Freedom of Religion and Reproductive Rights: A Study of Conscientious Objections to Emergency Contraception by Physicians and Pharmacists

by

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Abstract

This thesis argues that physicians and pharmacists have the right to refuse to prescribe and dispense emergency contraception, such as Plan B and abortifacient drugs, because of the right to freedom of religion. However, in order to properly protect women’s access emergency contraception as part of their right to reproductive health care, physicians and pharmacists who choose to object to emergency contraception on grounds of conscience must disclose this information to their patients, and refer their patients to a non-objecting practitioner. This thesis applies to the situation in Canada, and Ontario where the laws between provinces differ, but uses experiences and legislation from the United States of America as a comparator. Finally, this thesis concludes by proposing various methods to ensure delivery and access to emergency contraception, while protecting physicians’ and pharmacists’ right of refusal.
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Chapter 1
Introduction

1 Introduction

Health care professionals are faced with many kinds of ethical issues. As new medications are developed, physicians and pharmacists are challenged to balance their own morals with their commitment to treat their patients. One particularly difficult challenge lies in the area of reproductive health rights and, more specifically, emergency contraception. Emergency contraception, or post-coital contraception, as I define it, is medication that is taken after sexual intercourse that either prevents pregnancy or terminates pregnancy at a relatively early stage. It includes Plan B, also known as the morning-after pill, and abortifacient drugs. There are significant differences between these two kinds of medications, but they present similar challenges to physicians prescribing and pharmacists filling prescriptions for them. The ethical dilemma presented by emergency contraception is one that places physicians’ and pharmacists’ conscientious objection to preventing and terminating pregnancy in direct opposition to their patients’ rights to receive appropriate medical care, which may at times involve preventing or terminating pregnancy.

This thesis will attempt to provide solutions to reconcile health care providers’ freedom of religion and patients’ rights to reproductive health care, by proposing that health care providers in Canada have the right to object to emergency contraception on grounds of religion or conscience, subject to the duty of disclosure and the duty of referral. I will reach this conclusion by considering whether physicians and pharmacists have the ethical or the legal right to object to prescribing or filling prescriptions for emergency contraception under Canadian law, or Ontario law where the laws between provinces differ. Currently, in Canada and Ontario, there is no explicit legal duty on health care providers to provide all medications all the time; but neither are there explicit legal conscientious objection clauses. However, several American state legislatures have either imposed legal duties on pharmacies or provided explicit conscience clauses allowing physicians and pharmacists to refuse medical service on the basis of religion. Accordingly, I will examine the American situation to apply its experience to Canada.
This thesis is divided into five Chapters, which are subdivided into seven Sections. In Chapter 2, I set up the medical context of this thesis by introducing the science of the particular emergency contraception medications under consideration. In Section 2, I discuss the mechanics of Plan B and abortifacient drugs. Plan B is a pill that must be taken within 72 hours after intercourse. “Abortifacient drugs” is a term I will use to describe two combinations of medications that cause the termination of pregnancy up to seven weeks after fertilization.1 Section 2 will also discuss the availability of these medications in Canada and the United States. Subsection 2.4 concludes Chapter 2 with a brief explanation that women’s reproductive rights include access to these methods of emergency contraception. Accordingly, there is a potential for conflict if health care providers object to these kinds of emergency contraception on grounds of conscience.

In Chapter 3, I set up and expand on this issue of conflicting rights. In Section 3 I discuss the right to freedom of religion on the part of physicians and pharmacists. More specifically, I focus on their right to refuse to prescribe or fill prescriptions for Plan B or for abortifacient drugs. In Section 4 I consider the other side of the issue: the limits and restrictions on health care professionals’ freedom of religion. This thesis mainly focuses on the Canadian context, and Ontario where it differs from the other provinces. However, since there is no specific law on this issue in Canada, either in legislation or cases, the second half of Sections 3 and 4 will use the United States as a comparator.

Chapter 4 attempts to reconcile the conflicting rights. In Section 5, I propose that the balance between the rights is to allow health professionals to refuse to prescribe or fill prescriptions for emergency contraception, subject to the duties of disclosure and referral, as proposed by Bernard Dickens and Rebecca Cook in Canada, and Catherine Grealis in the United States. In Section 6, I discuss practical issues and propose practical solutions relating to the access of emergency contraception. Chapter 5 concludes the thesis.

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1 Women’s Health Centre, “Medical Abortion” (Toronto: Women's College Hospital and the Women’s College Research Institute, 2008), online: Women’s Health Centre <http://www.womenshealthmatters.ca/centres/sex/abortion/medicalab.html> [Women’s Health Centre, “Medical Abortion”].
Chapter 2
The Medical Context

In this Chapter, I will describe the medical context as background for the dispute over whether health care providers should have the right to refuse to provide emergency contraception. In Section 2, I define “emergency contraception” and discuss the mechanics and availability of two kinds of emergency contraception. In Subsection 2.4, I discuss briefly the history of contraception and women’s reproductive health rights.

2 Emergency Contraception

Emergency contraception, both Plan B and abortifacient drugs, present ethical dilemmas for health care providers because of the way they interfere with pregnancy. Plan B contains some of the same hormones that are in oral contraceptive pills and act to prevent implantation of the fertilized egg. Abortifacient drugs block the creation of progesterone, which is necessary to sustain pregnancy, and can terminate pregnancy up to 7 weeks after fertilization. The two medications have very different effects on pregnancy; therefore, some people object only to one, and others object to both. To understand the controversy surrounding these medications, Plan B in particular, it is useful to have a brief understanding of the stages of development in a normal pregnancy. While this thesis does not purport to determine the moment life begins, it is instructive to know the early stages of development, as the objection to emergency contraceptives tends to be that it prevents or terminates life.²

A woman’s ovaries release one egg during a normal menstrual cycle. If it is not fertilized, it gets passed with the next menstrual period. However, if a sperm penetrates the egg, it is fertilized. The fertilized egg is called a “zygote.” In three to five days, the zygote reaches the uterus, where the cells continue to divide until it is a hollow ball of cells called a “blastocyst.” Between five and eight days after fertilization, the blastocyst attaches itself to the lining of the walls of the uterus. This “implantation” is usually completed by the ninth or tenth day after fertilization. The blastocyst has a thickened area of about three to four cells thick. The inner cells in this area develop into the embryo, while the outer cells develop into the placenta. The

embryo develops internal organs and an external body shape, and by the eighth week after fertilization (which is equal to the tenth week of pregnancy), most organs are developed. It is at this time, eight weeks after fertilization, or ten weeks of pregnancy, that the embryo is considered a fetus. The fetus is considered viable outside the womb by 24 weeks of pregnancy.\(^3\)

The key moments for our purpose are fertilization, implantation, and viability. It is important to clarify some terminology relating to the timing. In the previous paragraph, “weeks of pregnancy” is calculated from the first day of the woman’s last menstrual period. However, according to general medical practice, “pregnancy” is considered to begin at implantation.\(^4\)

When discussing the mechanics of these medications, I will be clear in which starting point I am using.

### 2.1 Plan B and How It Works

Plan B is the brand name of an emergency contraceptive pill (“ECP”), also known as the “morning-after pill.” It is intended to be used as a secondary form of birth control, if a primary method of birth control failed or was forgotten and pregnancy is unwanted. It must be taken within 72 hours after intercourse during which the primary method of birth control failed, but is more likely to be effective the sooner it is taken. The woman must take two tablets of 0.75 mg of Levonorgestrel at the same time. This is the same ingredient commonly found in oral contraceptive pills, but at a stronger dose.\(^5\)

Levonorgestrel is a synthetic form of the hormone progestin. Progestin can prevent fertilization and implantation.\(^6\) Accordingly, Plan B is called a contraceptive because it prevents pregnancy. While the exact mechanism of Plan B is not precisely known in each woman’s case, since it

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\(^6\) Kohm, supra note 4 at 791.
contains progestin, it prevents pregnancy by doing one or more of three things: preventing ovulation; preventing fertilization of an egg; or preventing a fertilized egg from attaching to the uterus. It will not interfere with a fertilized egg that is already implanted in the uterus.\footnote{Plan B: The Morning After Pill, “How it Works” (Canada: Paladin Medinfo, 2008), online: Plan B <http://www.planb.ca/how.html>.

8 See \textit{supra} note 4.

9 “Because, for example, the National Right to Life organization regards fertilization as the beginning of life, they will consider prevention of the implantation of embryos to constitute abortion. If, however, an emergency contraceptive pill prevents either ovulation or fertilization, then under no construal is it an abortifacient.” Fenton, \textit{supra} note 4 at 590, n. 2.


