69.

Similarly, “undue hardship”, a pivotal concept in reasonable accommodation, is not easily applicable to a legislature enacting laws... Rather than strain to adapt “undue hardship” to the context of s. 1 of the *Charter*, it is better to speak in terms of minimal impairment and proportionality of effects.¹²⁰

Therefore, from this recent Supreme Court of Canada case, we have the view that human rights legislation focuses more specifically on the individual, and how accommodations can allow the individual to exist and succeed in a particular work or education environment. The *Charter*, on the other hand, while written with the individual in mind, has a strong override component in section 1 that seeks to find ways to “minimally impair” the rights of the individual, while ensuring the rights and needs of society as a whole.

2.5.1 Section 2(a) of the *Charter of Rights and Freedoms*

2. Everyone has the following fundamental freedoms:
 - (a) freedom of conscience and religion

The wording of section 2(a) of the *Charter* seems to promise limitless freedom of conscience and religion, including, one might assume, the unfettered right to practice the tenets of a particular faith or ideology. In reality, there are significant limits to these rights, due to the fact that this “freedom” is not occurring in isolation. The limits of these

¹²⁰ *Ibid.*, at para. 70.

rights are ultimately determined by the courts and specifically relate to *manifestations* of religious belief¹²¹ as there is, so far, no legal attempt to limit religious belief itself.

The courts have had to balance the right to freedom of religion and conscience against other rights in Canadian society, and have chosen to support the right to represent certain manifestations of religious belief and/or freedom of conscience “provided that such manifestations do not injure his or her neighbours or their parallel rights to hold and manifest beliefs and opinions of their own.”¹²² It is important to distinguish the right to hold specific beliefs from the right to act on the basis of those beliefs. “The freedom to hold beliefs is much broader than the freedom to manifest those beliefs in a discriminatory way, because the freedom of religion co-exists with equality rights.”¹²³

Contravention of section 2(a) of the *Charter* does not, of course, necessarily invalidate legislation. As with other *Charter* guarantees, freedom of religion is subject to a limitation as determined by section 1 analysis. “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.”¹²⁴ Section 1 of the *Canadian Charter of Rights and Freedoms* is the section that confirms that the rights listed in the *Charter* are guaranteed. It is also known as the reasonable limits, or limitations clause. It legally allows the government to limit an individual's *Charter* rights if certain criteria are met. “[The Supreme] Court has clearly

¹²¹ Nayha Acharya, “Freedom of Religion”, Centre for Constitutional Studies, online: <http://www.law.ualberta.ca/centres/css/issues/freedomofreligion.php> [Acharya].

¹²² *R v. Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295 [Big M] at para. 123.

¹²³ Acharya, *supra* note 121.

¹²⁴ *Charter*, *supra* note 3.

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."¹²⁵ Section 1 analysis follows the general outline prescribed by the *Oakes test*.¹²⁶ There are two specific criteria that need to be met in order to confirm that a limitation of a right, or freedom, is justified. The objective of the limitation must be sufficiently important to warrant undermining a right that would otherwise be guaranteed under the *Charter*. The objective must relate to concerns that are "pressing and substantial." If that is confirmed, then the means used to limit the right or freedom must be shown to be "reasonable and demonstrably justified." A type of proportionality test is mandated, comprised of three components. Proportionality is confirmed by demonstrating that: the means must be rationally connected to the objective (they must not be arbitrary or unfair); there must be minimal impairment of rights; and there must be proportionality between the infringement and the objective.

The Canadian jurisprudence on freedom of religion has numerous examples of courts accepting certain circumstances as violations of the freedom of religion, but going on to decide that the violation of freedom of religion is reasonable under the section 1 limitation.¹²⁷

The first freedom of religion case to reach the Supreme Court of Canada post-*Charter* was *Big M Drug Mart*.¹²⁸ *Big M* challenged the requirement, outlined by the *Lord's Day Act*, that all stores must close on Sundays in order to observe the Christian Sabbath. *Big M* argued that this Act violated its employees' freedom of religion, as

¹²⁵ *Multani v. Commission scolaire Marguerite-Bourgeoys*, 2006 SCC 6, [2006] 1 S.C.R. 256 [*Multani*] at para. 26.

¹²⁶ *R. v. Oakes* [1986] 1 S.C.R. 103 [*Oakes test*].

¹²⁷ *Acharya*, *supra* note 121.

¹²⁸ *Big M*, *supra* note 122.

guaranteed by the *Charter*, as employees were being forced to take a day off to “celebrate” a religious holiday that was not a part of their own personal religion. The Supreme Court agreed that this Act constituted a violation of freedom of religion and concluded that “freedom of religion includes freedom from religion.”¹²⁹

Beginning with *Big M* in 1985, the right to religious belief has been given a broad reading. Religious belief, and freedom of conscience, are generally accepted on their own merit, without need for definitive external validation. As long as an individual honestly holds a particular religious belief, and acts on that belief, then that belief is afforded *Charter* protection. An example of this is seen in *Syndicat Northcrest v. Amselem*.¹³⁰ In this case, orthodox Jewish residents built temporary homes (succahs) on the balconies of their condominiums as part of a religious celebration. Condominium bylaws prohibited decoration, alteration or any sort of construction on the balconies of the buildings. The residents were offered the opportunity to build a communal succah in the gardens but this was objected to by these residents who said that their religious beliefs required them to have individual succahs on their balconies. The trial judge ruled against the residents, finding that the objective obligatory requirement of Judaism did not, apparently, require the building of individual succahs. The Supreme Court allowed the appeal, establishing that “freedom of religion under the Quebec (and the Canadian) *Charter* does not require a person to prove that his or her religious practices are supported by any mandatory doctrine of faith.”¹³¹ The Supreme Court found that the

¹²⁹ *Acharya*, *supra* note 121.

¹³⁰ *Syndicat Northcrest v. Amselem*, 2004 SCC 47, [2004] 2 S.C.R. 551 [*Syndicat*].

¹³¹ *Syndicat*, *supra* note 130.

condominium bylaws interfered with the right of the Jewish residents to practice their religious beliefs, and that the interference was more than trivial – thus leading to an infringement of that right. From this case, we receive the determination that, in order for a religious belief to be supported under the *Charter*,

the claimant must establish that he or she has a sincere belief and that this belief is objectively connected to a religious precept that follows from a text or another article of faith. It is not necessary to prove that the precept objectively creates an obligation, but it must be established that the claimant sincerely believes he or she is under an obligation that follows from the precept.¹³²

Boundaries of this belief are vague, and are defined by the statement that interference with manifestation of belief that is more than “trivial” will not be permitted under the *Charter* unless justified under section 1. “The context of each case must be examined to ascertain whether the interference is more than trivial or insubstantial.”¹³³ As can be anticipated by this broad determination of what constitutes religious belief and practice, many challenges under section 2(a) have been successful at the first stage of analysis, with a finding of more than trivial interference in many cases.

As was previously recognized by La Forest J. in *B. (R.) v. Children’s Aid Society of Metropolitan Toronto*,

this Court has consistently refrained from formulating internal limits to the scope of freedom of religion in cases where the constitutionality of a legislative scheme was raised; it rather opted to balance the competing rights under s. 1 of the *Charter*.¹³⁴

¹³² *Ibid.*

¹³³ Section 2(a), Canadian Charter of Rights Decisions Digest, online: http://www.canlii.org/en/ca/charter_digest/s-2-a.html [*Rights Digest*].

¹³⁴ *B. (R.) v. Children’s Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315 [*B.(R.)*] at paras. 109-110.

Another early Canadian case, post-*Charter*, was *R v. Jones*.¹³⁵ In this case, a pastor of a fundamentalist church refused to send his children to school (on religious grounds) and instructed them, himself, in a church basement. He also refused to apply for an exemption through a mechanism available to him via government legislation. “Section 143(1) provides alternatives and allows for instruction at home or elsewhere, so long as that instruction is certified to be efficient.”¹³⁶ He argued that the requirement that he send his children to the public school system “contravened his religious beliefs that God, rather than the Government, had the final authority over the education of his children, and deprived him of his liberty to educate his children as he pleased contrary to the principles of fundamental justice.”¹³⁷ The Supreme Court determined that the legislation being challenged did not specifically prevent Jones from educating his children in the church school and therefore did not place an excessive or unreasonable burden on Jones and his students. The majority thought that the provincial legislation offended Jones’ section 2(a) rights, whereas Wilson J. was not convinced of this, stating that “section 2(a) does not require the legislature to refrain from imposing any burdens on the practice of religion. Legislative or administrative action whose effect on religion is trivial or insubstantial is not a breach of freedom of religion.”¹³⁸ Justice Wilson’s view was a dissenting one in this case, and the jurisprudence since then has tended to err on the side of acknowledging a section 2(a) violation, then turning to a section 1 analysis to balance the competing societal rights.

¹³⁵ *R. v. Jones*, [1986] 2 S.C.R. 284 [*Jones*].

¹³⁶ *Ibid.*

¹³⁷ *Ibid.*

¹³⁸ *Jones*, *supra* note 135.

In *Multani v. Commission scolaire Marguerite-Bourgeois*¹³⁹, an orthodox Sikh schoolboy was not permitted to wear a kirpan (religious object that resembles a dagger) under his clothing because it apparently contravened school board rules about dangerous weapons at school. The challenge was taken to the SCC and here it was decided that the decision to not allow the boy to wear the kirpan was an unreasonable infringement of his religious beliefs and rights. Section 1 analysis did not support, what was confirmed to be, a section 2(a) violation.

Freedom [of religion] is not absolute and can conflict with other constitutional rights. Since the test governing limits on rights was developed in *Oakes*, the Court has never called into question the principle that rights are reconciled through the constitutional justification required by s. 1 of the *Canadian Charter*.¹⁴⁰

Assessment of freedom of religion cases, as heard by the Supreme Court, tells us that there is, so far, a relatively simple test to apply when gauging whether or not a particular religious belief (more correctly – the manifestation of that religious belief) should be constitutionally protected. The belief simply has to be sincerely held, and sincerely acted upon. The belief does not have to be supported by many other people, or form part of a dominant religious theology, in order for it to be accorded equal significance with any other belief of a religious nature that meets the above two requirements.

A more recent Supreme Court of Canada case moved slightly away from this approach, requiring definite proof of impedance of the ability to practice one's religion in

¹³⁹ *Multani*, *supra* note 125.

¹⁴⁰ *Ibid.*

order to show a violation of section 2(a). *S.L.v. the Commission scolaire des Chenes*¹⁴¹ is a 2012 case in which parents challenged the government's requirement that all elementary and secondary students in Quebec (whether public, private or home schooling students), beginning in 2008, must take the new Ethics and Religious Culture program (ERC). This course was meant to replace all existing denominational religion and ethics courses previously being taught in the province. The parents claimed that the program's relativist approach to religion and ethics undermined their right to educate their children, with respect to religious beliefs, in the manner they felt was appropriate. The Court responded by determining that the parents had not proven "harm" in terms of the application of this law and that the government's goal in setting up this program overruled the parents' rights to educate their children in a particular manner.

Although the sincerity of a person's belief that a religious practice must be observed is relevant to whether the person's right to freedom of religion is at issue, an infringement of this right cannot be established without objective proof of an interference with the observance of that practice.¹⁴²

In this recent case, the Supreme Court bases its decision strictly on whether or not there has been proven interference with *current observance* of a religious practice (manifestation of religious belief). Nonetheless, it reiterates (as identified in *Syndicat*) that the two relevant criteria necessary to prove a violation of section 2(a) of the *Charter* are that an individual must have a sincere belief in a particular religious tenet, and that the manifestation of that religious belief is being impeded or infringed by specific

¹⁴¹ *S.L. v. Commission scolaire des Chênes*, 2012 SCC 7 [S.L.].

¹⁴² *Ibid.*

legislation.

Religious belief and manifestation of that belief are, of course, intimately and necessarily connected. Instructing students about other religions, and some of the beliefs held by those religions, has the potential to change the beliefs of the students taking the instruction. This, in turn, may lead directly to interference with religious practice. If you no longer believe that a particular religious practice is necessary, or required, then you are unlikely to continue to manifest the same behaviours previously considered “necessary”. This is, presumably, what the parents in the *S.L.* case were worried about. The majority of the Supreme Court Justices managed to brush by these concerns without directly addressing them. “L and J have not proven that the ERC Program infringed their freedom of religion, or consequently, that the school board’s refusal to exempt their children from the ERC course violated their constitutional right.”¹⁴³

Justices Fish and LeBel, in their concurring remarks, allude to these concerns, saying that the Ethics and Religious Culture Program (“ERC”) that had been established in Quebec (at the time of the Court assessment) had a specific course outline associated with it, but that it was not well “fleshed out” in the documents supplied to the Court and that implementation of these teaching directives was left up to individual teachers who were administering the course. “In its current form, the program says little about the actual content of the teaching and the approach that teachers will actually take in dealing with their students.”¹⁴⁴ Justices Fish and LeBel state that, in the future, more information about the content of the course and about how that information is imparted to students,

¹⁴³ *S.L.*, *supra* note 141.

¹⁴⁴ *S.L.*, *supra* note 141.

may give individuals further ammunition to claim a section 2(a) violation. “The state of the record, however, does not make it possible to conclude that the ERC Program and its implementation could not, in the future, possibly infringe the rights granted to L and J and persons in the same situation.”¹⁴⁵

The non-nuanced approach taken in this case by the majority of the Supreme Court Justices has the potential to threaten religious doctrine and may make it more difficult for someone to challenge the requirement to learn about certain behaviours (including medical procedures) that are considered heretical by that individual’s particular religious group. Following this line of thinking, for example, a medical student who argued that they did not want to work at a clinic where they had to sit and learn about abortion or contraception (even if they were not prescribing those activities themselves) would not be successful in legally challenging a requirement to complete this course because they would not be able to prove that the course interfered with their current ability to “practice” their religious beliefs. A skeptic might be correct, however, in pointing out that attendance at such a clinic would have the possibility of changing the individual’s perspective (and possibly belief in particular religious ideology) and subsequently lead to a change in religious practice (although indirect and certainly theoretical).

Two areas of controversy have emerged from analysis of these different cases dealing with religious tolerance. Are all *Charter* rights to be read as equal, and how do we decide between two competing rights?¹⁴⁶ “Logically, where there is not an apparent infringement of more than one fundamental right, no reconciliation is necessary at the

¹⁴⁵ *Ibid.*

¹⁴⁶ Alex Fielding, “When Rights Collide: Liberalism, Pluralism and Freedom of Religion in Canada” (2008) 13 Appeal 28.

initial stage.”¹⁴⁷ However, in situations where more than one right is in competition, “the Court has on numerous occasions stressed the advantages of reconciling competing rights by means of a s. 1 analysis.”¹⁴⁸

A verdict in a recent Supreme Court of Canada case demonstrates the interplay between religious freedom and the realization of an important societal objective. This recent case involved the request by the victim of a sexual assault to wear a niqab during the trial of the accused.¹⁴⁹ The accused individuals objected to this, arguing that the niqab would interfere with the right to a fair trial and to the ability of the accused individuals to adequately cross-examine the witness (the victim). Their concern was that the facial expression of the complainant would not be visible during cross-examination. The Ontario Court of Appeal reinforced the current perspective regarding claims of section 2(a) violation, pointing out that the witness need only prove that she believes that the practice of wearing the niqab is sincerely connected to her faith or spirituality, and that she is being prevented from wearing the niqab by requirements of the Court.

If a witness establishes that wearing her niqab is a legitimate exercise of her religious freedoms, then the onus moves to the accused to show why the exercise of this constitutionally protected right would compromise his constitutionally protected right to make full answer and defence.¹⁵⁰

The Supreme Court delivered a nuanced and divided response to this question, consistent with the idea that request for differential treatment is not an all-or-none phenomenon and

¹⁴⁷ *Multani*, *supra* note 125 at para. 28.

¹⁴⁸ *Ibid.*, at para. 26.

¹⁴⁹ *N.S. v. Her Majesty the Queen*, et al. (Ontario) (Criminal) (By Leave) 33989 [N.S.].

¹⁵⁰ *R. v. N.S.*, 2010 ONCA 670.

that it requires a balanced assessment of competing rights and requirements. Four of the seven justices thought that

two sets of Charter rights are potentially engaged — the witness’s freedom of religion and the accused’s fair trial rights, including the right to make full answer and defence. An extreme approach that would always require the witness to remove her niqab while testifying, or one that would never do so, is untenable. The answer lies in a just and proportionate balance between freedom of religion and trial fairness, based on the particular case before the court.¹⁵¹

Two of the seven justices thought that wearing of the niqab would undermine the openness of the Canadian court system and that

wearing a niqab in the courtroom does not facilitate acts of communication. Rather, it shields the witness from interacting fully with the parties, their counsel, the judge and the jurors. Wearing the niqab is also incompatible with the rights of the accused, the nature of the Canadian public adversarial trials, and with the constitutional values of openness and religious neutrality in contemporary democratic, but diverse, Canada.¹⁵²

One of the Supreme Court Justices (J. Abella) pointed out that a sexual assault victim who is pressing charges against her accused is already in a very vulnerable position and should not be forced to remove her niqab in order to testify.