The controversy over Plan B is whether it is a true contraceptive or whether it acts as an abortifacient. According to the medically accepted definition, pregnancy begins at implantation.\footnote{See \textit{supra} note 4.} Consequently, since Plan B will not affect a fertilized egg after it is implanted in the uterus, it does not terminate a pregnancy, as defined by general medical practice. However, there is a subset of pro-life advocates who argue that pregnancy begins at fertilization and before implantation.\footnote{“Because, for example, the National Right to Life organization regards fertilization as the beginning of life, they will consider prevention of the implantation of embryos to constitute abortion. If, however, an emergency contraceptive pill prevents either ovulation or fertilization, then under no construal is it an abortifacient.” Fenton, \textit{supra} note 4 at 590, n. 2.} For these people, if Plan B simply prevents ovulation or fertilization, it is not terminating a pregnancy and can essentially be called a contraceptive. However, because the exact mechanism of Plan B is not specifically known, it is possible that it works by preventing implantation. For this group, Plan B is considered an abortifacient, as it is terminating pregnancy by interfering with the process of a fertilized egg attaching to the uterus.\footnote{The Truth About the “Morning After Pill,” “How Does It Work?” (Stafford, Virginia: American Life League, Inc., 2008), online: <http://www.morningafterpill.org/how-does-it-work.html>.} There is a final subset of pro-life advocates who oppose any interference with the natural cycle, by preventing either ovulation or fertilization, as they believe it interferes with the creation of life.\footnote{Encyclical Letter “\textit{Humanae Vitae}” of the Supreme Pontiff Paul VI on the Regulation of Birth (St. Peter’s Rome, 25 July 1968). \textit{The Pope Speaks}, 13 (Fall 1969), 329-46, at para. 14. \textit{Acta Apostolicae Sedis}, 60 (1968) 481-503, online: The Holy See (The Vatican: The Vatican Library, 2010) <http://www.vatican.va/holy_father/paul_vi/encyclicals/documents/hf_p-vi_enc_25071968_humanae-vitae_en.html>.}

For this group Plan B acts as an abortifacient, regardless of the exact mechanism. If a physician or pharmacist belongs to either one of these two subsets of pro-life advocates, he or she may object to prescribing or filling prescriptions for Plan B on religious or conscientious grounds.
2.2 Abortifacient Drugs and How They Work

“Abortifacient drugs” is the term I am using for two different combinations of drugs that terminate pregnancy. There are two drug combinations that can be used to terminate pregnancy. The first is the combination of methotrexate and misoprostol. The second is the combination of mifepristone and misoprostol. Methotrexate and misoprostol are licensed for use in Canada. Mifepristone is licensed for use in the United States, but not in Canada.\(^{12}\) With the exception of mifepristone in the United States, these medications are not licensed specifically to terminate pregnancy, but are used off-label (for purposes other than that for which they are licensed) because of the effects they have on pregnancy.

Methotrexate is a drug that is licensed in Canada to treat psoriasis, some cancers, and certain kinds of arthritis. It is contraindicated for use in pregnant women, as it can cause fetal death or congenital abnormalities in a fetus.\(^{13}\) Because of this side effect, it is sometimes prescribed off-label with misoprostol to terminate an unwanted pregnancy without surgery.\(^{14}\)

Mifepristone, previously known as RU486, is also known by its brand name, Mifeprex, and is not licensed for use in Canada. In the United States, the Food and Drug Administration approved Mifeprex on September 28, 2000.\(^{15}\) Mifepristone works by blocking the creation of progesterone, which is necessary to create and sustain pregnancy.\(^{16}\) Mifeprex is indicated for the medical termination of pregnancy up until the forty-ninth day of pregnancy (seven weeks of pregnancy). In this case, pregnancy is dated from the first day of the latest menstrual period. Two days after taking Mifeprex, a woman must take misoprostol, unless there has already been confirmation of a complete abortion.\(^{17}\)

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\(^{14}\) Women’s Health Centre, “Medical Abortion,” supra note 1.


\(^{16}\) Kohm, supra note 4 at 792-793.

\(^{17}\) U.S. Food and Drug Administration, “Drugs@FDA,” s.v. “Mifeprex” U.S. Food and Drug Administration (Silver Spring, Maryland: Food and Drug Administration, 2010), online: U.S. Department of Health and Human Services.
Misoprostol is licensed in Canada and the United States to treat stomach ulcers. However, one of its side effects is to cause premature birth, congenital defects, and abortion.\(^1\) It can be used off-label to terminate pregnancies.\(^2\) It is used in combination with either methotrexate or mifepristone to complete a medical abortion by causing the muscles of the uterus to contract, pushing out the contents. It is usually taken two days after mifepristone and five to seven days after methotrexate.\(^3\)

These drugs can be taken up to seven weeks of pregnancy, which is approximately equivalent to five weeks after fertilization. Biologically at this time, the embryo is not considered a fetus by medical standards; however, implantation has occurred, and the embryo is forming organs and the external structure. By the definition that pregnancy begins with implantation, methotrexate, mifepristone and misoprostol act as abortifacients because they terminate a pregnancy. There are those who do not oppose these abortifacient drugs because, although they technically terminate a pregnancy, the embryo is not a fetus or viable outside the womb. However, most, if not all, pro-life advocates oppose the use of these drugs on the grounds that terminating a pregnancy at any stage ends a life, as they define it. Physicians and pharmacists who hold this position may object to prescribing or filling prescriptions for these medications because of their belief that the pills end a life.

Although these combinations of drugs are conventionally regarded as abortifacients because they act after implantation, I refer to them as emergency contraception because they are taken after sexual intercourse and relatively early in a pregnancy.\(^4\) In addition, mifepristone inhibits


\(^{\text{[3]}}\) Women’s Health Centre, “Medical Abortion,” supra note 1.


Women’s Health Centre, “Abortion” (Toronto: Women's College Hospital and the Women’s College Research Institute, 2008), online: Women’s Health Centre <http://www.womenshealthmatters.ca/centres/sex/abortion/abortion.html>. Plan B is taken within 72 hours of
ovulation and implantation, like oral contraceptive pills and Plan B, which means that if taken soon enough after intercourse, it may act in a similar way as Plan B.  

2.3 Availability

In Canada, emergency contraception pills such as Plan B, which is the only approved emergency contraceptive pill in Canada, is available without a doctor’s prescription. It is generally available over the counter, as it is not classified in one of the schedules of the Controlled Drugs and Substances Act. However, the National Association of Pharmacy Regulatory Authorities (“NAPRA”), a voluntary association of provincial and territorial pharmacy regulatory bodies, also classifies drugs according to schedules. Each schedule provides rules for pharmacists dispensing and providing these drugs. NAPRA’s intention in classifying drugs is to harmonize the dispensing procedure across the country.25 Levonorgestrel, when packaged in two doses of 0.75 mg, as it is in Plan B, was classified as Schedule II as of April 2005, and reclassified as Schedule III as of May 2008.26 Schedule II drugs “require professional intervention from the pharmacist” and must be kept behind the counter.27 Schedule III drugs do not require direct intervention by the pharmacist and can be kept over the counter in the self-selection area of the pharmacy, as long as it is under the direct supervision of the pharmacist. The pharmacist must still be easily accessible to answer any questions.28
Accordingly, subject to any provincial association regulations tightening the restrictions, Plan B is available over the counter without any interaction with pharmacists. However, the Ontario College of Pharmacists’ policy on dispensing Plan B continues to treat it as a Schedule II drug, meaning that it must be kept behind the counter so that the pharmacist can ensure that the product is appropriate for the patient.\footnote{Ontario College of Pharmacists, “Ontario Guidelines for Provision of Plan B (Schedule II)” Ontario College of Pharmacists (Toronto: Ontario College of Pharmacists, 2010), online: Ontario College of Pharmacists <http://www.ocpinfo.com/client/ocp/ocphome.nsf/object/ECP+Provisions/$file/ECP_provision.pdf>.} In provinces where it is treated as Schedule III, Plan B can be found in one of the following sections in the pharmacy: Birth Control, Contraceptives, Feminine Hygiene or Family Planning. Plan B costs about $40.00.\footnote{Plan B: The Morning After Pill, “Where to Get It” (Canada: Paladin Medinfo, 2008), online: Plan B <http://www.planb.ca/where.php>.}

As discussed in Section 2.2, methotrexate and misoprostol are licensed for sale in Canada, but are not indicated for the termination of pregnancy. Nonetheless, this combination is occasionally prescribed off-label.\footnote{Weeks, supra note 19.} Methotrexate is a Schedule I drug, as classified by NAPRA, meaning that it requires a prescription from a physician and direct intervention by the pharmacist in a regulated sale environment.\footnote{National Association of Pharmacy Regulatory Authorities, “Search National Drug Schedules,” s.v. “Methotrexate” NAPRA (Ottawa: NAPRA, 2009), online: NAPRA <http://napra.ca/pages/Schedules/Search.aspx>. National Association of Pharmacy Regulatory Authorities, “Outline of the Schedules” NAPRA (Ottawa: NAPRA, 2009), online: NAPRA <http://napra.ca/Content_Files/Files/Schedules-Outline.pdf>.} Misoprostol is classified as a prescription drug pursuant to Schedule F of the Food and Drug Regulations.\footnote{Health Canada, “Drug Product Database: Terminology” Health Canada (Ottawa: Health Canada, 2010), online: <http://www.hc-sc.gc.ca/dhp-mdp/prodpharma/databasdon/terminolog-eng.php>.} Accordingly, for a woman to obtain this combination of abortifacient drugs, she would require an examination and a prescription by a physician and direct interaction with a pharmacist.

Mifepristone is not currently licensed for sale in Canada, although it may eventually be licensed in Canada. Presumably it would undergo the same process of regulation taken by Health Canada with respect to Plan B: first categorized as a prescription drug, and later as a drug that can be sold by the pharmacist.\footnote{CTV.ca News Staff “Ottawa to make Morning-After Pill More Accessible” CTV News (18 May 2004), online: CTV News <http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/1084889235066_25/?hub=CTVNewsAt11>.} Before being licensed for sale and use in Canada, mifepristone must be reviewed by Health Canada to have its safety, efficacy, and quality

\footnote{Plan B: The Morning After Pill, “Where to Get It” (Canada: Paladin Medinfo, 2008), online: Plan B <http://www.planb.ca/where.php>.}
\footnote{Weeks, supra note 19.}
assured. Once it is licensed for sale, it will be regulated under the *Food and Drugs Act* and Regulations, as are the other drugs referred to above.\(^{35}\)

In the United States, Plan B is licensed for sale in two forms: two 0.75 mg tablets, or one 1.5 mg tablet. Women under the age of 17 require a prescription for either form of Plan B; while women 17 years of age and older can obtain Plan B over the counter.\(^ {36}\) Pharmacists still interact with women 17 and older to ensure that Plan B is necessary and required by the patient.

Mifepristone has been licensed for sale as Mifeprex in the United States since September 28, 2000.\(^ {37}\) It is to be used with misoprostol for the termination of pregnancy through the fortieth day of pregnancy. A physician must prescribe it and supervise its administration. The patient must visit the physician three times. At the first visit, the woman takes three tablets of Mifeprex (600 mg). On the third day, she returns to take two tablets of misoprostol (400 µg). Two weeks after the administration of Mifeprex, the patient returns to receive confirmation that the pregnancy was terminated.\(^ {38}\) Accordingly, a woman seeking to use mifepristone and misoprostol to terminate a pregnancy will have significant interaction with a physician. Mifeprex is a prescription drug; however, it is not supplied to the American public through pharmacies. Rather, female patients in the United States obtain it directly from the treating physician.\(^ {39}\)

Some states require emergency contraception to be provided, while other states have put restrictions on its access.\(^ {40}\) Legislation of this sort is discussed in Subsection 3.4.2 and Subsection 4.2.2, below.

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\(^{40}\) Guttmacher Institute, “State Policies in Brief: Emergency Contraception” (New York: Alan Guttmacher Institute, 2010), online: Guttmacher Institute <http://www.guttmacher.org/statecenter/spibs/spib_EC.pdf> at 1-2. Twelve states and the District of Columbia require hospital emergency rooms to dispense emergency contraception on request to sexual assault victims. Nine states allow pharmacists to dispense emergency contraception without a physician’s prescription under certain conditions. Three states allow pharmacists to distribute emergency contraception in accordance with a state protocol. Three states mandate that pharmacies fill all valid prescriptions
2.4 Access to Emergency Contraception as a Reproductive Right

In the early twentieth century, British and American feminists launched a number of social reform programs to better the status of women, including advocating the provision of methods of contraception.\(^{41}\) Some feminists campaigned for legislative changes to legalize contraceptive use, while others such as Margaret Sanger advocated sexual autonomy through birth control.\(^{42}\) This movement towards the sexual emancipation of women coincided with the political emancipation of women through suffrage.\(^{43}\) As women began to gain independence in the public sphere, they also sought independence in the sexual sphere. Advocating contraceptive use was one way to achieve this autonomy.

The Canadian *Criminal Code* criminalized contraceptive devices and drugs from 1892 to 1969. Under the pre-1969 *Criminal Code*, providing anything to prevent conception was an offence in the Part “Offences Tending to Corrupt Morals.” Unless the accused could prove that he or she provided the contraception for “the public good,” he or she was liable to two years’ imprisonment.\(^{44}\) Pierre Trudeau, as the federal Minister of Justice, removed the prohibition on advertising contraceptive devices and drugs from the *Criminal Code* in 1969 after the Planned Parenthood Federation of Canada and the Canadian Medical Association lobbied the Canadian

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\(^{42}\) *Ibid.* at 159.

\(^{43}\) *Ibid.* at 56. “Sexual autonomy” as a feminist argument for birth control “is best described as a theory maintaining a woman should have control over her sex life as well as the number of children she chooses to have.”


*Criminal Code*, S.C. 1953-54, c. 51, s. 150(2)(c) provided that: “Every one commits an offence who knowingly, without lawful justification or excuse, (c) offers to sell, advertises, publishes an advertisement of, or has for sale or disposal any means, instructions, medicine, drug or article intended on represented as a method of preventing conception or causing abortion or miscarriage” [Criminal Code 1954].
government to change the law.\footnote{Canadian Encyclopedia, supra note 44.} Since then, birth control methods have been available to all Canadians, subject to the regulations of Health Canada. The 1969 amendments also removed the blanket prohibition on abortions, creating a legal system regulating the provision of abortions.\footnote{S.C. 1968-1969, c. 38, s. 13 amended s. 150(2)(c) of the Criminal Code 1954, supra note 44 by removing the words and “preventing conception” from the last phrase of the subsection.} The Supreme Court of Canada declared this regulatory system unconstitutional in \textit{R. v. Morgentaler} (1988).\footnote{S.C. 1968-1969, c. 41, s. 2 amended s. 3 of the Food and Drugs Act by adding the following subsection: “Except as authorized by regulation, no person shall advertise to the general public any contraceptive device or any drug manufactured, sold or represented for use in the prevention of contraception.” In other words, providing contraception is no longer a criminal offence, but is still regulated by law.}

The majority of the Supreme Court of Canada decided the case on the grounds that the impugned legislation, when considered from the pregnant woman’s perspective, violated the woman’s section 7 rights to security of her person and liberty, whether because of her right to therapeutic health care, the fairness of criminal law, or the autonomy of women over procreation.\footnote{S.C. 1968-1969, c. 38, s. 18. See Lorraine Eisenstat Weinrib, “The Morgentaler Judgment: Constitutional Rights, Legislative Intention, and Institutional Design” (1992) 42:1 U.T.L.J. 22 at 25 for a brief discussion of the history of the 1969 amendment and for a discussion of the Supreme Court of Canada’s decision in Morgentaler.} Justice Wilson, in her concurring opinion, wrote, “The right to liberty contained in s. 7 guarantees to every individual a degree of personal autonomy over important decisions intimately affecting their private lives.” She accordingly concluded, “the decision of a woman to terminate her pregnancy falls within this class of protected decisions.”\footnote{R. v. Morgentaler, [1988] 1 S.C.R. 30 [Morgentaler].} The use of emergency contraception would fall into this category of protected private decisions. In addition, Wilson J. also emphasized freedom of conscience in s. 2(a) of the Charter because “the decision whether or not to terminate a pregnancy is essentially a moral decision, a matter of conscience,” or in other words, the conscience that matters is that of the person most deeply affected by the legislation.\footnote{Lorraine Eisenstat Weinrib, “The Morgentaler Judgment: Constitutional Rights, Legislative Intention, and Institutional Design” (1992) 42:1 U.T.L.J. 22 at 66 [Weinrib, “Morgentaler Judgment”].} Women’s right to emergency contraception can be based on the right to access to therapeutic health care, as Beetz J. reasoned for abortion, or based on a woman’s right to her bodily autonomy, which Wilson J. considered to include the decision whether to nurture a pregnancy.

\footnote{\textit{Morgentaler}, supra note 47 at 171, Wilson J.}

\footnote{\textit{Ibid.} at 175-176, Wilson J..}

\footnote{Weinrib, “Morgentaler Judgment,” supra note 48 at 54.}
In the United States, access to contraception was not granted to married couples until 1965, when the Supreme Court held that access to contraception was within the privacy rights of married women, stemming from the Ninth Amendment to the Constitution. In 1972, this right was extended to all adults. In *Eisenstadt v. Baird*, the Court stated:

> If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether beget a child.

Alice Dong, in considering these cases, stated:

> This constitutional foundation provides individuals with the right to privacy in their choice of childbearing. However, this is only a right to freedom from the state's interference in the decision of obtaining contraceptives; it has not been interpreted as a positive right conferred upon the individual.