The harmful effects of requiring a witness to remove her niqab, with the result that she will likely not testify, bring charges in the first place, or, if she is the accused, be unable to testify in her own defence, is a significantly more harmful consequence than the accused not being able to see a witness’s whole face. Unless the witness’s face is directly relevant to the case, such as where her identity is in issue, she should not be required to remove her niqab.¹⁵³

This interesting case serves to point out the complicated to-and-fro that takes place in a situation where one is trying to balance competing rights and accommodate requests for

¹⁵¹ *N.S.*, *supra* note 149.

¹⁵² *Ibid.*

¹⁵³ *N.S.*, *supra* note 149.

differential treatment.¹⁵⁴ The solutions to these problems are seldom simple to negotiate. “The collision between rights must be approached on the contextual facts of actual conflicts. The first question is whether the rights alleged to conflict can be reconciled.”¹⁵⁵ If rights cannot be reconciled then some limits may need to be applied and a section 1 analysis will be carried out to confirm the need for such limitation. In coming to a conclusion “the Court must proceed on the basis that the Charter does not create a hierarchy of rights”¹⁵⁶ and the freedom to express religious or other beliefs “is restricted by the right of others to hold and to manifest beliefs and opinions of their own, and to be free from injury from the exercise of the freedom of religion of others.”¹⁵⁷

2.5.2 How Do the Boundaries, Established by Our Legal System and By Our Constitution, Act to Limit Freedom of Conscience? (Section 2(a))

There has not yet been a Supreme Court of Canada case that deals specifically with freedom of conscience, unencumbered by religious ideology.

While the Canadian Charter of Rights and Freedoms (“Charter”) s. 2(a) provides that “everyone has the right of freedom of conscience and religion”, the Supreme Court of Canada (“SCC”) has only ever heard cases that primarily engage freedom of religion. It has not yet heard a freedom of conscience case that does not also involve freedom of religion.¹⁵⁸

¹⁵⁴ David M. Brown, “Freedom from or Freedom for?: Religion as a Case Study in Defining the Content of Charter Rights” (2000) 33 U.B.C.L Rev. 551 [*D.Brown*] at 35.

¹⁵⁵ *Trinity Western University v. British Columbia College of Teachers*, 2001 SCC 31, [2001] 1 S.C.R. 772 at para. 29.

¹⁵⁶ *Dagenais v. Canadian Broadcasting Corp.*, [1994] 3 S.C.R. 835, at p. 877.

¹⁵⁷ *Ross v. New Brunswick School District No. 15* (1996), 133 D.L.R. (4th) 1 (S.C.C.) at para. 72.

¹⁵⁸ Linda McKay-Panos, “Freedom of Conscience: What It Means for Canadians”, online: <http://www.lawnow.org/d/sites/default/files/SR1364.pdf>.

It is difficult to be sure how strongly the Court would support individuals, or groups, who act against specific legislation, claiming to do so on the basis of freedom of conscience (not connected with underlying religious doctrine). There have been lower court cases that have commented on this issue, as well as Supreme Court obiter dictum suggesting that freedom of conscience should be treated like freedom of religion (based as they are within the same *Charter* section). “The purpose of s. 2(a) is to ensure that society does not interfere with profoundly personal beliefs that govern one's perception of oneself, humankind, nature, and, in some cases, a higher or different order of being.”¹⁵⁹ This account of the section seems to suggest that there is no real need to differentiate between a strongly held religious belief, or a strongly held belief of conscience, both being personal beliefs that are integral to one’s identity and therefore worth protecting.

In *R. v. Morgentaler*, Wilson J. attempts to differentiate between freedom of conscience and religion, particularly if these tenets are able to be adequately distinguished from each other. This differentiation seems important because freedom of conscience can involve strong moral concerns that exist distinct from religious ideology, and therefore need to be judged on their own merits.

It seems to me, therefore, that in a free and democratic society "freedom of conscience and religion" should be broadly construed to extend to conscientiously-held beliefs, whether grounded in religion or in a secular morality. Indeed, as a matter of statutory interpretation, "conscience" and "religion" should not be treated as tautologous if capable of independent, although related, meaning.¹⁶⁰

¹⁵⁹ *R. v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713 [*Edwards Books*] at 759.

¹⁶⁰ *R. v. Morgentaler*, [1988] 1 S.C.R. 30 [*Morgentaler*].

In *R. v. Big M Drug Mart Ltd*, Chief Justice Dickson also seems to suggest that non-religious beliefs should have the benefit of section 2(a) protection:

The values that underlie our political and philosophic traditions demand that every individual be free to hold and to manifest whatever beliefs and opinions his or her conscience dictates, provided *inter alia* only that such manifestations do not injure his or her neighbours or their parallel rights to hold and manifest beliefs and opinions of their own.¹⁶¹

It will be very interesting to observe a Supreme Court case that deals strictly with a section 2(a) challenge that is devoid of any religious connection. How will the Court assess such a claim and will the Court think that manifestations of the right to freedom of conscience (or conscientious objection) are worthy of the same protection given to the practices associated with a particular religious ideology?

It seems that freedom of conscience is broader than freedom of religion. The latter relates more to religious views derived from established religious institutions, whereas the former is aimed at protecting views based on strongly held moral ideas of right and wrong, not necessarily founded on any organized religious principles. These are serious matters of conscience.¹⁶²

In *Ontario (Attorney General) v. Dieleman*,¹⁶³ the judge asked the question

“is “action” motivated by conscience intended to be protected by the Charter in contrast to “protection against invasion” of a sphere of individual intellect and spirit such as protection against officially disciplined uniformity on orthodoxy?”

¹⁶¹ *Big M*, *supra* note 122 at para. 123.

¹⁶² *Roach v. Canada (Minister of State for Multiculturalism and Citizenship)*, [1994] 2 FC 406, 13 DLR (4th) 67.

¹⁶³ *Ontario (Attorney General) v. Dieleman et al.* (1994), 20 O.R. (3d) 229; 117 D.L.R. (4th) 449 (Gen. Div.).

Will the courts be willing to protect *manifestations* of freedom of conscience – or only the right to believe what you want to believe (the inner workings of the mind – which are very difficult to control to begin with)? Where will the lines be drawn if the right to act according to your conscience is permissible? Theoretically, any legislation could be challenged by someone who: believed that the legislation was morally wrong; was legally obliged to obey the legislation; and, therefore argued that the legislation offended his or her freedom of conscience. Presumably, as with freedom of religion, the boundaries of the right to challenge legislation under this section (relating to conscience) would be defined more completely through a section 1 analysis (once section 2(a) rights had been shown to have been violated).

2.5.3 Where Does “Culture” Fit Into This Picture?

It seems most reasonable to classify “freedom of culture” as a component of freedom of conscience, unless the culture-based belief and behaviour is intimately associated with an underlying religious belief or practice. If this is the case, then the question of accommodation should be approached from a freedom of religion perspective. Culture as a particular entitlement is dealt with more specifically in section 27 of the *Charter*, which will be discussed briefly below.

2.5.4 Section 15 of the *Charter of Rights and Freedoms*

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.¹⁶⁴

The concept of equality for all was formalized in legislation in 1960 when the *Bill of Rights*¹⁶⁵ was introduced. This federal statute promised equality for all citizens under the law. Described as “an Act for the Recognition and Protection of Human Rights and Fundamental Freedoms”¹⁶⁶, it was generally unsuccessful at providing real equality because it was, ultimately, a simple piece of legislation that did not supercede other legislation and/or constitutional doctrine, and could therefore be overruled or even overturned in particular circumstances.

In 1982, the *Charter* was enacted as a new part of the Canadian constitution. The “purpose of s. 15 is to ensure equality in the formulation and application of the law.”¹⁶⁷ Section 15 of the *Charter* did not come into effect until 1985, three years after the rest of the *Charter*, in order that governments would have the time to bring their legislation in line with section 15 requirements. Interpretation of section 15 has involved a number of changes over the years as the judiciary has struggled with how to ensure that the law applies equally to all citizens, consistent with the concept of substantive, rather than formal, equality.

¹⁶⁴ *Charter*, *supra* note 3.

¹⁶⁵ *Canadian Bill of Rights*, SC 1960, c. 44.

¹⁶⁶ *Ibid.*

¹⁶⁷ Joel Backan et al., *Canadian Constitutional Law*, 3d ed (Toronto: Emond Montgomery, 2003) at 1151.

The first section 15 case to be heard by the Supreme Court of Canada was *Andrews v. Law Society of British Columbia*¹⁶⁸ in 1989. In *Andrews*, the Court confirmed the notion that laws should be assessed on the basis of substantive, rather than formal, equality and that implementation of “formal” equality actually had the potential to lead to increased distinctive and discriminatory legislative action. The decision in *Andrews* introduced a two-step approach to the analysis of section 15. As a first step, the court should determine whether an infringement of a guaranteed right has occurred. Secondly, if an infringement has occurred, the court must determine whether or not the infringement can be justified under section 1. In *Andrews*, the Supreme Court identified that the term “discrimination” was critical to any section 15 analysis and that “grounds” of discrimination should be identified and tested to see if a violation has occurred. The specific “grounds” of discrimination “reflect the most common and probably the most socially destructive and historically practiced bases of discrimination.”¹⁶⁹ Enumerated grounds are those that are specifically noted in the definitional text of section 15. “The grounds of discrimination enumerated in s. 15(1) are not exhaustive. Grounds analogous to those enumerated are also covered.”¹⁷⁰ What constitutes analogous grounds has developed gradually over the years through varying cases heard by the Supreme Court. For example, writing for the majority in *Corbiere v. Canada*, Justices McLachlin and Bastarache stated that analogous grounds were those that

often serve as the basis for stereotypical decisions made not on the basis of merit but on the basis of a personal characteristic that is immutable or changeable only at

¹⁶⁸ *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143 [*Andrews*].

¹⁶⁹ *Andrews*, *supra* note 168.

¹⁷⁰ *Ibid.*

unacceptable cost to personal identity.¹⁷¹

An individual needs to identify that there has been a distinction with respect to his or her treatment based on an enumerated or analogous ground. The individual must then show “not only that he or she is not receiving equal treatment before and under the law or that the law has a differential impact on him or her in the protection or benefit accorded by law but, in addition, must show that the legislative impact of the law is discriminatory.”¹⁷²

The two-pronged *Andrews* method of analyzing a potential section 15(1) violation was fairly consistently utilized by the courts until 1999.

One of the most important cases in the development of section 15 jurisprudence has been that of *Law v. Canada*,¹⁷³ in which a unanimous court described a more expansive method of section 15(1) analysis. This broadened method of analysis contained three main components.

A court that is called upon to determine a discrimination claim under s. 15(1) should make the following three broad inquiries:

- A. Does the impugned law
 - (a) draw a formal distinction between the claimant and others on the basis of one or more personal characteristics, or
 - (b) fail to take into account the claimant’s already disadvantaged position within Canadian society resulting in substantively differential treatment between the claimant and others on the basis of one or more personal characteristics?

- B. Is the claimant subject to differential treatment based on one or more enumerated and analogous grounds?

¹⁷¹ *Corbiere v. Canada (Minister of Indian and Northern Affairs)*, [1999] 2 S.C.R. 203 at para. 13.

¹⁷² *Andrews*, *supra* note 168.

¹⁷³ *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S. C. R. 497 [*Law*].

and

C. Does the differential treatment discriminate, by imposing a burden upon or withholding a benefit from the claimant in a manner which reflects the stereotypical application of presumed group or personal characteristics, or which otherwise has the effect of perpetuating or promoting the view that the individual is less capable or worthy of recognition or value as a human being or as a member of Canadian society, equally deserving of concern, respect, and consideration?¹⁷⁴

The *Law* analysis then further subdivided the second part of this analysis on the basis of contextual factors.

The contextual factors which determine whether legislation has the effect of demeaning a claimant's dignity must be construed and examined from the perspective of the claimant. The focus of the inquiry is both subjective and objective. The relevant point of view is that of the reasonable person, in circumstances similar to those of the claimant, who takes into account the contextual factors relevant to the claim.¹⁷⁵

This more detailed approach to section 15(1) analysis was prone to criticism that a more stringent analysis made the assessment increasingly formalized and had the potential to create a higher bar for complainants to overcome in order to prove a section 15(1) violation. Contextual factors identified by the Court in *Law* include the following:

- (A) Pre-existing disadvantage, stereotyping, prejudice, or vulnerability experienced by the individual or group at issue.
- (B) The correspondence, or lack thereof, between the ground or grounds on which the claim is based and the actual need, capacity, or circumstances of the claimant or others.
- (C) The ameliorative purpose or effects of the impugned law upon a more disadvantaged person or group in society.

¹⁷⁴ *Ibid.*

¹⁷⁵ *Law*, *supra* note 173.

(D) The nature and scope of the interest affected by the impugned law.¹⁷⁶

The decision in *Law v. Canada* placed an enlarged focus on the importance of the maintenance of human dignity. Evidence of loss of human dignity, because of the effect of particular laws or legislative schemes, was felt to be critical in the assessment of whether or not a specific law violated section 15 of the *Charter*. This more formalized approach, as well as the inclusion of “human dignity” as a focal point within the analysis, increased the difficulty encountered by a number of courts when assessing a claim under section 15. “Human dignity” is a vague concept that is difficult to categorize and to measure. Assessment of what constitutes a violation of human dignity is very subjective and difficult to reproduce from case to case.

In addition to the challenges introduced in *Law v. Canada*, the challenge of identifying appropriate comparator groups during section 15 analysis became more apparent and important in subsequent SCC cases. “A misidentification of the proper comparator group at the outset can doom the outcome of the whole s. 15(1) analysis.”¹⁷⁷ A complainant has a right to suggest a comparator group to use in the section 15 analysis, but “while it is up to the claimant to make an initial choice of “the person, group, or groups with whom he or she wishes to be compared”, the correctness of that choice is a matter of law for the court to determine.”¹⁷⁸

¹⁷⁶ *Ibid.*

¹⁷⁷ *Hodge v. Canada (Minister of Human Resources Development)*, 2004 SCC 65, [2004] 3 S.C.R. 357 [*Hodge*].

¹⁷⁸ *Ibid.*

In 2008, in *R v. Kapp*¹⁷⁹, the Court seemed to revert to an *Andrews*-type of analysis of section 15(1), requiring a two-part examination that focused on discrimination and substantive equality as key components of the assessment. In this case, the Court also turned away from the requirement that a loss of human dignity play a large role in the establishment of a section 15 violation.

At the end of the *Law* era, in *Kapp* the Supreme Court conceded that human dignity had indeed turned out to be an additional barrier to equality-seekers, adding another hurdle to what they had to prove. *Kapp* marked the end of the use of human dignity in section 15 cases (although lower courts and lawyers were slow to appreciate that abandonment).¹⁸⁰

A number of lower court decisions that followed *Kapp* continued to use the four contextual components of section 15 analysis (from *Law*) in order to come to a conclusion regarding a possible *Charter* violation.

Even though *Withler*¹⁸¹ and *Hartling*¹⁸² noted that the Supreme Court in *Kapp* had moved away from *Law*'s insistence that discrimination be defined in terms of the impact of the law or program on human dignity, they still applied *Law*'s four contextual factors, as did the court in *Downey*^{183, 184}.

In *Kapp*, the Court also moved section 15(2) to the forefront in terms of the particular stages of section 15 analysis. Recognition of a section 15(2) rationale could

¹⁷⁹ *R. v. Kapp*, 2008 SCC 41, 2 S.C.R. 483 [*Kapp*].

¹⁸⁰ Jennifer Koshan and Jonnette Watson Hamilton, "The Continual Reinvention of Section 15 of the Charter" (2013) 64 *University of New Brunswick Law Journal* 19 at 23.

¹⁸¹ *Withler v. Canada (Attorney General)*, 2008 BCCA 539 [*Withler*].

¹⁸² *Hartling v. Nova Scotia (Attorney General)*, [2009] NSCA 130.

¹⁸³ *Downey v. Nova Scotia (Workers' Compensation Appeals Tribunal)*, 2008 NSCA 65.

¹⁸⁴ Jonnette Watson Hamilton and Jennifer Koshan, "The End of Law: A New Framework for Analyzing Section 15(1) Charter Challenges", *The University of Calgary Law Blog on Developments in Alberta Law*, online: <http://ablawg.ca/2009/02/20/the-end-of-law-a-new-framework-for-analyzing-section-151-charter-challenges/> [*Hamilton*].

excuse section 15(1) from being addressed when assessing the claim of a section 15 violation. “If the government can demonstrate that an impugned program meets the criteria of s. 15(2), it may be unnecessary to conduct a s. 15(1) analysis at all.”¹⁸⁵

In *Ermineskin Indian Band and Nation v. Canada*¹⁸⁶ (2009), the Supreme Court seemed to more definitively abandon *Law*, focusing instead on an *Andrews*-type of section 15 analysis.

The phrase “human dignity” is never mentioned in *Ermineskin*. None of the four contextual factors from *Law* are used; rather context is now the larger social, political and legal context of the impugned legislation... the *Ermineskin* decision is therefore a strong signal to lower courts and tribunals that the *Law* framework for analyzing an equality challenge should no longer be used.¹⁸⁷

This perspective has been reiterated in a recent Supreme Court of Canada case dealing with common law relationships and spousal support and family property provisions. As per Abella J.,

Kapp, and later *Withler v. Canada (Attorney General)*, [2011] 1 S.C.R. 396, restated these principles as follows: (1) Does the law create a distinction based on an enumerated or analogous ground? (2) Does the distinction create a disadvantage by perpetuating prejudice or stereotyping?¹⁸⁸

Despite the importance, reiterated in *Hodge*, of finding the relevant comparator group during section 15(1) analysis, the Court has, more recently, decided that the need

¹⁸⁵ *Kapp*, *supra* note 179 at para. 37.