Access to contraception of various kinds, both primary and emergency, allows women to plan their families. It provides them with control over their bodies, thereby giving them autonomy in their lives. Contraception prevents unwanted pregnancies, can lower the abortion rate, and can diminish the undesirable social effects of such unwanted pregnancies, including “teenage pregnancy, single parenthood, incomplete education of women, welfare dependency, poverty, lack of prenatal care, substance abuse in early pregnancy, low birth weight, infant mortality, and child abuse.” Since no contraception is fail-proof, emergency contraception is also necessary to prevent these social problems.

Contraception and emergency contraception have been linked to women’s sexual and general health and women’s autonomy in their sexual and everyday lives; they are an important aspect of women’s reproductive rights. There is a potential for conflict between women’s reproductive rights and health care providers’ freedom of religion, if health care providers object to emergency contraception on grounds of conscience. The next Chapter considers this conflict between women’s rights and health care practitioners’ religious freedom rights.

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51 *Griswold v. Connecticut*, 381 U.S. 479 (1965) [*Griswold*].
53 Dong, *supra* note 52 at 779.
Chapter 3
Freedom of Religion Issues

In this Chapter, I will set out the conflict of rights between health care providers on the one hand and patients on the other. In Section 3, I will discuss the health care professional’s right to freedom of religion, which grounds the claim that a physician or a pharmacist can object to prescribing or filling prescriptions for emergency contraception. In Section 4, I will discuss the limits on the health care professional’s right to freedom of religion, which includes the rights of the patient.

3 Health Care Professional’s Right to Freedom of Religion

Health care professionals such as physicians and pharmacists have a fundamental right to freedom of religion. In Canada, this right is grounded in the Canadian Charter of Rights and Freedoms and human rights codes. In the United States, this right is grounded in the First Amendment. Freedom of religion provides the basis of the claim that physicians and pharmacists have the right to object to prescribing or filling prescriptions for Plan B or abortifacient drugs if they are religiously opposed to these medications on the medically-inspired grounds that were discussed in Chapter 2 or on religiously-inspired grounds.

This Section begins with a discussion on theoretical justifications for religious freedom, and then considers the legal justifications for religious freedom, in both Canada and the United States.

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56 One religiously motivated argument why the rights of a fertilized egg are more important than the rights of the woman is founded on the doctrine of the Catholic Church. Rebecca Cook describes it this way:
   Because the unborn child is tainted by original sin, its entry to eternal life in heaven requires the sacrament of baptism, which can be undertaken only after live birth. In contrast, the living woman’s eternal soul is already redeemable from perdition or limbo. The unborn child must be favored to be born and baptized, in order that its soul too may be saved.
3.1 Justifications for Religious Freedom

There are a number of theoretical justifications for religious freedom in Canada and the United States. The backdrop to the issue of religious freedom is the fact that Canada and the United States have become increasingly religious pluralistic societies in the recent past. In order to protect the rights of all religions and belief systems, including agnosticism and atheism, the United States and other Western countries have adopted a more secular worldview. Religious diversity has made it necessary and widely accepted that in a democratic society “the political or public life of the community should not be based on the religious practices and values of the majority group” and that “citizens, regardless of their religious beliefs and practices, should be treated as full and equal members of the political community.”57 This in itself is a positive development.

However, it appears that the pendulum has swung too far the other way, with many viewing religious faith as odd and irrational. This has the consequence of making some conservative believers of the Christian faith and other religions feel sidelined. As Richard Moon writes:

> When the state treats the individual’s religious practices or beliefs as less important or less true than the practices of others...the individual adherent may experience this not simply as a rejection of her views and values but also as a denial of her equal worth or desert, as unequal treatment that affects her dignity.58

Consequently, Canada, the United States and other democratic societies must find a way to balance respect for religious diversity with the rights of their religious citizens.

There are various reasons why these religious rights claims should be entertained. Chief Justice Beverley McLachlin has considered the importance of freedom of religion in Canada, particularly in the context of the rule of law. In commenting on Clifford Geertz’ description of religion, she wrote, “religion is both worldview and ethos; it affects belief and action.”59 As the rule of law and religion both exert a total claim over human existence, the religious adherent “is

58 Ibid. at 217.
caught between two all-encompassing sets of commitments.”

Accordingly, courts are faced with the challenge of balancing these two competing worldviews, so that they promote anti-discrimination, while respecting conscientious belief.

Following from this description of religion, one reason why these claims should be entertained is that a person’s religious beliefs are at the core of his or her being, sense of self, and identity. Causing a person to separate her religious beliefs from her daily actions could cause her substantial harm because of the dissociation between her moral code and her actions. In other words, respecting a health care provider’s moral integrity is a legitimate and valid reason to allow her to object to prescribing or dispensing emergency contraception, as long as her objection is based on core ethical values that align with core values in medicine, such as life and health.

Richard Moon, in introducing Lorraine Weinrib’s article in his compilation of essays on religious pluralism in Canada, writes:

According to Weinrib, the protection of religious freedom in Canada reflects the “state’s commitment to individual liberty and equality.” The state, she says, must respect the individual’s spiritual “choices”, her “right to live according to her personal faith and conscience,” and it must respect her “desire to forge a more individual set of commitments, alone and in her community.” The focus of the right “is on the individual’s embrace of her own beliefs and values.”

He continues by writing that religion “shapes the individual’s worldview at a fundamental level so that the restriction or marginalization by lawmakers of her religious values and practices is experienced by the individual as a denial of her equal worth.”

Religion, as defined by the Supreme Court of Canada, is an individual choice, and yet also, “integ rally linked to one’s self-definition.” Accordingly, forcing a health care provider to

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60 Ibid. at 16.
61 Ibid. at 22.
64 Ibid. at 16.
65 Ibid. at 20.

The Supreme Court of Canada has rejected categorizing people based on their religious affiliation (Trinity Western University v. British Columbia College of Teachers, [2001] 1 S.C.R. 772 at para. 42 [Trinity Western]) and will not
choose between her religion and her daily life could cause her to undergo a crisis of identity. As Bruce Ryder writes, “Religious persons cannot be expected to park their beliefs at home or at places of worship.”

More specific to the issue at hand, physicians and pharmacists may object to prescribing or dispensing emergency contraception for a number of reasons, stemming from religious percepts, moral principles deriving from religious precepts, or secular moral principles. They may object on the basis of their duty not to harm because they believe that the medication may cause harm to the patient; they may object on the basis of their duty not to take life because they believe the medication acts as an abortifacient; and they may object on the basis of other religious or moral objections. A number of specific justifications for health care providers’ religious freedom are discussed in the context of American-style conscientious objection clauses in Subsection 3.4.2, below.

These arguments provide rationales for entertaining health care providers’ right to religious freedoms. The rationales will be critiqued later in Section 4.

### 3.2 Canada

#### 3.2.1 The Canadian Charter of Rights and Freedoms

In Canada, the *Canadian Charter of Rights and Freedoms* guarantees freedom of religion to everyone. This constitutional guarantee has been discussed in a number of important decisions by the Supreme Court of Canada, in which the Court has laid down principles important to our discussion of health care practitioners’ freedom of religion.

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Kohm, *supra* note 4 at 801-802.

*Charter, supra* note 55, s. 2(a). “Everyone has the following fundamental freedoms: (a) freedom of conscience and religion...”
In *R. v. Big M Drug Mart Ltd.*, the Supreme Court of Canada discussed s. 2(a) of the *Charter* for the first time since the *Charter* came into force. Justice Dickson, as he then was, made several important comments about the nature of freedom of religion, beginning with the foundation of freedom:

> Freedom must surely be founded in respect for the inherent dignity and the inviolable rights of the human person. The essence of the concept of freedom of religion is the right to entertain such religious beliefs as a person chooses, the right to declare religious beliefs openly and without fear of hindrance or reprisal, and the right to manifest religious belief by worship and practice or by teaching and dissemination.  

An emphasis on “individual conscience and individual judgment” in Canada’s “democratic political tradition” led Justice Dickson to elucidate the purpose of freedom of conscience and religion:

> 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.

This purpose of freedom of conscience and religion supports health care practitioners’ right to object to emergency contraception, to the extent that the objection does not injure other parties, such as female patients.

In *R. v. Edwards Books and Art Ltd.*, the Supreme Court expanded on the principles set out in *Big M*. Notably for our purposes, Chief Justice Dickson characterized religion as “profoundly personal beliefs that govern one’s perception of oneself, humankind, nature, and, in some cases, a higher or different order of being. These beliefs, in turn, govern one’s conduct and practices.” This definition of religion accords with the rationale for protecting health care providers’ right to object to emergency contraception because their religious beliefs inform all aspects of their actions and daily lives.

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70 *Ibid.* at para. 94.
The Supreme Court has also delineated the scope of the freedom of religion. As already mentioned, Justice Dickson held in *Big M* that the freedom of religion does not allow a person to injure his or her neighbours or their rights.\(^\text{73}\) He continued on to say that, while freedom means that no one is to be forced to act in a way that is contrary to her beliefs, the freedom is subject to limitations “necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.”\(^\text{74}\) Further, freedom of religion “safeguards religious minorities from the threat of the tyranny of the majority.”\(^\text{75}\)

In *B.(R.) v. Children’s Aid Society of Metropolitan Toronto*, the Supreme Court split 5-4 over whether the limitation on the freedom of religion is best considered under a s. 1 analysis or within the right itself.\(^\text{76}\) Justice LaForest, with four Justices concurring, held that while freedom of religion is not absolute, particularly with respect to religious practices that impact on the rights of others, competing rights ought to be balanced under the more flexible tool of s. 1 of the *Charter* rather than imposing internal limits in s. 2(a).\(^\text{77}\) Justices Iacobucci and Major, with two Justices concurring, would define an outer boundary on the right itself, with conduct outside the boundary not being protected by the *Charter*.\(^\text{78}\) The outer boundary was defined in this way: “…although the freedom of belief may be broad, the freedom to act upon those beliefs is considerably narrower…” and does not protect “activity that threatens the physical or psychological well-being of others.”\(^\text{79}\)

More recently, in *Syndicat Northcrest v. Amselem*, the Supreme Court again discussed the scope of freedom of religion.\(^\text{80}\) Justice Iacobucci, with four Justices concurring, held that no right is absolute because “we live in a society of individuals in which we must always take the rights of others into account.”\(^\text{81}\) The Justice further held:

> Conduct which would potentially cause harm to or interference with the rights of others would not automatically be protected. The ultimate protection of any

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\(^{73}\) *Big M*, *supra* note 69 at paras. 122-123.  
\(^{74}\) *Ibid.* at para. 95.  
\(^{75}\) *Ibid.* at para. 96.  
\(^{77}\) *Ibid.* at paras. 107, 110, LaForest J.  
\(^{78}\) *Ibid.* at para. 224, Iacobucci and Major JJ.  
\(^{79}\) *Ibid.* at para. 226, Iacobucci and Major JJ.  
\(^{80}\) *Amselem*, *supra* note 65.  
\(^{81}\) *Ibid.* at para. 61.
particular *Charter* right must be measured in relation to other rights and with a view to the underlying context in which the apparently conflict arises.\textsuperscript{82}

It is clear from these Supreme Court cases that freedom of religion does not extend to protect conduct that harms others physically or psychologically or to conduct that denies others equal protection of their religious freedom. In the situation at hand, this means that physicians’ and pharmacists’ freedom of religion does not protect their decision to refuse to provide emergency contraception to women if that decision will harm the women or if that decision amounts to the physician and pharmacist imposing their religious beliefs upon a person who does not share those beliefs.

In addition, although the right to freedom of religion is guaranteed and cannot be abrogated except in accordance with the provisions of the *Charter* itself, the right can be limited by s. 1 of the *Charter*. This section provides that:

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.\textsuperscript{83}

Accordingly, physicians and pharmacists have a guaranteed right to exercise their freedom of religion, subject to reasonable and justifiable limits set out in laws. If the legislature were to enact a law mandating that physicians prescribe and pharmacists fill prescriptions for emergency contraception, it would have to justify this limit on the health care professionals’ freedom of religion according to the principles developed under s. 1. This will be discussed more in Subsection 4.1.1. However, before the government would have to justify any potential infringement, the physician or pharmacist would first have to prove that her religious rights were infringed upon. To do so, she has to satisfy the test articulated in *Amselem*.\textsuperscript{84} First, she must prove that she has a practice or belief connected to religion that calls for particular conduct to connect her to the divine or spiritual force, in this case, a religious belief that opposes emergency contraception. Second, she must show that she is sincere in her belief.\textsuperscript{85} Third, she must show that the particular legislation in question interferes with her ability to act in

\textsuperscript{82} *Ibid.* at para. 62.
\textsuperscript{83} *Charter*, supra note 55, s. 1.
\textsuperscript{84} *Amselem*, supra note 65 at para. 56-63.
\textsuperscript{85} *Ibid.* at para. 56.
accordance with her religious beliefs in a manner that is “more than trivial or insubstantial.”

Fourth, she must show how the exercise of her religious rights interferes with other, competing, rights of private individuals. This final criterion could pose a problem for a health care professional who attempts to claim an absolute right to object to emergency contraception. However, subject to the duties of disclosure and referral that I have proposed, the rights of others, including female patients, will be less impacted. Restrictions on the freedom of religion will be discussed more in Sections 4 and 5.

In conclusion, physicians and pharmacists have a constitutional right to have religious beliefs and to live their lives in accordance with these beliefs. However, the right is not absolute, and can be limited in appropriate legislation or if their beliefs conflict with others’ rights.

### 3.2.2 Human Rights Codes

Human rights codes also protect freedom of religion. In particular, physicians and pharmacists cannot be discriminated against in the employment sector because of their religion. Subsection 5(1) of the Ontario Human Rights Code provides that:

> Every person has a right to equal treatment with respect to employment without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, record of offences, marital status, family status or disability [emphasis added].

In Ontario Human Rights Commission v. Simpsons-Sears (“O’Malley”), a Seventh Day Adventist claimed that she was discriminated against on the basis of her religion because she was required to work on Saturdays, which she considered to be her Sabbath. The Supreme Court found:

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88 Justices Iacobucci and Bastarache, writing for the majority in *Trinity Western*, supra note 65 at para. 29, quoted L’Heureux-Dubé J., writing for the majority on this point in *P. (D.) v. S. (C.)*, [1993] 4 S.C.R. 141 at 182: As the Court has reiterated many times, freedom of religion, like any freedom, is not absolute. It is inherently limited by the rights and freedoms of others. Whereas parents are free to choose and practise the religion of their choice, such activities can and must be restricted when they are against the child’s best interests, without thereby infringing the parents’ freedom of religion.
89 Ontario *HRC*, *supra* note 55, s. 5(1).
Facially neutral rules that have adverse effects on the basis of creed or religion are a violation of the right to religious equality unless the employer has taken reasonable steps, up to the point of undue hardship, to accommodate religious observance. Simpsons-Sears was found to have violated Mrs. O’Malley’s rights because it presented no evidence that accommodating her wish to observe her Sabbath would have constituted undue hardship.  

According to this decision, an employer must accommodate an employee’s religious beliefs to the point of undue hardship. Consequently, for example, a pharmacy employing a pharmacist who objects on religious grounds to fill prescriptions for emergency contraception could not discriminate against this pharmacist on the basis of the pharmacist’s religion. The pharmacy would have to accommodate the pharmacist employee to the point of undue hardship.  

However, as we will see in Section 4, the health care provider’s right not to be discriminated against in the workplace on the basis of religion is not an absolute right and cannot be used against the patient.

### 3.3 The Significance of Comparative Legal Systems

Because there is no Canadian legislation or jurisprudence explicitly providing a right of conscientious objection or refusal, I will conduct a detailed examination of the use of conscientious objections in the United States.

The Province of Ontario has enacted the *Religious Freedom Act* that provides some additional protection to a physician or pharmacist refusing to provide emergency contraception on the grounds of religion; however, a more persuasive claim can be made under the *Charter*, and this provision does not specifically deal with the issue of refusal of medical services.

In addition, the governing bodies and professional associations of physicians and pharmacists in Canada and Ontario have produced ethical codes and practice standards that consider the issue of objections on the ground of religion. These codes and standards do provide a certain degree of protection to the health care provider, but they also provide limits on the religious rights of

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91 Ryder, *supra* note 66 at 90.
92 *Nichols v. M.J.*, 2009 SKQB 299 (CanLII) at para. 56 [*Nichols*].
93 *Religious Freedom Act*, R.S.O. 1990, c. R.22, s. 1: “The free exercise and enjoyment of religious profession and worship, without discrimination or preference, provided the same be not made an excuse for acts of licentiousness, or a justification of practices inconsistent with the peace and safety of the Province, is by the constitution and laws of this Province assured to all Her Majesty’s subjects within the same.”
the health care provider. I will discuss these policies in greater detail in Subsections 4.1.3 and 4.2.3, below.

Although Ontario has the Religious Freedom Act and ethical codes, the American situation is relevant because of the lack of explicit Canadian or Ontarian provisions relating to the right to object or duty to provide emergency contraception. Canada can learn from the American experience and take the positive aspects, while avoiding the pitfalls, of refusal clauses in the hope of striking a balance between the religious rights of the health care providers and women’s reproductive rights. The proposals set forth in this thesis largely come out of the American experience and will potentially serve to inform future judicial or legislative decisions on this topic in Canada and Ontario.