¹⁸⁶ *Ermineskin Indian Band and Nation v. Canada*, 2009 SCC 9, [2009] 1 S.C.R. 222 [*Ermineskin*].

¹⁸⁷ *Hamilton*, *supra* note 184.

¹⁸⁸ *Quebec (Attorney General) v. A.*, [2013] S.C.J. No. 5.

for a **distinct** comparator group is not absolute. In *Withler v. Canada*¹⁸⁹, a complex class action suit, it was difficult for the Court to identify a specific comparator group. In this case, the Court decided that it was not always necessary to identify a specific comparator group and, instead, a court should identify if there is a distinction that has been made based on listed or analogous groups as outlined under section 15(1). If a distinction can be identified, then the court should move on to the next stage of analysis rather than continuing to try to determine a comparator group.

In summary, when assessing a complaint of section 15 violation, courts currently will: ensure that s. 15(2) doesn't immediately come into play and de-legitimize a claim of discrimination via s. 15(1); and, start by considering the claimant's point of view – objective and subjective perspectives – in order to ensure substantive rather than formal equality. If a section 15(1) violation is confirmed by a court, the assessment then turns to a section 1 analysis to determine whether the violation can be demonstrably justified in a free and democratic society. In terms of conscientious objection and application of a section 15 analysis, a complainant would need to identify that there is a distinction in their treatment, based on enumerated or analogous grounds, and then that this distinction resulted in discrimination. Finally, the discrimination must not be demonstrably justified under section 1 of the *Charter*.

¹⁸⁹ *Withler*, *supra* note 181.

2.5.5 Section 7 of the *Charter of Rights and Freedoms*

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Section 7 tends to play a less central role in determining the right to freedom of religion, and to freedom of conscience. In large part, this is due to the fact that these rights are already ostensibly protected under section 2(a) of the *Charter*. In addition, it is considerably more difficult to determine where the boundaries of the right to life, liberty and security of the person lie in assessing freedom of religion and conscience cases.

“The scope of s. 7...remains unsettled.”¹⁹⁰

The right to “Liberty” refers to the individual’s right to act without restraint and could therefore be relevant to a request for exemption from some particular educational activity. It generally refers to “physical restraint” but has also been framed as referring to the ability of the individual to act autonomously, without restraint in terms of freedom of thought and manifestation of those thoughts or beliefs. It may refer to the ability of an individual to make personal decisions that are not subject to specific limitation by the government or governmental bodies. This line of argument was attempted in *B. (R.) v. Children’s Aid Society*¹⁹¹, but was rejected by the Court because it argued for family, rather than individual, rights to liberty of personal choice. It is possible that this approach may be used in the future in an attempt to argue for freedom for the

¹⁹⁰ *PHS Community Services Society v. Canada* (Attorney General), 2010 BCCA 15.

¹⁹¹ *B. (R.) v. Children’s Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315 [B.(R.)].

manifestation of religious thought or the ability to pursue specific behaviour consistent with strongly held moral or ethical ideals.

Security of the person is, once again, poorly defined, thus far, in Canadian jurisprudence. In *Rodriguez v. British Columbia (Attorney General)*, McLachlin J. writes that

decisions about one's body involve "security of the person" which s. 7 safeguards against state interference which is not in accordance with the principles of fundamental justice. Security of the person has an element of personal autonomy, protecting the dignity and privacy of individuals with respect to decisions concerning their own body. It is part of the persona and dignity of the human being that he or she have the autonomy to decide what is best for his or her body.¹⁹²

In *Blencoe v. B.C. (Human Rights Commission)*¹⁹³, Justice Bastarache interprets security of the person, under section 7, to include psychological harm to the individual concerned. Section 7 was successfully used to challenge legislation in the *R. v. Morgentaler*¹⁹⁴ with a finding that Therapeutic Abortion Committees (established to determine a woman's right to an abortion in the hospital setting) contravened a woman's right to security of the person because they delayed implementation of the procedure and therefore had the potential to threaten a woman's physical and mental health.

In *A.C. v. Manitoba (Director of Child and Family Services)*¹⁹⁵ the Court accepts that legislation under the *Manitoba Child and Family Services Act* may have contravened some of the child's section 7 rights, but determines that the violation does not function in

¹⁹² *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519.

¹⁹³ *Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44, [2000] 2 S.C.R. 307.

¹⁹⁴ *R. v. Morgentaler*, [1988] 1 S.C.R. 30 [*Morgentaler*].

¹⁹⁵ *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 S.C.R. 181 [*A.C.*].

a manner that is contrary to the principles of fundamental justice. “The s. 7 liberty or autonomy right is not absolute, even for adults, nor does it trump all other values. Limits on personal autonomy that advance a genuine state interest do not violate s. 7 if they are shown to be based on rational, rather than arbitrary grounds.”¹⁹⁶ One can see where a claim of disruption of psychological integrity (due to inability to practice one’s religion, or follow strongly held moral or ethical beliefs), or a limit of one’s personal autonomy in relation to these matters, could be argued in an attempt to use the *Charter* to overrule legislation that impedes a individual’s freedom in these areas.

Assuming that a claimant is successful in arguing infringement of a section 7 right, he or she still may fail at the attempt to justify a manifestation of a particular belief if the deprivation of the section 7 right is demonstrated to be in accordance with the principles of fundamental justice. Section 7 rights can be compromised if there are core values within the justice system that are thought to take precedence over those rights (for the greater good of society). The principles of fundamental justice have been somewhat delineated in previous SCC cases and serve to provide a guide for establishment of a balance between rights of the individual, other rights guaranteed to individuals within society, and the overall benefit to society as a whole. “The principles of fundamental justice are to be found in the basic tenets and principles not only of our judicial process but also of the other components of our legal system.”¹⁹⁷ This includes other legal rights guaranteed within the *Charter*. Jurisprudential interpretation of the principles of fundamental justice are also informed by international instruments dealing with human

¹⁹⁶ *Ibid.*

¹⁹⁷ *Re B.C. Motor Vehicle Act*, [1985] 2 S.C.R. 486 at para. 64.

rights issues.

The use of international instruments to aid in the interpretation of the meaning and scope of rights under the *Charter*, and in particular the rights protected under s. 7 and the principles of fundamental justice, is well-established in Canadian jurisprudence.¹⁹⁸

Other descriptions of the principles of fundamental justice include the statement that

it must be a legal principle about which there is sufficient societal consensus that it is fundamental to the way in which the legal system should fairly operate, and it must be identified with sufficient precision to yield a manageable standard against which to measure deprivations of life, liberty, or security of the person.¹⁹⁹

Arbitrariness is not tolerated when assessing laws with respect to the principles of fundamental justice. “A deprivation of a right will be arbitrary, and will thus infringe s. 7, if it bears no relation to, or is inconsistent with, the state interest that lies behind the legislation.”²⁰⁰ Another principle of fundamental justice is the tenet that laws should not vague. They need to be able to be clearly interpreted so that the specific rule or offence can be adequately defined and understood by the general public. Another important principle is the requirement that the means used to reach the objective that is outlined by the law or regulation be as minimal as necessary to reach the desired outcome. “If the State, in pursuing a legitimate objective, uses means which are broader than is necessary to

¹⁹⁸ *Victoria (City) v. Adams*, 2009 BCCA 563 [*Adams*] at para. 35.

¹⁹⁹ *R. v. Malmö-Levine*; *R. v. Caine*, 2003 SCC 74, [2003] 3 S.C.R. 571.

²⁰⁰ *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 S.C.R. 791.

accomplish that objective, the principles of fundamental justice will be violated because the individual's rights will have been limited for no reason.”²⁰¹

Because of the difficulty defining the limits of section 7, and the fact that religion and conscience are already “protected” under section 2(a) of the *Charter*, the importance of section 7 of the *Charter* in protecting freedom of religion and conscience for anyone (including medical students) challenging specific legislation seems fairly limited. Although section 7 could, theoretically, be used to challenge a decision to refuse accommodation to a medical student, the likelihood of this is fairly low and therefore this section will not be discussed any further with respect to this thesis.

2.5.6 Section 27 of the *Charter of Rights and Freedoms*

27. This Charter shall be interpreted in a manner consistent with the preservation and enhancement of the multicultural heritage of Canadians.

Section 27 of the *Charter* reaffirms support for a multitude of different views within our society. It confirms an ideology that is consistent with the themes of the *Charter*, as enacted in 1982. It appears to support the philosophy inherent in the wording of section 2(a) of the Charter and argues against limitation of the scope of the rights contained therein. “A more restrictive interpretation would be inconsistent with the Court's decision in *R. v. Big M Drug Mart Ltd.* and with the Court's obligation under s. 27 of the

²⁰¹ *R. v. Heywood*, [1994] 3 S.C.R. 761.

Charter to preserve and enhance the multicultural heritage of Canadians.”²⁰² This section is unlikely to be used to definitively support or negate a particular argument, as it can be used to argue for, or against, particular manifestations of belief, if they have the potential to infringe upon the right of other cultures to practice their beliefs.

A limit on freedom of religion which recognizes the freedom of some members of the group but not of other members of the same group cannot be reasonable and justified in a free and democratic society...The *Charter*, when it protects group rights, protects the rights of all members of the group and not of just some members of the group because to do otherwise would introduce an invidious distinction into the group and sever the religious and cultural tie that binds them together. Section 27 of the *Charter*, which ties its interpretation to the preservation and enhancement of Canada's multicultural heritage, expressly precludes such an interpretation.²⁰³

In the following chapter, I will attempt to determine what level and type of accommodation is reasonable in terms of individual religious, cultural or conscience requests for differential treatment within medical school training, taking into account the legal framework outlined here. I will also identify how a challenge might be played out within a human rights tribunal, or in the courts, based on the current mechanisms of assessment of such claims – as described in this framework chapter.

²⁰² *Edwards Books*, *supra* note 159.

²⁰³ *Ibid.*

CHAPTER 3: APPLICATION OF THE LEGAL FRAMEWORK

3.1 Introduction

One of the main objectives of this thesis is to determine what level of accommodation is reasonable in terms of individual religious, cultural or conscience requests for differential treatment within medical school training. In order to achieve this goal, the following chapter will attempt to determine: how to decide whether specific knowledge or skills must be acquired by a person who is training to become a physician; who determines what knowledge and skills are required for the graduating physician, and how that determination is reached; what role the concept of *bona fide occupational requirement* might play in determining whether certain knowledge or skills are mandatory within the medical education setting; whether there should be differential requirements between physicians and student physicians with respect to the ability to “opt out” of aspects of patient care; and, how students who are refused accommodation might challenge that decision (i.e. a complaint under human rights legislation or a *Charter* challenge).

I will begin this chapter by discussing whether there is such a thing as a “generic physician”. I will look at how medical school training is evaluated in Canada and whether or not there are specific criteria that must be met in order for students to graduate as fully trained medical doctors. I will then give a brief comparison between the Canadian system and that found in the United States, but I will focus mainly on the Canadian system since it is much more consistent and reproducible from site to site. I will discuss *bona fide occupational requirement* (BFOR) more extensively as it is a

necessary component of the analysis of a human rights claim of discrimination. I will discuss whether or not accommodation should be applied equally between medical students who are training to become physicians and those licensed physicians practicing in a particular discipline. Undue hardship will be addressed in terms of the ability of a program to accommodate requests for differential treatment.

As the next phase in application of the legal framework, I will discuss the initial pathways that a student might follow in attempting to receive accommodation of requests for differential treatment. These would likely involve direct requests to medical school administrators and university grievance bodies. Initial assessment by college of medicine administrators would involve evaluating whether or not an educational or clinical experience was an “educational requirement” as determined by the school itself and, more particularly, by the accreditation body overseeing it. The students might then move on to challenging a refusal to accommodate via human rights legislation or components of the *Canadian Charter of Rights and Freedoms*. Specific examples of possible student requests will be presented within this chapter in order to identify the possible outcomes of particular requests or complaints, and to outline the approach that might be used to challenge negative decisions.

Finally, I will describe the importance of establishing a mechanism for dealing with accommodation requests that might occur within a medical school setting, and I will advance suggestions with respect to what might be included in such a policy document.

3.2 What is a physician and what knowledge/skills should a physician have?

3.2.1 Is there such a thing as a generic physician?

In trying to determine if certain educational and clinical experiences are mandatory within medical school training, it is necessary to establish what we mean when we say that someone has completed medical school training and is a medical school graduate, ready to move on to the next level of training. Is there a certain body of knowledge that we expect all medical school graduates to have mastered? Should all students be prepared to move into any area of training in any discipline that is a branch of medicine, or can we graduate students who are unprepared (either by way of the knowledge that they have acquired, or through lack of clinical readiness) to proceed with medical practice in particular areas? Currently, medical schools across Canada are all accredited through the same process and all schools require similar curricula to be completed by their graduating students. These graduates then move on to further training in residency programs in order to become qualified to practice medicine in one of a multitude of disciplines.

3.3 Medical School Training in Canada

3.3.1 Maintenance of Training Standards in Canada

Training within each Canadian medical school is assessed at least every eight years by the Committee on Accreditation of Canadian Medical Schools (CACMS), a committee of the Association of Faculties of Medicine of Canada (AFMC). The CACMS

works with the Liaison Committee on Medical Education (LCME)²⁰⁴ within the United States to ensure a good quality of medical education within Canadian medical schools. The CACMS and the LCME work together to develop and approve standards.²⁰⁵ Under “Accreditation Standards” on the LCME website the statement is made that:

The accreditation process requires a medical education program to provide assurances that its graduates exhibit general professional competencies that are appropriate for entry to the next stage of their training and that serve as the foundation for lifelong learning and proficient medical care. While recognizing the existence and appropriateness of diverse institutional missions and educational objectives, the LCME subscribes to the proposition that local circumstances do not justify accreditation of a substandard program of medical education leading to the M.D. degree.²⁰⁶

The accreditation process seems to be trying to ensure a general level of medical education that produces a generic physician, ready for entrance into post-graduate training in a number of different areas, and specific to none. Consistency in the accreditation process is a central theme. A medical school would presumably not meet accreditation requirements if it allowed individuals to excuse themselves from some

²⁰⁴ “The Liaison Committee on Medical Education (LCME) is the nationally recognized accrediting authority for medical education programs leading to the MD degree in the United States and Canada. The LCME is sponsored by the Association of American Medical Colleges and the American Medical Association.”, Liaison Committee on Medical Education, online: <http://www.lcme.org/>.

²⁰⁵The U.S. Department of Education recognizes the Liaison Committee on Medical Education (LCME) for accreditation of programs of medical education leading to the M.D. degree in the United States. For Canadian medical education programs, the LCME engages in accreditation in collaboration with the Committee on Accreditation of Canadian Medical Schools (CACMS). The LCME is recognized as the reliable accreditation authority for M.D. programs by the nation's medical schools and their parent universities. It also is recognized for this purpose by the Congress in various health-related laws, and by state, provincial (Canada), and territorial medical licensing boards - from **Recognition of the LCME as the accreditation authority for M.D. programs**, online: <http://www.lcme.org/overview.htm>.

²⁰⁶ “Functions and Structure of a Medical School: LCME Accreditation Standards,” Liaison Committee on Medical Education (LCME), online: <http://www.lcme.org/standard.htm>.

component of medical school training that was considered necessary by these accreditation bodies.

The same accreditation process applies to medical schools in Canada and the United States. Medical school training within Canada is fairly consistent from site to site. All Canadian medical schools are members of the AFMC and all Canadian medical schools must be LCME accredited. Most U.S. states require their medical schools to be LCME accredited but this is not a universal policy across the United States. All graduates of Canadian medical schools must pass the same licensing examination, the Licentiate of the Medical Council of Canada (LMCC), in order to practice medicine in Canada.

The accreditation process serves to create consistency between medical schools across North America, and currently establishes a standard that is fairly uniform and may restrict different approaches to medical training engendered by requirements framed through religious or cultural lenses. The accreditation standards could, theoretically, be challenged by individuals or groups that were anxious to modify an aspect of medical school training. Licensing requirements could also be challenged, and alternate methods of establishing practice patterns for physicians could be developed if there was significant support within the medical community, and society in general, to do so. For the purposes of this thesis, I will assume that current accreditation and licensing standards will apply and will, therefore, limit the ability of students to significantly modify medical school training to meet their own needs. The main focus here will be on medical school policies and decisions taken within this established framework.

In terms of the the design of a medical school curriculum, and the ability of a particular school to modify its educational requirements to accommodate specific religious or conscience requests, it may be relevant to consider whether or not a medical school is privately or publicly funded. There are no private medical schools in Canada; all are affiliated with a particular university. The United States, in contrast, has many private medical schools. Privately funded medical schools, theoretically, have a greater ability to modify their teaching to acquiesce to certain requests from students or special interest groups. This thesis will not consider private medical schools and the legal requirements for certain types of medical education within the United States as this differs with respect to the ability to practice medicine and obtain licensure from state to state within that country.