3.4 United States

The United States of America guarantees religious freedom in the First Amendment to its Constitution. More specifically, many individual states have enacted legislation that allows certain health care professionals the right to object to certain medical procedures on the grounds of conscience. These legislative provisions are referred to as “conscientious objection clauses” and “refusal clauses.”

Religion has an interesting place and religious freedom has an interesting history in the United States. Bruce Murray writes, “The United States is unique among nations in that it was founded not on kinship, blood lines, or ethnicity, but on an idea – liberty – as espoused by the Founders and embodied in the Constitution, the Declaration of Independence, and the Bill of Rights.”

Because of this, the United States has never been a country of only one religion; religious diversity has always been present. This can be a blessing or present a serious challenge. Charles Haynes accepts the challenge and writes, “[a]s we move into the 21st century and as we become more and more diverse, if we don’t define ourselves along principles and ideals – and instead define ourselves along race, religion and other ways – we are going to have a difficult time as a nation.”

95 Ibid. at 21, quoting Charles Haynes.
The United States is still a country of religious diversity. “According to a 2002 Pew study, 59 percent of Americans said religion plays a very important role in their lives, compared to Great Britain at 33 percent, Canada at 30 percent, and Germany at 21 percent.” However, it is also populated with non-religious people, who may not understand religious people and may find them irritating and nonsensical. However, religious people do not like it “when they are made to feel marginalized and their faith diminished,” and this can cause tension in society. For this reason, it is important to balance the rights of both religious people and those who come in contact with religious people.

3.4.1 First Amendment

The First Amendment to the United States Constitution reads as follows: “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof…” These words broadly translate to religious liberty. The second clause is known as the “free exercise” clause and it permits Americans to freely exercise the religion of their choosing.

The historical context of the First Amendment is instructive. The United States was founded by pilgrims, Puritans, and immigrants seeking to escape religious persecution in Europe during the Protestant Reformation, the Counter Reformation, and religious struggles in England that led to its Civil War. Roger Williams, an early New England colonist, founded Rhode Island as a “haven for the cause of conscience,” which gave complete religious freedom to all, including Catholics, Muslims and Jews. But other than Rhode Island, most American colonies were quite homogenous within themselves. The religious diversity in colonial America was found between colonies. It was this growing diversity in religious sects throughout the colonies that impacted the creation of the religious freedom clauses in the First Amendment. James Madison played “one ‘sect’ against another so that no one particular group, or coalition of groups, would

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96 Ibid. at 4.
97 Ibid. at 32.
98 Ibid. at 36.
99 U.S. Const. amend. I.
100 Murray, supra note 95 at p. xi and 7.
101 Ibid. at p. xi.
102 Ibid. at 9-10. The Northern colonies were adherents of the Congregational Church; the Southern colonies were adherents of the Anglican Church; Pennsylvania was a haven for Quakers; and for a brief time, Maryland was a haven for Catholics.
gain dominance and attempt to impose their sect as the state church.”\textsuperscript{103} In this way, Madison secured religious liberty for all.

The free exercise clause is preceded by the establishment clause. The First Amendment both prohibits the state from establishing religion and from preventing the exercise of religion. In the situation involving religious objections to emergency contraception, it is the free exercise clause that is at issue, so I will focus on that clause. Nonetheless, it is important to remember that the state must remain neutral with respect to the establishment of religion.

In its first decision regarding the religious exercise clause, \textit{Reynolds v. United States}, the Supreme Court created a distinction between belief and conduct.\textsuperscript{104} Religious belief was protected under the First Amendment, but religious conduct was not always protected. Eventually, the Court moved away from the belief-conduct dichotomy and balanced rights when religious conduct was involved. The Court articulated a compelling interest test in \textit{Sherbert v. Verner}.\textsuperscript{105} If a law substantially burdened a person’s right to free exercise of her religion, the state had to justify the law by showing they were “the least restrictive means of achieving a compelling state objective.”\textsuperscript{106}

However, in \textit{Employment Division v. Smith}, the Court essentially brought back the belief-conduct dichotomy.\textsuperscript{107} The Court held that the Free Exercise Clause affords no basis for exemption from a “neutral, generally applicable law.”\textsuperscript{108} \textit{Smith} is the current law: the Constitution does not protect the free exercise of religious actions from indirect effects of generally applicable law. The result is equal, but not substantive, protection, for religious exercise. However, legislatures can enact laws that protect the free exercise of religious conduct. Congress has done so with the \textit{Religious Freedom Restoration Act}, which restores the compelling interest test and protects religious conduct from indirect burdens, and conscientious

\textsuperscript{103} \textit{Ibid.} at 17.
\textsuperscript{104} \textit{Reynolds v. United States}, 98 U.S. 145 (1879) [\textit{Reynolds}].
\textsuperscript{105} \textit{Sherbert v. Verner}, 374 U.S. 203 (1963) [\textit{Sherbert}].
\textsuperscript{106} Ryder, \textit{supra} note 66 at 95.
\textsuperscript{107} \textit{Employment Division v. Smith}, 494 U.S. 872 (1990) [\textit{Smith}].
objection clauses. The Court held that the congressional RFRA is unconstitutional if applicable to the states (although it could be valid if applicable only to Congress) in City of Boerne v. Flores. The Court also reaffirmed the holding of Smith, making it clear that “adverse effects flowing from facially neutral rules do not violate religious freedom.” At least twelve states have responded to this decision by enacting their own RFRAs.

Because of the decision in Smith, the First Amendment no longer provides constitutional protection to the free exercise of religious conduct against generally applicable laws that are facially neutral. For example, a law that imposes a duty on health care providers to perform all medically necessary treatments and fill all legitimate prescriptions, as long as it does not expressly burden religious people, could pass constitutional muster. However, Congress and some states have enacted legislation that require new laws to use the least restrictive means to achieve a compelling state interest if the law affects religious exercise, either directly or indirectly. In addition, a number of states have enacted conscientious objection legislation, to which I will turn now.

### 3.4.2 Conscientious Objection Clauses

Several American states have legislated conscientious objection clauses for various health care providers. These refusal clauses, as they are also known, range in the subjects protected and the areas in which health care providers can object, but in general, they allow health care providers to refuse to perform abortions and provide various kinds of contraception on the grounds of religious belief.

The Guttmacher Institute collects data on which states have conscientious objection legislation. The following quotation lists the highlights from the February 2010 listing of states refusing to provide health services:

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110 Ibid., § 2000bb.
City of Boerne v. Flores, 521 U.S. 507 (1997) [City of Boerne].
111 Ryder, supra note 66 at 97.
13 states allow some health care providers to refuse to provide services related to contraception.

- 8 states allow individual health care providers to refuse to provide services related to contraception.
- 4 states explicitly permit pharmacists to refuse to dispense contraceptives. (5 additional states have broad refusal clauses that do not specifically include pharmacists, but may apply to them.)
- 1 state explicitly permits pharmacies to refuse to dispense contraceptives.
- 4 states have broad refusal clauses that do not specifically include pharmacies, but may apply to them.
- 9 states allow health care institutions to refuse to provide services related to contraception, 6 states limit the exemption to private entities.

The examples of Mississippi and Tennessee will be illustrative.

The Mississippi Health Care Rights of Conscience Act provides refusals to health care providers, health care institutions, and health care payers with the right to refuse health care services based on conscience. It applies to physicians and pharmacists, among other health care providers and health care institutions. “Conscience” is defined as “the religious, moral or ethical principles held by a health-care provider, the health-care institution or health-care payer.” “Health-care service” is defined as “any phase of patient medical care, treatment or procedure” and includes patient referral, prescribing, dispensing or administering any drug or medication, among others.

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114 Mississippi Health Care Rights of Conscience Act, Miss. Code. Ann. Sec. 41-107-1 [Miss. HCRCA]. The Act has been in force since July 1, 2004. Excerpts are in Appendix A.


116 Ibid., Sec. 41-107-5(1). “A health-care provider has the right not to participate, and no health-care provider shall be required to participate in a health-care service that violates his or her conscience. However, this subsection does not allow a health-care provider to refuse to participate in a health-care service regarding a patient because of the patient's race, color, national origin, ethnicity, sex, religion, creed or sexual orientation.”

117 Ibid., Sec. 41-107-3(b) and (c).

118 Ibid., Sec. 41-107-3(h).
Section 5 provides for the rights of conscience of health-care providers, such as pharmacists and physicians, allowing them to refuse to participate in health care services, and protecting them from liability and discrimination for those refusals. Section 7 provides for the rights of conscience of health-care institutions. It is identical to section 5, except that a health-care institution that declines to provide or participate in health-care services that violates its conscience is immune from liability only if “the institution provides a consent form to be signed by a patient before admission to the institution stating that it reserves the right to decline to provide or participate in a health-care service that violates its conscience.” Section 11 provides for civil remedies, including the right to bring a civil action for damages or injunctive relief, if any provision of the Act is violated.

Mississippi’s conscientious objection legislation allows physicians, pharmacists, physicians’ offices, and pharmacies, among others, to refuse to provide certain health-care services, including providing emergency contraception, if it violates their religious, moral or ethical principles. However, it expressly prohibits discrimination on the basis of human rights grounds, such as race, colour, sex, religion or sexual orientation, although not marital status. This will ensure that people are not denied medical care because of certain unchangeable characteristics. As well, health-care institutions are required to give prior disclosure to and obtain consent from patients if they wish to retain the right to refuse on the basis of conscience. This duty of prior disclosure is an element which I propose must be included if rights of refusal are to be given to health care professionals and institutions.

Tennessee enacted its Family Planning Act of 1971 in 1971. It applies to physicians, but not to pharmacists, and deals explicitly with contraceptives. Subsection 104(1) provides that contraceptives shall be available to anyone who wants them. However, the Act also protects

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119 Ibid., Sec. 41-107-5(1).
120 Ibid., Sec. 41-107-7.
121 Ibid., Sec. 41-107-7(2).
122 Ibid., Sec. 41-107-11. The relevant provisions are in Appendix A.
123 Tenn. Code, supra note 114, §101.
124 Ibid., §104.
125 Ibid., §104(1). “All medically acceptable contraceptive procedures, supplies, and information shall be readily and practicably available to each and every person desirous of the same regardless of sex, race, age, income, number of children, marital status, citizenship or motive.”
the rights of physicians to refuse to provide contraceptives on the basis of religious or conscientious objection.\footnote{Ibid., §104(5). “No private institution or physician, nor any agent or employee of such institution or physician, shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when such refusal is based upon religious or conscientious objection, and no such institution, employee, agent, or physician shall be held liable for such refusal.”}

Tennessee’s conscientious objection legislation is shorter and less comprehensive than Mississippi’s, but it does allow physicians to refuse to prescribe contraception, including emergency contraceptives, if it violates their conscience. It does not explicitly apply to pharmacists; however, it does apply to private institutions and employees and agents of those institutions. Private pharmacies could arguably fall under the gambit of “private institution” and accordingly, pharmacists who work at those private pharmacies would have the right to refuse to provide emergency contraception on the basis of conscience.

Some may argue that conscientious clauses are too heavily weighted in favour of health care providers and do not adequately protect patients’ rights, but there are theoretical justifications for the use of refusal clauses. First, conscientious objections respect the moral integrity of physicians and pharmacists. This justification is based on the premises that a health care provider has core ethical values, these core ethical values are integral to her understanding of herself, and if she were to provide contraception against her beliefs, she would be engaged in a “form of self-betrayal,” leading to a loss of self-respect.\footnote{Wicclair, supra note 62 at 213-214.} However, these core ethical values on which the objection is based must correspond to a core ethical value of medicine.\footnote{Ibid. at 217.} This would be the case for conscientious objections to emergency contraception since the ethical value of protecting life is a core value of medicine.

Second, conscientious objections are valid because they allow physicians and pharmacists to exercise independent judgment. They are professionals who owe their patients a duty of care, and accordingly, they should be given room to exercise their professional judgment in determining whether they are competent to provide the required services to a particular patient, particularly as to prescribing and dispensing medications.\footnote{J. Cantor and K. Baum, “The Limits of Conscientious Objection—May Pharmacists Refuse to Fill Prescriptions for Emergency Contraception?” (2004) 351:19 New Eng. J. Med. 2008 at 2008-2009 [Cantor].}
Third, professionals should not have to forsake their religious beliefs or morals as a condition of employment, as health care providers (other than emergency physicians) have the right to choose whom to treat. 130 As lawyers and accountants have the ability to accept or refuse new clients, non-emergency physicians have the ability to accept or refuse new patients. They may do so because they are not qualified in the area of expertise needed to treat a particular patient’s condition, their practices are too busy, or they are otherwise unable to accept a new patient. However, physicians must not refuse to accept a new patient because of a prohibited ground of discrimination, such as race, sex, or religion. In addition, once a physician has accepted a patient, she must continue to treat her and withdraw services only under certain conditions. 131

Pharmacists may not have quite the same freedom to choose whom to serve because often there is not the same ongoing relationship between a pharmacist and a patient as there is between a physician and a patient. However, pharmacists can refuse a patient if they do not have the required medication in stock or if they are not competent to provide the ongoing services required. Pharmacists’ right to object on conscientious grounds ought to be protected because, while dispensing emergency contraception may seem to be more passive than performing an abortion, “both forms link the provider to the final outcome in the chain of causation.”132

Finally, “the right to refuse to participate in acts that conflict with personal ethical, moral, or religious convictions is accepted as an essential element of a democratic society.”133 It would be ironic to provide women with personal choice in her sexual health, while denying choice for pharmacists and physicians in health matters relating to emergency contraception.134

Conscientious objection clauses protect health care providers, depending on the wording and scope of the provision. However, these clauses are not without their opponents, who argue that they do not adequately protect women’s rights. The arguments will be discussed in Section 4.3.

130 Ibid. at 2009.
133 Cantor, supra note 129 at 2009.
134 Ibid. at 2009.
4 Restrictions on Health Care Professionals’ Freedom of Religion

Although it is important and necessary to protect the religious rights of health care providers, so too is it important to protect the right of autonomy over one’s body, the right to control reproduction, and the right to be free from the imposition of conscience-based directives from the state. Accordingly, religious rights are not absolute and may be limited by law and by ethical codes. In Canada, these restrictions are found in the Charter, human rights codes, and professional association standards. In the United States, these restrictions are found in jurisprudence, legislation and professional association standards.

4.1 Canada

4.1.1 Charter of Rights and Freedoms

While the Charter of Rights and Freedoms does protect health care providers’ right to religious freedom, it also limits that right. Section 1 of the Charter provides that:

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.

Section 1 is important because it is a guarantee and limitation provision that brings the Canadian Charter in line with other rights-protecting instruments created since World War II, which permits states to limit, but not totally abrogate, constitutional rights. Professor Lorraine Weinrib differentiates between limitation and abrogation by comparing them to the exception to

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135 Historically, there have been certain professions that cannot refuse to provide services or goods on the basis of discriminatory grounds. Justice Harlan, in his dissenting opinion, discussed this common law principle in relation to the profession of innkeepers in The Civil Rights Cases, 109 U.S. 3 (1883), referring to Rex v. Ivens, 7 Carrington & Payne, 213, 32 E.C.L. 495, Coleridge J:

[A] keeper of an inn is in the exercise of a quasi-public employment. The law gives him special privileges and he is charged with certain duties and responsibilities to the public. The public nature of his employment forbids him from discriminating against any person asking admission as a guest on account of the race or color of that person [emphasis added].

By analogy, physicians and pharmacists, who also play a public role in society, ought not to discriminate against any person requesting treatment on the basis that the health care provider’s own religious beliefs conflict with the treatment required.

136 Charter, supra note 55, s. 1.

a rule and the absence of a rule. She argues that the limitation section in the Charter actually strengthens the rights within the Charter:

A limitation attests to the primacy of that which it limits and maintains some conceptual continuity with it, coming into play only upon demonstration of stringent justifying conditions. In contrast, abrogation nullifies that which it abrogates.138

The limitation in s. 1 of the Charter, then, is not intended to abrogate the rights and freedoms in the Charter but to strengthen them. Professor Weinrib, quoting A.C. Kiss, writes:

…the normative force of the guarantee of the rights continues into the limitation analysis because “…the ultimate objective of the limitation clauses is not to increase the power of a state or government but to ensure the effective enforcement of the rights and freedoms of its inhabitants.”139

Accordingly, s. 1 of the Charter is important because it guarantees the rights and freedoms in the rest of the Charter; the limitation portion of s. 1 serves to strengthen that guarantee.

The proper test to be conducted under s. 1 was first developed by the Supreme Court of Canada in R. v. Oakes.140 First, the limitation in question must be “prescribed by law.” Second, it must be “reasonable” and “demonstrably justified in a free and democratic society.” The party seeking to uphold the limitation bears the onus of proving that it is reasonable and demonstrably justified in a free and democratic society.141 The standard of proof is the civil standard: proof on the balance of probabilities.142

The Supreme Court established a two-criteria test to determine whether a limit is reasonable and demonstrably justified. First, the objective of the limitation must be “pressing and substantial” to be sufficiently important to warrant potentially overriding a constitutional right.143 Second, the means used to achieve the pressing and substantial objective must meet a three-part proportionality test. First, the means must be “rationally connected to the objective.” Second, the means should “impair as little as possible” the right or freedom in question. Third, there

138 Ibid. at 121.
141 Ibid. at para. 66.
142 Ibid. at para. 67.
143 Ibid. at para. 69.
must be a proportionality between the effects of the measures and the objective. In other words, “The more severe the deleterious effects of a measure, the more important the objective must be if the measure is to be reasonable and demonstrably justified in a free and democratic society.”