Within Canada, all medical schools are affiliated with a university and with the provincial government of the province in which they are situated. Medical schools within Canada receive much of their funding from provincial governments and this financial support means that provincial governments have some say over certain aspects of medical education (e.g. numbers of students, program funding). This would likely not be a consideration within a medical school that is funded privately. The close association that exists between Canadian medical schools and affiliated universities also gives students the opportunity to plead to the university administrative body to revisit decisions that are made by teachers and administrators within the medical school proper. Discussion of accommodation of religious and conscience requests by medical students in this thesis will deal primarily with Canadian medical schools.

3.4 What is a Bona Fide Occupational Requirement and what role does it play in deciding about accommodation in conscientious objection requests?

As discussed in chapter 2, *bona fide occupational requirement* (BFOR) is a term that applies in human rights law and refers to a work requirement that has been established, and is thought to be necessary in order for a job to be performed properly or efficiently. Medical training prepares a student to become a practicing physician. There are “occupational requirements” necessary for the practicing physician to obtain before the educational process is complete. One could, therefore, argue that the mandatory components of medical education, as outlined by CACMS and the LMCE, are *bona fide occupational requirements*. Alternatively, one would argue that the *educational requirements* for program completion, as outlined by these evaluating bodies, provide *bona fide* and reasonable justification for enforcing particular components of medical education.

The concept of a BFOR has the potential to play a very important role in determining whether or not medical students should be permitted to excuse themselves from some aspect of medical school training. Are there “bona fide occupational requirements” for physicians? Are there aspects of medical education and clinical exposure (in creation of the employable physician) that meet the BFOR criteria? If so, then these components of medical education would need to be completed, regardless of the rationale given by those requesting exemptions. If a component of the educational experience is not a BFOR, however, then perhaps a student could be excused from participating in this aspect of medical training. Current human rights legislation supports this concept. The Saskatchewan Human Rights Commission (referring to *the*

*Saskatchewan Human Rights Code*²⁰⁷) states that unless a requirement is determined to be a BFOR, a workplace must accommodate workers up to the point of “undue hardship”^{208,209}

As identified in *Moore v. B.C.*²¹⁰, human rights legislation might be used to challenge a refusal to accommodate without referring specifically to occupational requirements. Lack of access to education, even in a situation where there is a *bona fide* justification of a decision to exclude, can be challenged if meaningful attempts to accommodate have not been made. This perspective supports the need to demonstrate “undue hardship” in terms of accommodation, even in situations where BFORs are identified.

Medical training involves both educational (informational) and clinical components. If it is possible for a student to become “educated” in a particular area, without directly experiencing the associated clinical exposure, then accommodation that excluded a specific clinical activity could, perhaps, be allowed and would still meet accreditation guidelines. This would presumably be a judgment call based on assessment of the student’s request, success of the alternative educational experience, and importance of the educational or clinical component that was missed or modified. The area of debate that could arise might not always be related specifically to the requirement that the student acquire a particular type of information, or skill, but would more often relate to

²⁰⁷ *The Saskatchewan Human Rights Code*, SS 1979, c S-24.1.

²⁰⁸ *Canadian Human Rights Act* (R.S.C., 1985, c. H-6), ss. 15(2),(3).

²⁰⁹ “Bona Fide Occupational Requirement (BFOR)”, Saskatchewan Human Rights Commission, online: http://www.shrc.gov.sk.ca/pdfs/policies_guidelines/Bona-Fide-Occupational-Requirement.pdf.

²¹⁰ *Moore v. British Columbia (Education)*, 2012 SCC 61, [2012] 3 S.C.R. 360.

whether or not this information or skill could be accessed in a way that was different from the norm. For example, a student may not want to personally refer a patient for an abortion, or participate in performance of an abortion, but might still be willing to learn about the procedure, its indications and its complications. It would be more difficult for the student to persevere with requests for exemption from activities that are held to be BFORs or educational requirements and likely integral to accreditation (e.g. touching the human body; giving a blood transfusion to a person with extensive blood loss), particularly in light of the formal system of medical school accreditation that is well established within Canada. Lack of fulfillment of accreditation standards would likely meet the “undue hardship” descriptor in terms of proving inability to accommodate.

Medical education is comprised of different types of learning. Students learn about disease processes (book learning) but also learn to perform a number of clinical skills that range from interviewing a patient, to performing invasive procedures such as intravenous access and pelvic and rectal examination. Medical students learn how to acquire information on the health, behaviours and beliefs of individual patients, without allowing these diverse practices and beliefs to interfere with the application of excellent health care delivery. Many of the patients seen in medical practice may behave in ways that are anathema to maintenance of good health. Nonetheless, the medical student must learn to advise and support patients in a non-judgmental and caring fashion in order to move them towards a state of improved overall health. All of these components of medical training are integrated into the medical school educational experience and are overseen and evaluated by the accreditation system. Requests for individual accommodation may be challenging to deal with in this educational environment.

3.5 Should medical students and practicing physicians be permitted similar levels of accommodation of religious or conscience requests?

Should access to accommodation be more or less stringent in the medical school situation, in comparison to that afforded practicing physicians? As discussed in Chapter 1, the Canadian Medical Association *Code of Ethics*, (and other medical ethics codes established provincially) states the expectation that access to care will be facilitated by the physician, even if she or he is not willing to directly provide the care.²¹¹ No specific legislation has been established to allow physicians in Canada to choose to opt out of patient treatment in the emergency situation. “Good Samaritan” – type acts, such as *The Emergency Medical Aid Act*²¹² in Saskatchewan, prohibit prosecution of physicians who, in good faith, go to the aid of a patient in an emergency situation. But there is no legislation in Canada, that I am aware of, that permits physicians, because of faith (or other conscience reasons) to excuse themselves from care of a patient in an emergency situation. Physicians in Canada are expected to ensure that their patients can access the medical care they need, and are legally entitled to receive (including in a non-emergent situation), even if these physicians are unwilling to provide the care themselves. In contrast to this, a significant body of legislation has been established in the United States to protect practicing physicians from legal sanction when they opt out of certain aspects of patient care (see chapter 1).²¹³

²¹¹ Section 19, *Code of Ethics*: Canadian Medical Association, online: <http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>.

²¹² *The Emergency Medical Aid Act*, R.S.S. 1978, c. E-8.

²¹³ *The Coats Amendment; The Church Amendments*.

Should medical students be treated in the same way as practicing physicians with respect to their ability (or inability) to excuse themselves from certain aspects of patient care? These questions can be addressed from two distinctly different perspectives. Although medical students ultimately move on to become practicing physicians, the two groups have different roles and responsibilities and, therefore, it is reasonable that different rules might apply to medical students, than apply to physicians who are licensed to practice medicine.

Medical students do not have final responsibility for patient care. They are students, learning about the art and science of medical practice. Medical school training was previously much more of an apprenticeship, in which a student followed a practicing physician on his or her work rounds, learning from that physician and gradually taking on more and more responsibility for patient care. There has been increasing pressure, over the past twenty years, to reclassify medical students as “students” rather than “workers” and to make the educational component of medical education a priority, phasing out some of the service work previously delegated to medical students. This transformation has been stimulated by concerns about the sleep deprivation that is experienced by medical students and residents during the training process, and the risk to patient care that may be associated with this sleeplessness.^{214 215216} Medical students have more ability to leave the hospital or clinic and go home when they are tired, abandoning care of patients to the

²¹⁴ MJ Asken and DC Raham, “Resident performance and sleep deprivation: a review” (1983) 58(5) *Journal of Medical Education* 382.

²¹⁵ Matthew B. Weinger and Sonia Ancoli-Israel, “Sleep Deprivation and Clinical Performance” (2002) 287(8) *JAMA* 955.

²¹⁶ Ilene M. Rosen et al., “Evolution of Sleep Quantity, Sleep Deprivation, Mood Disturbances, Empathy, and Burnout among Interns” (2006) 81(1) *Academic Medicine* 82.

more legally responsible physician (resident or staff physician). From the perspective of responsibility for care, and effect on patient wellness, withdrawal from an aspect of care by a medical student need not have any significant overall effect on patient well-being (barring perceptions of discrimination or unequal treatment that patients might have if they were aware of the students' requests). Viewed from this perspective, it appears that we can be more accommodating of students' requests for differential treatment than we might be for physicians who bear total responsibility for their patients' care.

From another perspective, that of the medical student who is on a continuum from student to practicing physician, evading particular learning points or clinical experiences can, potentially, prove more troubling. Presumably these teaching sessions and clinical rotations have been developed for a particular purpose and with a generic physician in mind. This perspective is confirmed by reviewing LCME guidelines. "The accreditation process requires a medical education program to provide assurances that its graduates exhibit general professional competencies that are appropriate for entry to the next stage of their training and that serve as the foundation for lifelong learning and proficient medical care."²¹⁷ If a medical student is allowed to opt out of certain facets of medical training for religious or conscience reasons, will this affect his or her ability to meet the LCME mandate to gain the professional competencies necessary to move on to the next stage of training and, ultimately, into medical practice? An obvious example would involve a medical student who did not want to examine patients of the opposite sex. Learning the requisite anatomy would not deliver enough information and experience to

²¹⁷ "Functions and Structure of a Medical School: LCME Accreditation Standards," Liaison Committee on Medical Education (LCME), online: <http://www.lcme.org/standard.htm>.

permit the student to enter into a number of areas of post-medical school training. A male student who was unwilling to examine a female patient would specifically not be able to train as an Obstetrician/Gynecologist. He would not function adequately in an emergency department, intensive care unit, pathology department or operating theatre. He would not be able to resuscitate a baby in a delivery suite. His ability to function as a resident in any of these post-graduate programs would be severely compromised and the degree of difficulty it would take to incorporate him into a system wherein he was permitted to refuse to treat female patients would, I believe, be insurmountable, unless the system itself was divided into clinics and hospitals where only patients of one sex or another were permitted to enter.

Assuming that a college of medicine was willing to accommodate certain types of requests permitting students to be excused from involvement in some areas of medical training, concern persists with respect to the functional status of those students after graduation. Once a student leaves the confines of the medical school and proceeds to the next stage of training, how can we ensure that accommodations given at the training stage will not disadvantage a future patient of this medical student? These concerns suggest that accommodation within the medical school setting must still require that the medical student should have obtained the competencies required by accreditation bodies before being allowed to graduate with a medical degree. This perspective is particularly relevant for direct patient exposures in which acquisition of necessary clinical and procedural skills may not be adequately achieved through simply reading about a procedure or process. Familiarity with the signs and symptoms of disease processes, including physical examination findings related to these processes, is necessary for diagnosis of

such problems as miscarriage, sexually transmitted diseases and alcoholism. Direct patient interaction is, in some circumstances, the only definite method of teaching students to be a complete physician, ready to take on the complex and intimate role of patient confidant and caregiver.

3.6 Process for determining if a request for exemption should be accommodated

3.6.1 Does the request undermine a particular educational requirement and/or is the requirement a BFOR?

Medical education includes both knowledge acquisition and attainment of clinical experience. Enmeshed within this, and alluded to previously, is the fact that medical school training also teaches a student how to interact on a very personal level with another human being, in a manner that is extremely intimate, but at the same time, must be wholly professional. This is the “art” of medical school training and is a theme that runs throughout the educational experience. Development of these skills is critical to appropriate physician-patient interaction and must also be taken into consideration when contemplating any educational exemptions.

In order to determine if the missed educational experience is mandatory for completion of training, the school may try to ascertain if the educational experience is a BFOR. This determination would be made by identifying what medical knowledge and clinical experience the student is expected to have mastered by graduation time. Currently, in Canada, all students graduating from medical school are expected to have obtained the requisite knowledge and clinical exposure to allow them to move onto the next phase of their training (post-graduate programs). One could certainly argue that a

decision to accommodate, which led to accreditation concerns, would create an undue hardship for the medical school concerned. Determination that the educational experience is a BFOR would likely tie into accreditation requirements and therefore absolve the school of any legal need to accommodate the student's request for differential treatment. However, if the educational experience is not a BFOR, then human rights legislation generally would require that the medical school accommodate the student, if possible, to allow for claims of religious or conscience concerns that conflict with certain aspects of medical school training. This duty would be limited by the actual ability of the medical school to respond to the student's requests. For the purpose of this thesis, and a human rights challenge, I will assume that, in the context of medical school accreditation, an *educational requirement* is, essentially, a BFOR.

3.6.2 Would accommodation of the request impose undue hardship? (3rd arm of the Meiorin test)

As has been previously identified, the duty to accommodate is limited by a claim of *undue hardship* by the group being asked to allow the accommodation.

Undue hardship describes the limit on the duty to accommodate for employers, service providers and others covered by the *Code*. Undue hardship can only be defined on a case-by-case basis as its determination relies on the specific facts of each case. The point of undue hardship is only reached when the employer or service provider has done everything reasonably possible to accommodate a need.²¹⁸

In terms of medical school training, undue hardship might involve such particulars as: financial ability of the medical school to meet student requests; ability of the school's

²¹⁸ Bona Fide Occupational Requirement (BFOR), Saskatchewan Human Rights Commission, online: http://shrc.gov.sk.ca/pdfs/policies_guidelines/Bona-Fide-Occupational-Requirement.pdf.

other resources (instructors, patients, physical space) to be modified to meet student requests; impact on other medical students in the same college (increased work load and difficulty in coordinating experience in different areas of training); and, effect on the general goals and requirements of the educational process undertaken by the school in terms of the request advanced by the student.

3.6.3 Refusal of Request for Accommodation – Challenge by Student and Potential Mechanisms for Relief

A student who is denied a request for accommodation would likely initially appeal within the medical school for reconsideration of the refusal. The next level of appeal might be to the university with which the medical school is affiliated. A human rights claim would likely focus on whether or not the student's request undermined an educational requirement and/or caused undue hardship for the medical school. Finally, a *Charter* challenge through the courts could be a route taken by a student intent on training to be a physician but troubled by questions of conscience or by religious ideology that conflicted with certain components of the curriculum.

Three specific examples of possible student requests for accommodation have been chosen in order to demonstrate the mechanism that would likely be used by students to challenge a refusal of request for accommodation, and the analysis that would be used to determine the outcome. These examples have been chosen because they are consistent with the kinds of requests that have been written about in the literature²¹⁹ and are

²¹⁹ *Card, supra* note 6.

therefore examples that may be encountered by medical schools in Canada currently and in the future.

3.6.4 Examples of possible requests for accommodation

Student A does not want to be involved with the arrangement or performance of an abortion during medical school training;

Student B does not want to examine patients of the opposite sex (this request for accommodation might range from the request to never see or touch the naked body of a person of the opposite sex, to not being alone in the room with a person of the opposite sex);

Student C wants to be excused from educational and clinical activities for certain periods of time in order to pray.

3.6.5 Relief mechanisms within the medical school and university

Individual medical schools and universities will have processes available for students to grieve a particular decision that is made with respect to their educational experience. There appear to be very few medical schools that have specific policies developed to deal with conscience or religion-based student requests for exemption from educational or clinical experiences within medical school training. Such requests may currently be dealt with through general anti-discrimination policies that have been established within the affiliated university. Decisions like these are often made on a case-by-case basis and therefore may suffer from inconsistency and from the lack of any underlying unifying philosophy regarding medical education. Nonetheless, a student

requesting an exemption would likely plead his or her case to the specific medical school and/or university site prior to proceeding with human rights or *Charter* challenges.

3.6.6 Does the request undermine a particular educational requirement (BFOR)?

Medical schools would likely assess requests for accommodation based on whether or not that accommodation would undermine a particular educational requirement and, therefore, threaten medical school accreditation.

3.6.6(A) *Student A* is requesting to be excused from being involved in the performance of an abortion. Access to abortion is a legal and accepted standard of medical care within Canada. All medical students in Canada are taught about abortion as a component of their educational exposure to information pertaining to the discipline of Obstetrics and Gynecology. The generic physician, graduating from a Canadian medical school, might possibly enter into Family Medicine, Emergency Medicine or Obstetrics and Gynecology residency training programs, all of which would require the student to function as a first line physician providing care to a patient requesting access to abortion, or suffering a complication of this procedure. Although a graduating medical student would not be expected to know how to perform an abortion, he or she would be expected to know a significant amount about the procedure, potential indications for the procedure, and complications related to this procedure. Therefore, knowledge about the procedure, rather than performance of the procedure, would be considered an educational requirement within Canadian medical schools.

3.6.6(B) *Student B* is requesting to be excused from ever examining a patient of the opposite sex. Examination of individuals of both sexes is currently a component of the educational experience of students in medical schools across Canada. As noted on the LCME website²²⁰, Educational Objectives ED-13²²¹ and ED-15²²² state the expectation that students within a medical school that is accredited by the LCME will be trained to become “generic physicians”, ready to move into any post-graduate program to which they might wish to apply. These stipulations would require a student to be familiar with both the educational and the clinical components of caring for patients of both sexes. Although a medical student could learn about the anatomy and physiology of a patient of either gender from a textbook and other non-clinical instructional models, clinical experience is a necessary component of the educational process that would allow a student to move into a post-graduate position in any residency program. Currently, it is an educational requirement for medical students training in Canada to obtain the necessary educational and clinical expertise to care for members of both sexes.

²²⁰ FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree, online: <http://www.lcme.org/functions.pdf>.

²²¹ ED-13. The curriculum of a medical education program must cover all organ systems, and include the important aspects of preventive, acute, chronic, continuing, rehabilitative, and end-of-life care.

²²² ED-15. The curriculum of a medical education program must prepare students to enter any field of graduate medical education and include content and clinical experiences related to each phase of the human life cycle that will prepare students to recognize wellness, determinants of health, and opportunities for health promotion; recognize and interpret symptoms and signs of disease; develop differential diagnoses and treatment plans; and assist patients in addressing health-related issues involving all organ systems. *It is expected that the curriculum will be guided by the contemporary content from and the clinical experiences associated with, among others, the disciplines and related subspecialties that have traditionally been titled family medicine, internal medicine, obstetrics and gynecology, pediatrics, preventive medicine, psychiatry, and surgery.*

3.6.6(C) *Student C* wants to be excused from educational and clinical activities to pray (potentially up to five times per day).²²³ These prayer sessions will likely last between 5 and 10 minutes. Student C and several other students within the medical school (with similar religious backgrounds) think that it would be a good idea to establish a place to pray for these students where they can go to pray away from their educational and clinical duties. The first concern to address is whether or not it is feasible to acquiesce to this request for the student to be excused from educational and clinical duties a number of times per day on a regular basis. Will this undermine a particular educational requirement? As mentioned previously, medical students now tend to have more focus placed upon their educational experience, rather than filling an integral role in the network that cares for the patient population within a community setting or hospital environment. If there is some flexibility with respect to the scheduling of prayer time periods, then it should be possible to accommodate this request without undermining the educational experience in any significant way. If the student must pray at regular, specific times each day, this requirement may interfere more substantially with his or her duties and educational experiences. It will also be more problematic if the student needs to go to a specific site to pray that is a significant distance away from where the educational experience is taking place. Having a preordained site to pray may be a positive or a negative addition from this perspective, depending upon whether or not the identified site is in close proximity to the place where the student is training. If no significant component of the educational experience is being missed by allowing these

²²³ The Basics of the Muslim's Prayer, online:
<http://www.sunna.info/prayer/TheBasicsoftheMuslimsPrayer.php>.

prayer times, then it would not be necessary to determine whether or not the time that is being missed undermines an educational requirement.

3.6.7 Mechanisms Beyond Medical School and University Administration

If student satisfaction is not achieved by grieving to the medical school or university, then a student might proceed with a human rights complaint or *Charter* challenge in an attempt to have his or her goals met.

Education in Canada is a provincial responsibility and a medical student who is looking to human rights legislation to challenge a refusal to accommodate would likely deal with human rights legislation in the province where the medical school is located. As identified in the chapter 2, individuals would need to prove that there has been differential treatment, and that this differential treatment has led to *prima facie* discrimination, in order to proceed with a human rights claim when requesting accommodation within the medical school paradigm. I will refer to *the Saskatchewan Human Rights Code*²²⁴ in discussing these various requests for accommodation. The human rights codes across the country are similar and these steps can be translated to processes that would occur in other Canadian provinces. The initial step in all of these instances would be to register a complaint of discrimination with the Saskatchewan Human Rights Commission [Commission]. The complaint process²²⁵ outlined in the *Code* describes mechanisms for proceeding with a complaint and the criteria that would

²²⁴ *The Saskatchewan Human Rights Code*, SS 1979, c S- 24.1 [*Code*].

²²⁵ *Ibid.*, at s. 27(1).

establish the validity of such claims. Once a complaint has been made, the Commission can proceed with management of the complaint or dismiss the complaint for a variety of reasons.²²⁶ Management of the complaint might include an attempt at resolution or settlement of the complaints, or a decision to proceed with further investigation of the complaint if there is a failure of mediation.²²⁷ Criteria for proceeding with a complaint analysis are found within the guidelines established for each provincial human rights commission. Once a complaint has been accepted for investigation, the commission must determine if the discrimination is unavoidable, due to the particular circumstance, or deserving of sanction and/or punishment. Integral to this discussion is the requirement for accommodation to the point of undue hardship.

In the following section, I will address the specific legal mechanisms that Students A, B and C might use (human rights legislation and *Canadian Charter of Rights and Freedoms*) to challenge a refusal to accommodate. I will describe these mechanisms for each student individually. In each situation, the student will be trying to prove *prima facie* discrimination and will then claim relief for this discrimination through the legal mechanisms available to them via human rights legislation or the *Charter*. As noted in chapter 2, in order to prove a *Charter* violation, the student must demonstrate that he or she has been subject to unequal treatment with respect to a prohibited ground and within a protected sphere of activity (section 15), and/or that there has been a violation of the individual's freedom of religion or conscience (section 2(a)).

²²⁶ *Ibid.*

²²⁷ *Ibid.*, at s. 28(1).

3.6.8 Applying Human Rights Legislation or Charter Rights to Refusal of Accommodation Requests

3.6.8 (A) Student A:

does not want to be involved with the arrangement or performance of an abortion during medical school training

3.6.8(A)1 *Human Rights Legislation:*

As with all areas of medical training, learning about abortion involves: knowledge acquisition; development of particular clinical skills; emotional and ethical understanding of this area of medical care; and, learning to directly interact with patients when providing care to them. In order for a student to properly care for a patient who is requesting an abortion, or has suffered some complication related to this process, knowledge about this procedure is “integral to carrying out the requirements”²²⁸ of the role of the generic physician who is ready to enter into any post-graduate residency training program. Actual performance of the **procedure**, on the other hand, is something that a physician would learn while in a post-graduate training program, and ability to perform this procedure at the medical student level is not a requirement of medical schools across Canada. Interaction with patients who are requesting an abortion, or recovering from such a procedure, gives students insight (that they may not otherwise gain) into patients’ physical and emotional states while they are experiencing these processes. Therefore, it is knowledge about the procedure and its complications, as well as an understanding of the lives of the individuals who present for such a procedure, rather than performance of the procedure itself, that would be considered either an

²²⁸ “Bona Fide Occupational Requirement (BFOR)”, Saskatchewan Human Rights Commission, online: http://www.shrc.gov.sk.ca/pdfs/policies_guidelines/Bona-Fide-Occupational-Requirement.pdf.

educational requirement or a BFOR. A medical student would not be expected or permitted to perform an abortion on a patient requesting or requiring such a procedure. Therefore, there is no argument to be made that acquisition of the skill of performing an abortion is a requirement within the Canadian medical school educational scenario. Because mastery of the procedural component of abortion management is not required for graduation from medical school, students could likely be accommodated in terms of excusing them from watching or being directly involved in performance of an abortion without compromising their medical education experience. Matters become a bit more grey when one considers the patient interaction that could be missed when students are permitted to excuse themselves from interacting with patients who are involved in requesting such a procedure, or recovering from the procedure itself. Allowing accommodation of this degree of withdrawal from patient interaction would be a judgment call and I believe that one could argue that some type of patient interaction in the above scenario is an educational necessity for the generic physician who will be practicing medicine independently in the near future.

3.6.8(A)1.1 *Undue Hardship*

It is unlikely to cause undue hardship to accommodate a student's request not to be directly involved in the procedural component of an abortion. Acquisition of knowledge about abortion methods, without direct patient interaction, could be achieved fairly easily, in consultation with a teacher within the medical school. The request might necessitate a change in scheduling for the student and oversight will be required to ensure

that appropriate knowledge is gained through the process of self-study. Undue hardship could possibly be claimed in a situation where the presence of a student in the operating room to help with performance of an abortion was necessary in order for the operation to proceed. This is unlikely and, as noted previously, the use of medical students as “worker bees” on the wards, rather than students who are observing the treatment process, is no longer encouraged by the Canadian medical school training system.

3.6.8(A)2 *Charter challenge*

Assuming that Student A was not successful in applying human rights legislation to force accommodation of the request to be excused from involvement with any patients requesting an abortion, or having one performed, the student could then move on to the courts and attempt to use the *Canadian Charter of Rights and Freedoms* to force the medical school to allow him or her to be excused from this component of the medical school curriculum. The sections of the *Charter* that would be most useful in advancing this challenge would be section 2(a) and section 15. Section 1 would then play the important role of potentially allowing for infringement of religious freedom, or for permitting differential treatment, in situations where discrimination has occurred but is judged to be necessary or reasonable. Assuming that a medical school, as part of a university, would be subject to the *Charter* (see discussion on this point in chapter 2), section 2(a) is the section that would most likely be used to challenge a decision not to accommodate a religious or conscience-based request for differential treatment.

3.6.8(A)2.1 Section 2(a)

In order to prove a section 2(a) violation, the individual making the request to be excused from involvement in anything to do with an abortion could argue that his or her religious or conscience beliefs prevented involvement in this process. The belief about the “wrongness” of abortion would need to be shown to be a belief that was sincerely held by the individual concerned. The individual would then need to be able to show that the belief created an obligation on the part of the individual to avoid being involved in carrying out an abortion.²²⁹ The amount of involvement in a process, such as abortion, that a student might be willing to accept would depend upon the individual’s interpretation of the tenets of his or her religion. This could vary significantly, consistent with the wide range of beliefs and uneven adherence, with respect to standard teachings, between individual members of a religious group.²³⁰ Once a violation of section 2(a) had been proven, the medical school/university would then be required to show that the violation was justified via a section 1 analysis. Failure to do this would require implementation of the student’s request for accommodation.

As outlined in chapter 2, a section 1 analysis that permits a *Charter* violation to be upheld (justification component) requires that the limitation applied to the individual is based on an **objective** that is shown to be important enough to warrant undermining a right that would otherwise be available to the person under the *Charter*. The objective

²²⁹ *Multani, supra* note 125.

²³⁰ Roni Caryn Rabin, “Respecting Muslim Patients’ Needs”, November 1st, 2010, The New York Times, online: http://www.nytimes.com/2010/11/01/health/01patients.html?_r=0.

must be “pressing and substantial”²³¹ and if those requirements are met, then the **means** used to obtain the objective (resulting in limitation of the individual’s rights) must be shown to be “reasonable and demonstrably justified.”²³² Assessment of the means involves a *proportionality* test that is comprised of three components: the means must be rationally connected to the objective (they must not be arbitrary or unfair); there must be minimal impairment of rights; and there must be proportionality between the infringement and the objective.

In a case such as this, one would want to divide the request for accommodation into an assessment that involves the knowledge acquisition component of the process (what is an abortion, how is it performed, what are the complications that might be associated with such a process?) versus the procedural component of performing an abortion. Since the ability to perform an abortion is not a usual requirement of a student graduating from medical school, it is extremely unlikely that a requirement that a student actually participate in the procedure would be held to be necessary. In this instance, therefore, the objective (knowing how to **perform** an abortion) would not meet the requirement of being sufficiently important to warrant limiting the individual’s rights. On the other hand, it is very likely that the requirement that the student learn about the procedure, the reasons for it and any associated complications, would be upheld and the student would be required to proceed with this component of his or her education or not complete the training to become a physician. Assuming, once again, that we are training a generic physician who is ready to enter into any residency training program, and may encounter a

²³¹ *R. v. Oakes*, [1986] 1 S.C.R. 103.

²³² *Ibid.*

patient who wants to have an abortion performed (or has recently had this process completed), an understanding of the procedure and its complications would be required knowledge for a newly graduated physician. A physician is expected to safeguard the health and rights of patients under his or her care. Patients have the right to make decisions about their own health care.²³³ In order to do so, they need to be properly educated about their medical condition and about the possible medically acceptable and legal options for treatment. Only a physician who is properly educated about the options for management of a pregnant patient (including a patient who does not want to be pregnant) can provide the appropriate level of care.

Further discussion would likely center around the means by which the student might acquire information about an abortion and its complications. The three subsets of a proportionality assessment would be explored to be certain that: there was a rational connection between the means of acquiring the educational objective and the educational outcome; that the student's rights were minimally impaired so as to limit hardship for the individual in terms of his or her religious or conscience concerns; and, that there was appropriate proportionality between infringement of the student's rights and the objective of teaching the student about abortion. Infringement of the student's right to practice conscience or religious beliefs (in this case, the request not be involved in an abortion in any way) must be balanced against the objective of ensuring that the student is appropriately educated such that he or she can competently care for the pregnant patient.

²³³ CMA Code of Ethics, online: <http://policybase.cma.ca/PolicyPDF/PD04-06.pdf>.

(This very well may include the ability of the student to interact with and respond to the needs of the patient requesting an abortion).

A student who was opposed to abortion might be willing to learn about the procedure, but might object to doing so in a situation in which it was necessary to actually observe an abortion, or might object to being responsible for facilitating an abortion (referring the patient to someone who would perform the abortion, or counseling a patient about the possibility of having an abortion). In a case scenario such as abortion, careful balance between the specific, necessary objective and a minimal impairment of rights must be negotiated in order to provide balance and fairness to students entering the medical school environment. Management of this ethical dilemma must also take into consideration the expectation in Canada that a patient has a right to have access to appropriate and legally available medical care, even if the individual physician does not want (personally) to provide that care.

3.6.8(A)2.2 Section 15

This same student might use section 15 of the *Charter* to challenge a refusal to accommodate a request not to be involved with any patients requesting an abortion, or having an abortion performed. As a first step, a court would determine whether an infringement of a guaranteed right had occurred. The court would accomplish this by identifying if a distinction had been made based on enumerated or analogous grounds as set out under section 15(1). If a distinction is identified, then the court would need to determine if the purpose or effect of this differential treatment was discriminatory. Identification of discrimination would then lead the court to a section 1 analysis to

determine if this distinction could be upheld as being demonstrably justified. In this particular circumstance, a student might attempt to claim discrimination based on a prohibited ground or analogous ground (religion and/or culture might be possibilities).

It may be relatively straightforward for the student to show that involvement with **performance** of an abortion would directly conflict with the student's ability to practice his or her religion or maintain a functioning association with a particular culture. The individual might argue that these beliefs should be respected and that the requirements set forth by the medical school conflicted with these beliefs and therefore interfered with the ability of the student to belong to (or function within) a particular community and still complete medical school training. The effect of the requirement to be involved in an abortion (based on the fact that the student might be unable to adhere to this requirement and also practice the tenets of his or her religion or cultural community) would be discriminatory (with religion as the enumerated ground resulting in the distinction that undermined the student's ability to participate). It would be more difficult to show that **learning about** an abortion, and its associated complications, would interfere with the ability of a student to maintain his or her beliefs and stay true to the doctrines of the religion or cultural community.

Although the sincerity of a person's belief that a religious practice must be observed is relevant to whether the person's right to freedom of religion is at issue, an infringement of this right cannot be established without objective proof of an interference with the observance of that practice.²³⁴

Assuming that the student could prove a section 15 violation in this particular

²³⁴ *S.L.*, *supra* note 141.

circumstance, the court would then move on to a section 1 analysis to see if the *Charter* violation should be upheld. As noted above, assuming that we accept the concept of a generic physician who is meeting accreditation requirements and is expected to have a certain body of knowledge and clinical experience in order to proceed to the next level of training, it is likely that a section 1 analysis would find that, at least, gaining knowledge about abortion and its potential indications/complications would pass the “pressing and substantial” objective test as the first part of the section 1 evaluation. What the student would be required to do, in order to gain the requisite knowledge, would need to be assessed in terms of a level of proportionality that would balance the individual’s religious beliefs against the requirements laid out by the medical school. Is the objective (learning about or performing an abortion) rationally connected to the educational requirement as mandated by accreditation bodies? Is there minimal impairment of the student’s rights? Is there proportionality between the infringement (challenging the individual’s rights to practice his or her religious beliefs) and the objective (becoming an appropriately knowledgeable and skillful physician)?

3.6.8(B) Student B:

does not want to examine patients of the opposite sex (this request for accommodation might range from the request to never see or touch the naked body of a person of the opposite sex, to not being alone in the room with a person of the opposite sex)

3.6.8(B)1 *Human Rights Legislation*

As identified previously, it is currently required that students who are graduating from accredited medical schools in Canada learn to care for patients of both sexes. This is a *bona fide* educational requirement, and one that cannot be modified within our system that deals with patients of both sexes in acute and chronic care settings. The school would, therefore, not legally need to accept the student's wish to excuse him or herself from examining patients of the opposite sex.

3.6.8(B)1.1 *Undue Hardship*

Designing a program that would allow student B to excuse him or herself from ever examining someone of the opposite sex would definitely create undue hardship for the medical school and for the community to accommodate. Specific training would need to be organized for this individual student, identifying patients of only one gender who would be available for this student to treat and examine. It would be very difficult to ensure that the student was never placed in a position where he or she might need to provide treatment to a patient of the opposite sex in an emergency situation. Such a scenario could potentially prove unsafe for the patient who needed to be treated emergently, either because the student refused to treat the opposite-sex patient, or treated

the patient in a substandard fashion because of lack of familiarity with the care of the patient, or discomfort in dealing with a patient of the opposite sex when the student had not developed the skills to do so in a professional manner.

3.6.8(B)2 *Charter challenge*

3.6.8(B)2.1 **Section 2(a)**

An individual making a request to never examine someone of the opposite sex could argue that religious or conscience beliefs prevented him or her from engaging in this process. The religious or conscience belief would need to be shown to be a belief that was sincerely held by the individual concerned. The individual would then need to be able to show that the belief created an obligation on the part of the individual to avoid being in a situation where it might be necessary to see or touch the unclothed body of a member of the opposite sex. As with most other challenges that have gone before the courts using section 2(a) as a method of arguing for differential treatment, it is likely that the individual would be able to demonstrate a section 2(a) violation, and it would then fall to section 1 to determine whether or not this violation should be allowed.

Section 1 analysis would assess the request in terms of whether or not the limitation on the student's rights was demonstrably justified (pressing and substantial objective) and whether there was proportionality between the limitation of rights and the objective of the limitation. The objective of learning to examine and treat patients of both sexes, as a graduating physician, is supported by the medical school accreditation system and by our practice of medicine in Canada and the western world. This objective

meets the “pressing and substantial” benchmark. A proportionality assessment would determine if the means (teaching students about anatomy, physiology and examination skills for patients of both sexes) were rationally connected to the objective of educating students with respect to the medical care of patients of both sexes. The next step would involve ensuring that there was minimal impairment of the student’s rights while ensuring the requisite objective. Finally, it would need to be demonstrated that there was proportionality between infringement of rights and the objective. As noted above, acquisition of skills in examining someone of the opposite sex is a process that is multifaceted and involves more than just an anatomic understanding of the opposite-sex patient.

A generic physician, unleashed upon the general public, must currently be able to deal appropriately with patients of both sexes. Application of the minimal impairment component of the Oakes test would demonstrate that the rights of the individual, who is required to learn about and examine patients of the opposite sex, are as minimally impaired as is possible in this particular scenario. The minimal impairment test would not require that request for exemption from the requirement to examine someone of the opposite sex be permitted, since this component of medical education is integral to the training and practice of medicine in Canada (bona fide educational requirement). It is difficult to contemplate permitting a student to learn only so much about examination (including body contact) of someone of the opposite sex when requirement for complete care is the goal. It is likely that a section 1 analysis would support a limitation of the right in this circumstance, and that the student would be required to proceed with learning about the care of members of the opposite sex.

3.6.8(B)2.2 Section 15

In this circumstance, the individual claiming a section 15 violation would need to demonstrate that he or she was being discriminated against based on a listed or analogous ground (possibly religion or culture) and that his or her beliefs did not allow visualization or examination of the body of someone of the opposite sex. Inability to complete medical school without caring for and examining members of the opposite sex would impede the student from reaching the goal of becoming a physician through training in the Canadian medical system. The individual's membership in a particular group that prevented these type of examinations would provide the requisite distinction needed to begin the process of claiming a section 15 violation. Inability to graduate from medical school because of membership in a religious or cultural group could be claimed to result in discrimination against that individual (effect of the distinction) and confirm a section 15 violation.

A section 1 analysis would then be carried out to determine if this violation should be upheld. As identified previously, our current system requires that all medical school graduates acquire a certain level of knowledge and clinical experience that would allow them to proceed on to a wide variety of post-graduate training options. This generic physician would, currently, need to be able to examine members of both sexes. Only a major change in our society, such as creating clinics and hospitals that look after only men or only women, would allow medical students to opt out of learning about the examination of patients of both sexes. A section 1 analysis would find that a requirement to learn about and care for members of both sexes is a requirement in the Canadian medical training system (pressing and substantial), and that this section 15 violation is warranted.

3.6.8(C) Student C:

wants to be excused from educational and clinical activities for certain periods of time in order to pray.

3.6.8(C)1 *Human Rights Legislation*

As long as student C is not having to miss a critical educational component of medical school curriculum on a regular basis, then he or she should be able to be excused from medical school for short periods of time in order to take part in these prayer sessions. In the event that the request for prayer time includes considerable time for travel to and from a prayer site, or in the circumstance where the prayer must take place at a certain time or times of the day, accommodation may be significantly more difficult to facilitate. In these cases, it may be very difficult for a student to achieve a specific educational requirement. Attempts at accommodation could be made, but ability to do so would depend upon the concept of undue hardship and whether or not such options for accommodation were possible.

3.6.8(C)1.1 *Undue Hardship*

It is unlikely that it would create undue hardship for a medical school to accommodate a student's wish to be excused to pray for short periods of time, a number of times per day, during medical school training. This accommodation may be more difficult in a residency program where the resident is expected to play a larger role in caring for the patient and would be participating in various processes and procedures that may not break at the times needed for the individual who was hoping to be excused to pray. Undue hardship may be encountered if it is necessary to establish a permanent

prayer site and to allow medical students to access this site several times a day – especially if they are away at other educational centers. As noted above, requirement for specific, unchanging prayer times may also be extremely difficult to accommodate within a medical education framework in which patient care is not necessarily taking place within usual work hours.

3.6.8(C)2 *Charter* challenge

3.6.8(C)2.1 Section 2(a)

A student who is refused the right to pray several times per day as a part of his or her religious beliefs might also claim a section 2(a) violation in an attempt to push for accommodation. The need to engage in these prayer sessions could be shown to be a strongly held belief, integral to the practice of this individual’s religion. As such, refusal to accommodate would likely be shown to be a section 2(a) violation. Section 1 analysis would look at the request that was being made and the circumstances surrounding the need to attend these prayer sessions.

The pressing and substantial objective of ensuring acquisition of an educational requirement has the potential to be undermined by excessive time away from the educational setting. If the prayer times were flexible and short, and the prayer site was close to the individual’s education and clinical exposure sites, then accommodation of such a request would likely require little work on the part of the medical school involved and would result in minimal diminution of the educational and clinical exposure on the part of the student. In this case, a section 1 analysis would likely find that the *Charter* violation could not be upheld and that the student’s requests should be accommodated.

The proportionality component of a section 1 analysis would need to demonstrate a rational connection between the means of the achieving the particular educational requirement and the educational objective itself. These means must not be arbitrary or unfair. For example, a student may be able to learn about a particular clinical situation by reading about it, or watching videos, rather than being at the bedside at all times. The option to learn in different ways that might better accommodate the student's requests would need to be considered. The assessment would look at whether there was minimal impairment of the individual's rights in the effort to ensure that the academic mandate was achieved. For example, although it might be necessary to limit the individual's right to be away from the educational process for certain times during the day (or certain events) a total ban on taking a break from clinical experience would likely not be necessary or reasonable. This more specific assessment of how much of a limitation is really necessary speaks to the "minimal impairment" component of the proportionality assessment. Finally, there must be proportionality between the infringement (the degree that the individual's rights are compromised) and the objective of attaining a particular quality and quantity of educational experience. Are the individual's rights compromised more than is actually necessary in order to achieve the desired objective?

3.6.8(C)2.2 Section 15

Sections 15 may also be used to challenge a decision or policy that medical students not be excused from educational and clinical duties in order to pray one or multiple times per day. A student would claim discrimination based on enumerated or analogous grounds (likely religion) and would argue that his or her religion required daily prayer as an important component of religious practice. A section 15 violation would be

shown by demonstrating that the demands of the distinction associated with the student (religious belief, cultural requirements) resulted in differential treatment that was discriminatory in that it did not allow the student equal access to education and employment (training as a physician).

A section 1 analysis would then assess whether or not the objective (learning the components of medical education that would be missed by accommodating the student's wishes) was pressing and substantial enough to support refusing the request. A proportionality assessment would then be carried out to determine if the means used to ensure that the objective was met did not unduly impair the rights of the individual making the section 15 claim. Perhaps some middle ground could be arrived at wherein the student would attend some prayer sessions, but not others, or another prayer site could be set up closer to sites of educational or clinical training so that student prayer could be facilitated. Minimal impairment of the individual's right to be involved in his or her usual activity, while still learning the requisite information, must be established.

Proportionality between the amount of infringement experienced and the importance of the goal would finally need to be demonstrated to ensure that the goal of educating the student in the particular area of concern did not blind administrators or instructors to the opportunity for accommodation that may be identified if alternative options were more readily embraced.

In summary, these three case examples serve to identify the conflicts (and potential resolutions) that may occur when individuals with certain religious or cultural beliefs and practices, different from the established Eurocentric perspective, enter medical school in

Canada and other western countries. Refusal to accommodate may result in a challenge to this decision by the student involved. These challenges would likely be brought to the medical school and the university with which the medical school was affiliated. If resolution did not occur at this stage, the student might go on to challenge a decision or policy via human rights legislation or the *Canadian Charter of Rights and Freedoms*. Human Rights assessment would involve a *Meiorin*-type evaluation to determine if there was a *bona fide* educational requirement or BFOR involved that required the student to meet the educational mandate as determined by the medical school involved. An evaluation of undue hardship would then be carried out to see if accommodation of the individual's requests was possible.

Charter challenge would most likely focus on sections 2(a) and 15 in an attempt to prove that a particular medical school policy or educational requirement violated an individual's rights. If a violation could be demonstrated, then section 1 analysis would assess whether or not the violation could be upheld. Ultimately, the proportionality assessment carried out through a section 1 analysis is the most important, and most interesting, component of this process. Some degree of accommodation will usually be possible and the section 1 analysis will then tend to look most specifically to the minimal impairment component of the assessment in an attempt to limit the damage to individual rights and autonomy as much as possible. Minimal impairment certainly applies in the case of abortion, where the right of the student not to be involved directly in the **performance** of an abortion must be balanced against the need for the student to understand the procedure, its process and complications. The student should be able to remove him or herself from the actual procedure (although this may not be possible for a

physician training in another area of medical training- such as obstetrics and gynecology- depending upon the mandate of the particular residency training program) but would not be allowed to completely avoid this portion of educational training towards becoming the “generic” physician.

Minimal impairment is also an important concept when determining how one might accommodate prayer within a medical school educational environment. Some amount of educational exposure could likely be “missed”, or accessed in an alternative form, such that the individual would be able to excuse him or herself from a scheduled educational experience in order to attend prayer. This accommodation would require that a balance be established between time spent away from school and the acquisition of necessary educational information and experience. Excessive time away would likely not be possible or acceptable.

Finally, minimal impairment assessment, in the case of the request to not examine someone of the opposite sex as a component of medical school education, would come to the conclusion that no alternative approach is possible other than a definitive requirement for the student to learn to examine and interact with patients of both sexes. In our western medical training experience and practice situation, the student must be wholly familiar with the anatomy, physiology and clinical methods of examining someone of the opposite sex (as with someone of the same sex as the examiner). Physical examination is an intimate exercise that must be practiced by the physician student in order that he or she is ready to engage in this process competently and appropriately once medical school training is completed. There really is no way to allow for some degree of lessened contact and still acquire the skills that are necessary for competent patient care. If a

student felt that a request for this type of accommodation was non-negotiable, then his or her admittance to medical school in Canada would not be reasonable or possible.

3.7 Importance of Establishing A Protocol for Managing these Requests at a Medical School

As noted previously, requests for accommodation may become more frequent over time as we experience an alteration in our population mix from a religious and cultural perspective (due to such things as a changes in immigration patterns and entry of more Aboriginal students into medical school). Decisions to allow for accommodation are complex and sometimes controversial. Discussions may be emotional and difficult to resolve since they often arise in association with deeply held beliefs and ideals that are not easily abandoned by the students involved, and may be poorly understood by teachers and administrators in a college of medicine. Establishment of a protocol for dealing with these issues would enhance the transparency of the decision-making, allow for consistency from one request to another and, hopefully, limit the conflict that will arise between teachers/administrators and the students they are trying to educate.

3.8 Examples of Medical Schools with Conscientious Objection Request Mechanisms

Many universities have developed policies to deal with accommodation requests by students for claims of physical or intellectual disability.^{235 236} Very few medical schools have developed accommodation policies that are specific to the study of medicine

²³⁵“Academic Accommodation and Access for Students with Disabilities”, University of Saskatchewan Policies, online: http://www.usask.ca/university_secretary/policies/student/6_02.php.

²³⁶ “Policy for Students with Disabilities”, Policies and Guidelines, University of Alberta, online: <http://www.ssd.ualberta.ca/en/PoliciesandGuidelines/PolicyforStudentswithDisabilit.aspx>.

and to the religion and conscience concerns addressed by this thesis. As our population in Canada becomes more diverse, greater numbers of individuals with perspectives that differ significantly from the previous mainstream “Canadian culture” may enter medical school training in Canada. These individuals may challenge our established views about how to educate medical students, what type of medical care should be available, and how to practice medicine in this country. We need to prepare for these potential challenges by establishing a method of dealing with requests, and by reassessing our training systems in order to identify what components of medical education should really be considered mandatory. The University of Manitoba College of Medicine has a policy on Conscience-Based Exemptions that outlines some requirements that must be fulfilled in order for accommodation of any requests for a change to the medical school curriculum for the individual (see Appendix). The existence of this form presupposes that there may be instances that arise where students do not want to participate in aspects of standard medical school training.

3.9 Designing a Conscientious Objection Request Form

The existence of a conscientious objection request policy within a college of medicine would facilitate decision-making when teachers and administrators are faced with these complex and emotional issues. I would suggest that the following questions be taken into consideration when designing such a policy:

- What is the request?
- What is the reason for the request?
- Does the request weaken the educational process and raise accreditation concerns?
- Can the educational component be acquired in any other manner?

- Does the request undermine an educational requirement or BFOR?
- Does the request require undue hardship on the part of the system for accommodation to occur?
- Will accommodation of the request put patients at risk (emotionally/psychologically or physically)?
 - Now (i.e. while the individual is a medical student)
 - Future (i.e. while the individual is a resident or fully-qualified physician)

As identified in the *Conscience-Based Exemption Policy* from the University of Manitoba, it would be helpful to reiterate to any student who is requesting an exemption that patient care cannot be compromised by allowing the exemption to be enacted. This perspective is consistent with the CMA *Code of Ethics* and differs from the situation in the United States where many states have introduced legislation to protect physicians from litigation when they act in a manner to assuage their conscience, even if their behaviour results in harm to patients. Collection of information for analysis and assessment of student requests for accommodation will allow teachers and administrators to identify what requests might be amenable to accommodation. It will also allow decision-makers to determine when refusal to accommodate has the potential to fail a human rights or *Charter* challenge.

3.10 Conclusion Chapter 3

Medical students have a number of options available to them, if they want to challenge decisions not to accommodate their requests for exemption from certain areas of medical training due to conscience or religion-based concerns. Accommodation of

these requests may often be the best approach to take from both a legal and an ethical perspective. Refusal to accommodate may lead to human rights and *Charter* challenges from aggrieved students. As can be seen from the previous examples, legal challenges have a significant likelihood of resulting in a determination that some degree of accommodation should be attempted, and that the individual's rights should be impaired as minimally as possible in an attempt to acquire the objective of ensuring that all medical students are educated to the level necessary to engage in medical practice in our Canadian health care system.

In light of this, all parties could benefit from the establishment and publication of a process for assessing these requests that is transparent and widely available to all concerned. Accommodation requests could then be dealt with in a step-wise, open fashion that is reproducible and observable, so that the stress and controversy that often surrounds these types of difficult decisions can be reduced.

CONCLUSION

Conscientious objection by medical students, with respect to involvement in certain aspects of medical school education, is likely to increase in frequency over the next ten to twenty years. The reason for this increase is multi-factorial and relates to: the changing philosophy about patient care and the doctor-patient relationship; ideas about the unassailable rights of the individual (which apparently includes physician rights); and, a fairly recent change in the cultural and religious backgrounds of students who are accepted into medical school in Canada and other westernized nations.

Some of these conscientious objections and requests for differential treatment will challenge our ideas about what should be mandatory in medical school education, and cause us to question whether or not there is, or should be, a generic physician produced at the completion of medical school training. Medical education in Canada is accredited by the Committee on Accreditation of Canadian Medical Schools (CACMS). In order for this accreditation to be bestowed, certain mandatory aspects of medical training must be completed by students registered in these programs. Assuming that these accreditation requirements do not change (and I have assumed this for the purpose of this thesis), accommodation of requests for curriculum modification must take these accreditation requirements into consideration. Types and amounts of training that are necessary for accreditation therefore become bona fide occupational requirements (BFOR) and inability to accommodate students without losing accreditation would appear to meet the “undue hardship” test.

Students, who do not have their accommodation requests acceded to by the medical school they are enrolled in, might choose to challenge these decisions by launching a human rights challenge, or a court challenge by claiming that their rights, as defined by the *Canadian Charter of Rights and Freedoms*, have been violated. The *Charter* sections most applicable to this type of challenge would be section 2(a), section 15 and, possibly, section 7. Section 2(a) has been explored fairly extensively through litigation and in the legal academic literature with respect to freedom of religion and the boundaries of this *Charter* right. *Freedom of conscience*, although a theoretical legal twin of *freedom of religion* within the description of section 2(a) of the *Charter*, has not been specifically dealt with to any extent by Canadian courts.

The requirement for a student (and College of Medicine) to embark upon a human rights or legal challenge to settle an accommodation dispute is not ideal. It would be preferable that Colleges of Medicine across Canada have an understanding of the right to accommodation engendered by human rights and *Charter* legislation, and that fair and transparent procedures be drawn up for management of these situations in advance of any requests that might occur. Human rights legislation tends to support the individual's right to accommodation to the point of undue hardship, and the *Canadian Charter of Rights and Freedoms* seeks to find a solution to individual and societal needs that, as much as possible, minimally impairs the individual's rights to manifest belief, despite a frequent finding of *Charter* violation at the initial stage of the evaluation.

In conclusion, I argue that it is important for medical schools to establish policies with respect to accommodation of religious and cultural differences, such that students applying to these medical schools will have reasonable expectations about the degree of

accommodation that is acceptable and possible. In Canada, I would suggest that a policy should begin by stating that the knowledge and clinical abilities that a student will be expected to master, within a Canadian medical school curriculum, will be consistent with the expectation of non-discrimination, as identified by provincial and national human rights legislation, and with the rights and freedoms as guaranteed by the *Canadian Charter of Rights and Freedoms*. Accommodation is an important component of human rights legislation and students can expect reasonable accommodation up to the point of “undue hardship.” Undue hardship will be defined by such things as accreditation requirements, fundamental educational objectives (creation of the “generic” physician), financial and physical realities of the particular medical school, and the specific effects that accommodation might have on the ability of other students to have fair and equitable access to training opportunities. Rights guaranteed by the *Canadian Charter of Rights and Freedoms* are not without limit and may be curtailed, through section 1 of the *Charter*, if they infringe too significantly on other, equally important, individual rights and/or societal objectives.

As with most educational and employment situations, “chance favours the prepared”²³⁷ and whether it be attributed to luck or to good planning, successful integration of Canadians of different cultural and religious backgrounds into our education and employment sectors will proceed most smoothly through advance preparation.

²³⁷ Louis Pasteur.

BIBLIOGRAPHY

Jurisprudence

A.C. v. Manitoba (Director of Child and Family Services), 2009 SCC 30, [2009] 2 S.C.R. 181.

Alberta (Aboriginal Affairs and Northern Development) v. Cunningham, 2011 SCC 37, [2011] 2 S.C.R. 670.

Alberta v. Hutterian Brethren of Wilson Colony, 2009 SCC 37, [2009] 2 S.C.R. 567.

Andrews v. Law Society of British Columbia, [1989] 1 S.C.R. 143.

Blencoe v. British Columbia (Human Rights Commission), 2000 SCC 44, [2000] 2 S.C.R. 307.

British Columbia (Ministry of Education) v. Moore, 2010 BCCA 478, 326 D.L.R. (4th) 77.

British Columbia (Public Service Employee Relations Commission) v. British Columbia Government Service Employees' Union 1999 SCC 48, [1999] 3 S.C.R. 3.

British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights), [1999] 3 S.C.R. 868.

B. (R.) v. Children's Aid Society of Metropolitan Toronto, [1995] 1 S.C.R. 315.

CCLA's Supreme Court of Canada factum.

Chamberlain v. Surrey School District No. 36, 2002 SCC 86, [2002] 4 S.C.R. 710.

Chaoulli v. Quebec (Attorney General), 2005 SCC 35, [2005] 1 S.C.R. 791.

Dagenais v. Canadian Broadcasting Corp., [1994] 3 S.C.R. 835.

Doré v. Barreau du Québec, 2012 SCC 12, [2012] 1 S.C.R. 395.

Downey v. Nova Scotia (Workers' Compensation Appeals Tribunal), 2008 NSCA 65.

Egedebo v. Windermere District Hospital Association (1993), 78 B.C.L.R. (2d) 63.

Eldridge v. British Columbia (Attorney General), [1997] 3 S.C.R. 624.

Ermineskin Indian Band and Nation v. Canada, 2009 SCC 9, [2009] 1 S.C.R. 222.

Hartling v. Nova Scotia (Attorney General), [2009] NSCA 130.

Hodge v. Canada (Minister of Human Resources Development), 2004 SCC 65, [2004] 3 S.C.R. 357.

Kelly v. University of British Columbia (No. 3) (2012), CHRR Doc. 12-0032, 2012 BCHRT 32.

Law v. Canada (Minister of Employment and Immigration), [1999] 1 S. C. R. 497.

McInerney v. MacDonald, [1992] 2 SCR 138.

McKinney v. University of Guelph, [1990] 3 S.C.R. 229.

Moore v. British Columbia (Education), 2012 SCC 61, [2012] 3 S.C.R. 360.

Moore v. British Columbia (Ministry of Social Services), 1992 B.C.C.H.R.D. No. 15.

Multani v. Commission scolaire Marguerite-Bourgeoys, 2006 SCC 6, [2006] 1 S.C.R. 256.

Nichols v. M.J., 2009 SKQB 299.

Norberg v. Wynrib, [1992] 2 S.C.R. 226.

N.S. v. Her Majesty the Queen, et al. (Ontario) (Criminal) (By Leave) 33989.

Ontario (Attorney General) v. Dieleman et al. (1994), 20 O.R. (3d) 229; 117 D.L.R. (4th) 449 (Gen. Div.).

PHS Community Services Society v. Canada (Attorney General), 2010 BCCA 15.

Pridgen v. University of Calgary, 2010 ABQB 644.

Pridgen v. University of Calgary, 2012 ABCA 139.

Quebec (Attorney General) v. A, [2013] S.C.J. No. 5

Re B.C. Motor Vehicle Act, [1985] 2 S.C.R. 486.

R v. Big M Drug Mart Ltd., [1985] 1 S.C.R. 295.

R. v. Edwards Books and Art Ltd., [1986] 2 S.C.R. 713.

R. v. Heywood, [1994] 3 S.C.R. 761.

R. v. Jones, [1986] 2 S.C.R. 284.

R. v. Kapp, 2008 SCC 41, 2 S.C.R. 483.

R. v. Malmo-Levine; R. v. Caine, 2003 SCC 74, [2003] 3 S.C.R. 571.

R. v. Morgentaler, [1988] 1 S.C.R. 30.

R. v. N.S., 2010 ONCA 670.

R. v. Oakes, [1986] 1 S.C.R. 103.

R. v. Whatcott, 2002 SKQB 399, 225 Sask. R. 205.

Roach v. Canada (Minister of State for Multiculturalism and Citizenship), [1994] 2 FC 406, 13 DLR (4th) 67.

Rodriguez v. British Columbia (Attorney General), [1993] 3 S.C.R. 519.

Roe v. Wade, 410 U.S. 113.

Ross v. New Brunswick School District No. 15 (1996), 133 D.L.R. (4th) 1 (S.C.C.).

RWDSU v. Dolphin Delivery Ltd., [1986] 2 S.C.R. 573.

S.L. v. Commission scolaire des Chênes, 2012 SCC 7, [2012] 1 SCR 235.

Syndicat Northcrest v. Amselem, 2004 SCC 47, [2004] 2 S.C.R. 551.

Trinity Western University v. British Columbia College of Teachers, 2001 SCC 31, [2001] 1 S.C.R. 772.

Victoria v. Adams, 2008 BCSC 1363.

Withler v. Canada (Attorney General), 2008 BCCA 539.

Legislation

American Medical Association Policy H-295.896 Conscience Clause, online:
<http://www.consciencelaws.org/policies-papers/pppmedicalorg06.html>.

Canadian Bill of Rights, S.C. 1960, c. 44.

Canadian Human Rights Act, R.S.C., 1985, c. H-6.

Church Amendment, an amendment to the Health Programs Extension Act of 1973 §401, 42 U.S.C. §300a-7.

Coats Amendment, an amendment to the Public Health Services Act of 1996 §245, 42 U.S.C. §238n.

Health Professions Act, RSA 2000, c H-7, s. 25 (2-4).

Indian Civil Rights Act of 1968, Pub.L. 90-284, 82 Stat. 73, enacted April 11, 1968.

International Covenant on Civil and Political Rights, opened for signature 16 December 1966, UNTS171 (entered into force 23 March 1976).

Mississippi Senate Bill 2619, Health Care Rights of Conscience Act (2004), online: <http://billstatus.ls.state.ms.us/documents/2004/html/sb/2600-2699/sb2619sg.htm>.

Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

Saskatchewan Human Rights Code, SS 1979, c S-24.1.

The Emergency Medical Aid Act, R.S.S. 1978, c. E-8.

The Human Rights Code, CCSM c H175.

Secondary Materials

Acharya, Nayha. “Freedom of Religion”, Centre for Constitutional Studies, online: <http://www.law.ualberta.ca/centres/css/issues/freedomofreligion.php>>.

Almeling, Rene et al. “Abortion Training in U.S. Obstetrics and Gynecology Residency Programs,” (2000) 32(6) *Family Planning Perspectives* 268.

American Medical Association Policy H-295.896 Conscience Clause: Final Report, online: <http://www.consciencelaws.org/policies-papers/pppmedicalorg06.html>.

AMA, REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, 2006.

“A Short History of Conscientious Objection in Canada”, online: <http://www.alternativeservice.ca/uncertainty/community/COhistory.htm>.

Backan, Joel et al. *Canadian Constitutional Law*, 3d ed (Toronto: Emond Montgomery, 2003).

Belgrave, Kevin. “Conscience and Compromise: Abortion and the Requirements of Justice in Medical Schools” (2005) 8(2) *McGill Journal of Medicine* 1999.

Berger, Benjamin L. “Law’s Religion: Rendering Culture” (2007) 45(2) *Osgoode Hall Law Journal* 277.

Bouchard, Gérard and Taylor, Charles. BUILDING THE FUTURE A Time for Reconciliation, online: <http://www.accommodements.qc.ca/documentation/rapports/rapport-final-integral-en.pdf>.

Bradley, Ishmeal. “Conscientious Objection in Medicine: A Moral Dilemma” (2009) *Clinical Correlations/The NYU Langone Online Journal of Medicine*, online: <http://www.clinicalcorrelations.org/?p=1454>.

British Columbia Medical Association (1996) *Code of Ethics*, “Responsibilities to the Patient”, online: <https://www.bcma.org/about-bcma/code-ethics>.

Brodsho, Kelsey C. “Patient Expectations and Access to Prescription Medication Are Threatened by Pharmacist Conscience Clauses” (2006) 7(1) Minn. J.L. Sci. & Tech. 327.

Brown, David M. “Freedom from or Freedom for?: Religion as a Case Study in Defining the Content of Charter Rights” (2000) 33 U.B.C.L. Rev. 551.

Brown, David M. “The Courts’ Spectacles: Some Reflections on the Relationship between Law and Religion in Reasonable Accommodation and Role of the State: A Democratic Challenge” CIAJ Conference, Quebec City, September 24, 2008.

Brown, Nathaniel J. *Conscientious objection in medicine: An hypothesis towards a federated solution*, (ProQuest, UMI Dissertation Publishing, 2011).

Canadian Human Rights Commission, online: http://www.chrc-ccdp.ca/discrimination/apfa_uppt/page1-eng.aspx.

Cantor, Julie D. “Conscientious Objection Gone Awry – Restoring Selfless Professionalism in Medicine” (2009) 360(15) NEJM 1484.

Card, Robert F. “Is there no alternative? Conscientious objection by medical students” J Med Ethics (2012), online: <http://jme.bmj.com.cyber.usask.ca/content/early/2012/05/02/medethics-2011-100190.full.pdf+html>.

Casey, Samuel B. GENERAL COUNSEL & EXECUTIVE VICE PRESIDENT ADVOCATES INTERNATIONAL, “The Health Care Right of Conscience” May 2009, online: http://www.iirf.eu/fileadmin/user_upload/PDFs/ConscienceHC.pdf.

Charo, R. Alta. “The Celestial Fire of Conscience – Refusing to Deliver Medical Care” (2005) 352(24) N Engl J Med 2471.

CMA Code of Ethics, online: <http://policybase.cma.ca/PolicyPDF/PD04-06.pdf>.

Collett, Teresa Stanton. “Protecting the Healthcare Provider’s Right of Conscience”, online: <http://cbhd.org/content/protecting-health-care-providers-right-conscience>.

Collier, Roger. “Professionalism: the historical contract” (2012) 184(11) CMAJ 1233.

“Conscientious Objection to War and Tax Redirection (1986)”, The United Church of Canada, online: <http://www.united-church.ca/beliefs/policies/1986/c551>.

Cook, Rebecca J. and Dickens, Bernard M. “The Growing Abuse of Conscientious Objection” (2006) 8(5) Virtual Mentor 337.

Cook, Rebecca J. et al. “Healthcare responsibilities and conscientious objection” (2009) 104 International Journal of Gynecology and Obstetrics 249.

- Curlin, Farr A., et al. "Religion, Conscience, and Controversial Clinical Practices" (2007) 356(6) NEJM 593.
- Dickens, Bernard M. "The art of medicine Conscientious commitment" (2008) 371 The Lancet 1240.
- Dickens, Bernard M. "Legal Protection and Limits of Conscientious Objection: When Conscientious Objection is Unethical" (2009) 28 Med Law 337.
- Dorfman, Avihay. "Freedom of Religion" (2008) 21 Can. J.L. & Juris. 279.
- Downie, Jocelyn and Nassar, Carla. "Barriers to Access to Abortion Through a Legal Lens" (2007) 15 Health L. J. 143.
- Dyer C. "GMC guidance on conscience goes too far", says BMA. BMJ 2007;335:688.1 (Published 04 October 2007).
- Fenton, Elizabeth and Lomasky, Loren. "Dispensing with Liberty: Conscientious Refusal and the "Morning-After Pill" (2005) 30 Journal of Medicine and Philosophy 579.
- Fielding, Alex. "When Rights Collide: Liberalism, Pluralism and Freedom of Religion in Canada" (2008) 13 Appeal: Review of Current Law and Law Reform 28.
- Foggo, D. and Taher, A. "Muslim medical students get picky", The Times Online. 2007, online: www.timesonline.co.uk/tol/news/uk/health/article2603966.ece.
- Frader, Joel and Bosk, Charles L. "The Personal is Political, the Professional is Not: Conscientious Objection to Obtaining/Providing/Acting on Genetic Information" (2009) 151C American Journal of Medical Genetics Part C (Seminars in Medical Genetics) 62.
- "Good Medical Practice – explanatory guidance", General Medical Council – Undergraduate Board, April 2012, online: http://www.gmc-uk.org/5_Good_Medical_Practice_explanatory_guidance.pdf 48639321.pdf.
- Grimm, Dieter. "Conflicts Between General Laws and Religious Norms" (2009) 30(6) Cardozo Law Review 2369.
- Guideline: Unplanned Pregnancy*, College of Physicians and Surgeons of Saskatchewan, online: https://one45.usask.ca/webeval/admin/files/learning_objs/learning_object11149.pdf.
- GUTTMACHER INSTITUTE. *STATE POLICIES IN BRIEF: Refusing to Provide Health Services* -As of November 1, 2013, online: http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf.
- "Has Your Physician Refused to Provide a Referral for Abortion Care?" A Patient's Guide to Action – National Abortion Federation, online: http://www.prochoice.org/pubs_research/publications/downloads/canada/patientguide.pdf

Hill, B. Jessie. "Legislative Restrictions on Abortion: More anti-abortion legislation was passed in the United States in 2011 than in any other year since 1973" (2012) 14(2) *Virtual Mentor* 133.

Hippocratic Oath, History of Medicine Division, National Library of Medicine, National Institutes of Health, online: http://www.nlm.nih.gov/hmd/greek/greek_oath.html.

Hogg, Peter. *Constitutional Law of Canada*, Student Edition. (Toronto: Carswell, 2008).

Holmes, Nancy. "HUMAN RIGHTS AND THE COURTS IN CANADA" Law and Government Division, November 1991, Revised October 2001, online: <http://publications.gc.ca/Collection-R/LoPBdP/BP/bp279-e.htm>.

Kislowicz, Howard et al. "Calculations of Conscience: The Costs and Benefits of Religious and Conscientious Freedom" (2011) 48 *Alta. L. Rev.* 679.

Koshan, Jennifer and Watson Hamilton, Jonnette. "The Continual Reinvention of Section 15 of the Charter" (2013) 64 *University of New Brunswick Law Journal* 19.

MacNaughton, Heather M. and Connell, Jessica. "A Delicate Balance: The Challenges Faced By Our Democratic Institutions in Reconciling the Competing Rights and Interests of a Diverse Population" (2011) 44 *UBC L Rev* 149.

Madden, Mike. "Second Among Equals? Understanding the Short Shrift that Freedom of Religion is Receiving in Canadian Jurisprudence" (2010) 7(1) *J.L. & Equality* 57.

Mathen, Carissima. "What Religious Freedom Jurisprudence Reveals About Equality" (2009) 6(2) *J.L. & Equality* 163.

McKay-Panos, Linda. "Freedom of Conscience: What It Means for Canadians", online: <http://www.lawnow.org/d/sites/default/files/SR1364.pdf>.

Padela, Aaim I. and del Pozo, Pablo Rodriguez. "Muslim patients and cross-gender interactions in medicine: an Islamic bioethical perspective" (2011) 37 *Journal of Medical Ethics* 40.

Pate, Randolph W. "Protection of Health Care Providers' Right of Conscience: What Federal Law Says", WebMemo by The Heritage Foundation, online: www.heritage.org/Research/Religion/wm2385.cfm.

Patsner, Bruce. "Refusing to Treat: Are There Limits to Physician "Conscience" Claims?" (2008) *Health Law Perspectives*, online: [http://www.law.uh.edu/healthlaw/perspectives/2008/\(BP\)%20conscience.pdf](http://www.law.uh.edu/healthlaw/perspectives/2008/(BP)%20conscience.pdf).

Personal Beliefs and Medical Practice: General Medical Council, online: http://www.gmc-uk.org/static/documents/content/Personal_Beliefs.pdf.

Policy re “Religious Observance” and “Opting Out of Educational Experiences Due to Conscientious Objections, 2009” University of Rochester School of Medicine and Dentistry, online: <http://www.urmc.rochester.edu/education/md/documents/religious-observances.pdf>.

Policy Statement #5-08, Physicians and the Ontario *Human Rights Code*, online: http://www.cpso.on.ca/uploadedFiles/downloads/cpsodocuments/policies/policies/human_rights.pdf.

Rabin, Roni Caryn. “Respecting Muslim Patients’ Needs”, NY Times, Nov. 1st, 2010, online: http://www.nytimes.com/2010/11/01/health/01patients.html?_r=0.

Reasonable accommodation, online: http://en.wikipedia.org/wiki/Reasonable_accommodation.

Réaume, Denise. “Defending the Human Rights Codes from the Charter” (2012) 9 J.L. & Equality 67.

Riddell-Dixon, Elizabeth. “Assessing the Impact of Recent Immigration Trends on Canadian Foreign Policy” in David Carment & David Bercuson, eds., *The World in Canada: Diaspora, Demography, and Domestic Politics* (McGill: Queen's University Press, 2008) at 31.

Rioux, Marcia H. “Towards a Concept of Equality of Well-Being: Overcoming the Social and Legal Construction of Inequality” (1994) 7 Can. J.L. & Juris. 127.

Robeznieks, Andy. “Battle of the conscience clause: When practitioners say no - When do medical professionals have the right to opt out of treating patients?”, online: <http://www.ama-assn.org/amednews/2005/04/11/prsa0411.htm>.

Savulescu, Julian. “Conscientious Objection in Medicine” (2006) 332 BMJ 294.

Section 2(a), Canadian Charter of Rights Decisions Digest, online: http://www.canlii.org/en/ca/charter_digest/s-2-a.html.

Sepper, Elizabeth. “Taking Conscience Seriously” (2012) 98 Virginia Law Review 1501.

Serour, G.I. “Ethical guidelines on conscientious objection: FIGO Committee for the Ethical Aspects of Human Reproduction and Women’s Health”, FIGO Committee Report, (2006) 92 International Journal of Gynecology and Obstetrics 333.

Sonfield, Adam. “New Refusal Clauses Shatter Balance Between Provider ‘Conscience,’ Patient Needs”, (2004) 7(3) The Guttmacher Report on Public Policy, online: <http://www.guttmacher.org/pubs/tgr/07/3/gr070301.html>.

Strickland, S.L. “Conscientious Objection In Medical Students: A Questionnaire Survey” (2012) 38(1) J Med Ethics 22.

The Concept of Reasonable Accommodation in Selected National Disability Legislation, UN Enable A/AC.265/2006/CRP.1, online: <http://www.un.org/esa/socdev/enable/rights/ahc7bkgrndra.htm>.

The World Medical Association, Declaration of Geneva – Physician’s Oath (1948), online: <http://www.mma.org.my/Portals/0/Declaration%20of%20Geneva.pdf>.

UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III).

Walker, Anne F. “The legal duty of physicians and hospitals to provide emergency care” (2002) 166(4) CMAJ 465.

Watson Hamilton, Jonnette and Koshan, Jennifer. “The End of Law: A New Framework for Analyzing Section 15(1) Charter Challenges”, The University of Calgary Law Blog on Developments in Alberta Law, online: <http://ablawg.ca/2009/02/20/the-end-of-law-a-new-framework-for-analyzing-section-151-charter-challenges/>.

Weinrib, Sara. “An Exemption for Sincere Believers: The Challenge of *Alberta v. Hutterian Brethren of Wilson Colony*” (2011) 56(3) McGill LJ 719.

Wicclair, Mark R. *Conscientious Objection in Health Care: An Ethical Analysis*, (Cambridge, UK: Cambridge University Press, 2011).

Williams, Ariel. “Conscientious Objection: A Medical Student Perspective” (2009) 11(9) Virtual Mentor 686.



UNIVERSITY
OF MANITOBA

Faculty of Medicine Policy

Policy Name:	Conscience-Based Exemptions
Application/ Scope:	Undergraduate Medical Students; Postgraduate Medical Learners; Physician Assistant Learners
Approved (Date):	April 10, 2013
Review Date:	April 10th, 2014
Revised (Date):	
Approved By:	Faculty Executive Council

1. **PURPOSE**

- 1.1 To accommodate the Conscience-Based Objections of Learners in the Faculty of Medicine;
- 1.2 To ensure the health and safety of patients through timely and acceptable medical care notwithstanding any Conscience-Based Objections or Conscience-Based Exemptions;
- 1.3 To ensure Learners meet the objectives of their medical education program;
- 1.4 To set out a process for approval and administration of Conscience-Based Exemptions.

2. **DEFINITIONS**

- 2.1 **Learners:** means registrants in the University of Manitoba's Faculty of Medicine undergraduate, postgraduate, and physician assistant programs.
- 2.2 **Conscience-Based Objection:** An objection, by a Learner, to participate in certain health care activities related to their medical education program, based on ethical, religious or personal beliefs.
- 2.3 **Conscience-Based Exemption:** An approved exemption, for a Learner, from participation in certain health care activities.

3. **POLICY STATEMENTS**

- 3.1 A Conscience-Based Objection shall be accommodated by granting a Conscience-Based Exemption, subject to the provisions of this Policy.
- 3.2 A Conscience-Based Exemption will not be granted if the Conscience-Based

Objection is based on a prohibited ground of discrimination under the [University of Manitoba Respectful Work and Learning Environment Policy](#), [the Human Rights Code \(Manitoba\)](#) or the [Code of Conduct of the College of Physicians and Surgeons of Manitoba](#).

- 3.3 Any Conscience-Based Objection(s) cannot be so broad that the Conscience-Based Exemption(s), if granted, would limit a Learner's core goals, objectives and competencies such that, on completion of the program, the Learner is unable to provide recognized standards of care. If such is the case, the Learner may be required to withdraw from the program.
- 3.4 A Conscience-Based Exemption does not relieve a Learner from the following obligations:
 - (a) Effective communication about any services, treatments or procedures the Learner chooses not to provide because of his or her ethical, religious or personal beliefs
 - (b) The provision of information about the existence of any services, treatments or procedures, even if such matters conflict with his or her ethical, religious or personal beliefs;
 - (c) The provision of information without promoting his or her own ethical, religious or personal beliefs when interacting with patients;
 - (d) When ethical, religious or personal beliefs prevent a Learner from providing information about services, treatments or procedures, that Learner must inform his or her clinical preceptor such that the patient who seeks such advice or medical care is offered timely access to all available options related to such matters.
- 3.5. A Conscience-Based Exemption does not relieve a Learner from his or her professional responsibilities, including:
 - (a) To meet the current standard of timely and acceptable medical care;
 - (b) To respond expediently to medically emergent situations, including public health emergencies, within the boundaries of his or her clinical competence and authority, unless or until another practitioner with equal or greater skills assumes responsibility for the care of the patient(s);
 - (c) To engage in professional behaviour.
- 3.6 When a Conscience-Based Exemption prevents a Learner from participation in regular curricular learning activities, the Faculty of Medicine will make reasonable efforts to provide alternative learning opportunities to enable core learning objectives to be met. All curricular and clinical time missed shall be spent in alternative activities under the direction of an appropriate Faculty supervisor.
- 3.7 Notwithstanding a Conscience-Based Exemption, a Learner is responsible to learn and, through standard evaluative practices, demonstrate knowledge of indications, contraindications, benefits and risk pertaining to that procedure or service.

- 3.8 The Faculty of Medicine shall establish a committee (“**Committee**”) from its membership to receive and review requests from Learners for consideration of a Conscience-Based Exemption.
- (a) The Committee shall consist of, at a minimum,
 - (i) a Clinician;
 - (ii) an Individual with training in medical ethics; and
 - (iii) a Learner.
 - (b) The Committee shall have the authority to grant or deny a Conscience-Based Exemption based on the Conscience-Based Objection.
 - (c) The Committee shall advise the respective Associate Dean regarding the granting of a Conscience-Based Exemption to one of their program’s Learners.
- 3.9 If a Conscience-Based Exemption is denied, a Learner may appeal to the Faculty Appeals Committee.
- 3.10 No Learner shall be subject to intimidation, harassment or discrimination based on the granting of a Conscience-Based Exemption.
- 3.11 The Faculty of Medicine shall inform the Winnipeg Regional Health Authority if a postgraduate Learner has been granted a Conscience-Based Exemption.

4. **REFERENCES**

- 4.1 The University of Manitoba Respectful Work and Learning Environment Policy (http://www.umanitoba.ca/governance/governing_documents/community/230.html)
- 4.2 *The Human Rights Code* (Manitoba) (<http://web2.gov.mb.ca/laws/statutes/ccsm/h175e.php>)
- 4.3 College of Physicians and Surgeons of Manitoba, Code of Conduct, December 1, 2008. (<http://cpsm.mb.ca/about-the-college/by-laws-code-of-conduct-statements-and-guidelines/code-of-conduct>)
- 4.4 College of Physicians and Surgeons of Ontario Policy Statement #5-08 – Physicians and the Ontario Human Rights Code (http://www.cpso.on.ca/uploadedFiles/downloads/cpsodocuments/policies/policies/human_rights.pdf)

5. **POLICY CONTACT**

Please contact the Associate Dean, Professionalism and Diversity or the Associate Dean Students, with questions respecting this policy.



CMA Code of Ethics (Update 2004)

Last reviewed March 2014: Still relevant

This Code has been prepared by the Canadian Medical Association as an ethical guide for Canadian physicians, including residents, and medical students. Its focus is the core activities of medicine – such as health promotion, advocacy, disease prevention, diagnosis, treatment, rehabilitation, palliation, education and research. It is based on the fundamental principles and values of medical ethics, especially compassion, beneficence, non-maleficence, respect for persons, justice and accountability. The Code, together with CMA policies on specific topics, constitutes a compilation of guidelines that can provide a common ethical framework for Canadian physicians.

Physicians should be aware of the legal and regulatory requirements that govern medical practice in their jurisdictions.

Physicians may experience tension between different ethical principles, between ethical and legal or regulatory requirements, or between their own ethical convictions and the demands of other parties. Training in ethical analysis and decision-making during undergraduate, postgraduate and continuing medical education is recommended for physicians to develop their knowledge, skills and attitudes needed to deal with these conflicts. Consultation with colleagues, regulatory authorities, ethicists, ethics committees or others who have relevant expertise is also recommended.

Fundamental Responsibilities

1. Consider first the well-being of the patient.
2. Practise the profession of medicine in a manner that treats the patient with dignity and as a person worthy of respect.
3. Provide for appropriate care for your patient, even when cure is no longer possible, including physical comfort and spiritual and psychosocial support.
4. Consider the well-being of society in matters affecting health.
5. Practise the art and science of medicine competently, with integrity and without impairment.
6. Engage in lifelong learning to maintain and improve your professional knowledge, skills and attitudes.

© 2004 Canadian Medical Association. You may, for your non-commercial use, reproduce, in whole or in part and in any form or manner, unlimited copies of CMA Policy Statements provided that credit is given to the original source. Any other use, including republishing, redistribution, storage in a retrieval system or posting on a Web site requires explicit permission from CMA. Please contact the Permissions Coordinator, Publications, CMA, 1867 Alta Vista Dr., Ottawa ON K1G 5W8; fax 613 565-2382; permissions@cma.ca.

Correspondence and requests for additional copies should be addressed to the Member Service Centre, Canadian Medical Association, 1867 Alta Vista Drive, Ottawa, ON K1G 5W8; tel 888 855-2555 or 613 731-8610 x2307; fax 613 236-8864.

All policies of the CMA are available electronically through CMA Online (www.cma.ca).

7. Resist any influence or interference that could undermine your professional integrity.
8. Contribute to the development of the medical profession, whether through clinical practice, research, teaching, administration or advocating on behalf of the profession or the public.
9. Refuse to participate in or support practices that violate basic human rights.
10. Promote and maintain your own health and well-being.

Responsibilities to the Patient

General Responsibilities

11. Recognize and disclose conflicts of interest that arise in the course of your professional duties and activities, and resolve them in the best interest of patients.
12. Inform your patient when your personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants.
13. Do not exploit patients for personal advantage.
14. Take all reasonable steps to prevent harm to patients; should harm occur, disclose it to the patient.
15. Recognize your limitations and, when indicated, recommend or seek additional opinions and services.
16. In determining professional fees to patients for non-insured services, consider both the nature of the service provided and the ability of the patient to pay, and be prepared to discuss the fee with the patient.

Initiating and Dissolving a Patient-Physician Relationship

17. In providing medical service, do not discriminate against any patient on such grounds

as age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status. This does not abrogate the physician's right to refuse to accept a patient for legitimate reasons.

18. Provide whatever appropriate assistance you can to any person with an urgent need for medical care.
19. Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient; or until the patient has been given reasonable notice that you intend to terminate the relationship.
20. Limit treatment of yourself or members of your immediate family to minor or emergency services and only when another physician is not readily available; there should be no fee for such treatment.

Communication, Decision Making and Consent

21. Provide your patients with the information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.
22. Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood.
23. Recommend only those diagnostic and therapeutic services that you consider to be beneficial to your patient or to others. If a service is recommended for the benefit of others, as for example in matters of public health, inform your patient of this fact and proceed only with explicit informed consent or where required by law.
24. Respect the right of a competent patient to accept or reject any medical care recommended.
25. Recognize the need to balance the developing competency of minors and the role of families in

medical decision-making. Respect the autonomy of those minors who are authorized to consent to treatment.

26. Respect your patient's reasonable request for a second opinion from a physician of the patient's choice.

27. Ascertain wherever possible and recognize your patient's wishes about the initiation, continuation or cessation of life-sustaining treatment.

28. Respect the intentions of an incompetent patient as they were expressed (e.g., through a valid advance directive or proxy designation) before the patient became incompetent.

29. When the intentions of an incompetent patient are unknown and when no formal mechanism for making treatment decisions is in place, render such treatment as you believe to be in accordance with the patient's values or, if these are unknown, the patient's best interests.

30. Be considerate of the patient's family and significant others and cooperate with them in the patient's interest.

Privacy and Confidentiality

31. Protect the personal health information of your patients.

32. Provide information reasonable in the circumstances to patients about the reasons for the collection, use and disclosure of their personal health information.

33. Be aware of your patient's rights with respect to the collection, use, disclosure and access to their personal health information; ensure that such information is recorded accurately.

34. Avoid public discussions or comments about patients that could reasonably be seen as revealing confidential or identifying information.

35. Disclose your patients' personal health

information to third parties only with their consent, or as provided for by law, such as when the maintenance of confidentiality would result in a significant risk of substantial harm to others or, in the case of incompetent patients, to the patients themselves. In such cases take all reasonable steps to inform the patients that the usual requirements for confidentiality will be breached.

36. When acting on behalf of a third party, take reasonable steps to ensure that the patient understands the nature and extent of your responsibility to the third party.

37. Upon a patient's request, provide the patient or a third party with a copy of his or her medical record, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.

Research

38. Ensure that any research in which you participate is evaluated both scientifically and ethically and is approved by a research ethics board that meets current standards of practice.

39. Inform the potential research subject, or proxy, about the purpose of the study, its source of funding, the nature and relative probability of harms and benefits, and the nature of your participation including any compensation.

40. Before proceeding with the study, obtain the informed consent of the subject, or proxy, and advise prospective subjects that they have the right to decline or withdraw from the study at any time, without prejudice to their ongoing care.

Responsibilities to Society

41. Recognize that community, society and the environment are important factors in the health of individual patients.

42. Recognize the profession's responsibility to society in matters relating to public health, health education, environmental protection, legislation

affecting the health or well-being of the community and the need for testimony at judicial proceedings.

43. Recognize the responsibility of physicians to promote equitable access to health care resources.

44. Use health care resources prudently.

45. Recognize a responsibility to give generally held opinions of the profession when interpreting scientific knowledge to the public; when presenting an opinion that is contrary to the generally held opinion of the profession, so indicate.

Responsibilities to the Profession

46. Recognize that the self-regulation of the profession is a privilege and that each physician has a continuing responsibility to merit this privilege and to support its institutions.

47. Be willing to teach and learn from medical students, residents, other colleagues and other health professionals.

48. Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.

49. Be willing to participate in peer review of other physicians and to undergo review by your peers. Enter into associations, contracts and agreements only if you can maintain your professional integrity and safeguard the interests of your patients.

50. Avoid promoting, as a member of the medical profession, any service (except your own) or product for personal gain.

51. Do not keep secret from colleagues the diagnostic or therapeutic agents and procedures that you employ.

52. Collaborate with other physicians and health professionals in the care of patients and the

functioning and improvement of health services. Treat your colleagues with dignity and as persons worthy of respect.

Responsibilities to Oneself

53. Seek help from colleagues and appropriately qualified professionals for personal problems that might adversely affect your service to patients, society or the profession.

54. Protect and enhance your own health and well-being by identifying those stress factors in your professional and personal lives that can be managed by developing and practising appropriate coping strategies.