The Oakes test has been refined in later cases. In the recent case of Alberta v. Hutterian Brethren of Wilson Colony, the Supreme Court relied on its earlier articulation of the test for when a publication ban is to be ordered in Dagenais v. Canada Broadcasting Corp. to refine the Oakes test. The first parts of the test are the same as in Oakes: it must be prescribed by law, the objective must be pressing and substantial, and the means by which the objective is met must be proportional. The proportionality test has the same three parts as in Oakes: is the limit rationally connected to the purpose; does the limit minimally impair the right; and is the law proportionate in its effect.

Rational connection requires a “causal connection between the infringement and the benefit sought on the basis of reason or logic.” The second part of the proportionality test can be rephrased as “whether there are less harmful means of achieving the legislative goal.” It is the third part of the proportionality test that has been refined in Hutterian Brethren, in which the Court relies most heavily on Dagenais. This part of the test takes account of the “severity of the deleterious effects of a measure on individuals or groups.”

This internal proportionality test also has three parts to it. First, the court must consider the salutary effects or benefits of the objective of the law. Second, the court must consider the seriousness of the negative effects of the limitations on the particular right or freedom. This

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144 Ibid. at para. 70.
145 Ibid. at para. 71.
146 Dagenais v. Canadian Broadcasting Corp., [1994] 3 S.C.R. 835 at 878 [Dagenais]. A publication ban is only to be ordered when it is necessary to prevent a “real and substantial risk to the fairness of the trial, because reasonably available alternative measures will not prevent the risk” and “the salutary effects of the publication ban outweigh the deleterious effects to the free expression of those affected by the ban.”
148 Ibid. at paras. 48, 53 and 73.
149 Ibid. at para. 48.
150 Ibid. at para. 53.
151 Ibid. at para. 76.
152 Ibid. at para. 79.
153 Ibid. at para. 87.
requires the court to consider the impact on the freedom of religion “in terms of Charter values, such as liberty, human dignity, equality, autonomy, and the enhancement of democracy.” The limitation is very serious if it amounts to state compulsion on matters of belief or if it creates a stark choice for the religious adherent to either violate her religious belief or disobey the law such that there is no meaningful choice. However, if the incidental effects of the law imposes a cost on the religious practitioner in terms of money, tradition, or inconvenience but still leaves the religious practitioner with a meaningful choice, the limitation may have less serious effects than if it effectively deprives the adherent of a choice. “The Charter guarantees freedom of religion, but does not indemnify practitioners against all costs incident to the practice of religion.” After considering the benefits and the seriousness of the limitations of the law, the court must then “balance these deleterious effects against the salutary effects of the law, in order to determine whether the overall impact of the law is proportionate.”

The Court generally is more deferential to the legislature when the Court is considering limitations on freedoms that were enacted to reconcile the rights of competing groups. Chief Justice Dickson phrased it this way in Edwards Books: “The courts are not called upon to substitute judicial opinions for legislative ones as to the place at which to draw a precise line.” The Court will not second-guess the legislature’s decision if it has been made based on a reasonable assessment of the competing claims. The Court stated, in Hutterian Brethren, that the courts would take a more deferential position when a complex regulatory response to a social problem is challenged. Accordingly, it is likely that the Court would be deferential to a legislature that enacted a law regulating the duties of health care providers respecting the provision of emergency contraception so as to balance the rights of two competing groups.

Professor Lorraine Weinrib argues against this deferential approach of the Court to judicial review. She argues that the deferential approach disregards the history and context leading up to the Charter’s adoption, particularly that the Charter intended to withdraw certain rights and

154 Ibid. at para. 88.
155 Ibid. at para. 91, 94.
156 Ibid. at para. 95.
157 Ibid. at para 100.
158 Edwards Books, supra note 72 at para. 147.
160 Hutterian Brethren, supra note 147 at para. 37.
freedoms from the ordinary political process; disregards the text which was explicitly drafted to protect rights; essentially creates a hierarchy of rights; and disregards the fact that the *Charter* redesigned the institutional structure in Canada. Judicial deference may be the conclusion of the analysis, but it is not a pre-emptive strike.\(^{161}\) Professor Weinrib further argues that when the Court interprets s. 1 as requiring deference to the legislature, “the Court enables the state to abrogate rights without paying the cost of using the override.”\(^{162}\) She concludes that judicial review is necessary to hold the legislature accountable and to protect rights and freedoms:

> Judicial review does not undermine the democratic function. On the contrary, it intensifies accountability and broadens representation. It thus legitimates the democratic, majoritarian process in an increasingly diverse and pluralistic society.\(^{163}\)

On this view, the Court should not be deferring to the legislature immediately, simply because it is mediating between two competing groups, such as health professionals and women requiring emergency contraception. Instead, the Court should conduct the appropriate test as set out in *Oakes* to determine whether a particular limitation on a right is reasonable and demonstrably justified.

The purpose of any restrictions on a health care provider’s freedom of religion is the protection of women’s rights, based on their personhood, specifically, their right to life, liberty and security of the person found in s. 7 of the *Charter*, and their equality rights, found in s. 15 of the *Charter*.\(^{164}\) A woman can claim autonomy over her body based on these rights, which includes the decision of whether to nurture a pregnancy. Women’s *Charter* rights are sufficiently important to justify some limitations on health care professionals’ right to freedom of religion, which includes the right to perform or abstain from performing certain actions in accordance with religious precepts. In this case, these actions based on religious precepts affect another person making an intimate and important life decision pertaining to autonomy and health. If a legislature were to enact a law that imposed a duty on health care professionals to provide

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\(^{161}\) Weinrib, “Paradigm Lost?” *supra* note 137 at 123-124.

\(^{162}\) *Ibid.* at 173.

\(^{163}\) *Ibid.* at 176.

\(^{164}\) *Charter, supra* note 55, s. 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.” *Charter, supra* note 55, s. 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.”
access to emergency contraception, the objective of the law, to protect women’s Charter rights, would likely be found to be “pressing and substantial.”

Such a law would then need to pass the three-part proportionality analysis as set out in Oakes. Is the pressing and substantial objective rationally connected to the means used? Do the means used impair as little as possible the rights of the health care providers? Do the benefits of the limitation, that is, providing timely access to emergency contraception, outweigh the harm of the limitation, preventing health care providers from fully following their religious belief? The outcome of this analysis would depend on the particular means used. The proposals I set out in Chapter 4 would likely be justified, as health care providers would not be compelled to provide emergency contraception against their religious objections, except in the case the alternatives cannot be met.

The case of Nichols is instructive, as it involved the Charter restricting the religious freedom of a public official. The complainants brought a complaint under the Saskatchewan Human Rights Code against Mr. Nichols, a marriage commissioner, for refusing to perform a civil marriage ceremony for them because they are a same-sex couple. Mr. Nichols accepted that the prohibition against discrimination in the Human Rights Code is a pressing and substantial objective, but argued that the lack of a defence based on religious freedom does more than minimally impair his freedom of religion and is not proportionate to the objective. However, the Court of Queen’s Bench of Saskatchewan held that being compelled by The Marriage Act to perform same-sex civil marriage ceremonies did not infringe Mr. Nichol’s freedom of religion. The judge concluded:

It seems to me that when Mr. Nichols acts as a marriage commissioner, his freedom of religion ought to be limited to exclude discrimination on the basis of sexual orientation. I agree with the tribunal that Mr. Nichols, in his capacity as a marriage commissioner acting as government, is not entitled to discriminate, regardless of his private beliefs.

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165 Nichols, supra note 92 at para. 1.
166 Ibid. at para. 63.
167 Ibid. at para. 73.
The question of marriage commissioners’ right to refuse to marry same-sex couples is currently in a reference to the Saskatchewan Court of Appeal. Accordingly, a public official’s religious beliefs can be limited and will not necessarily be protected by the Charter if those beliefs would result in discrimination based on a prohibited ground against another person.

So far in this Section, I have examined the way in which s. 1 of the Charter restricts the rights of health care providers, such as in the situation where a legislature enacts a legislative duty compelling them to provide emergency contraception. The Charter can also restrict the rights of health care providers in another way: if physicians are bound by the Charter as government actors because they are licensed and funded by the government, then they could be found to have breached the Charter rights of women to whom they refuse to provide emergency contraception.

The Charter applies to the government, government institutions, and government actors. The Supreme Court in Eldridge provided a framework for determining whether the Charter applies to a person or institution, and held that hospitals may be considered public entities for purpose of applying the Charter. The Charter may apply to an entity because the entity is “government,” either by its nature or by the degree of governmental control exercised over it. The Charter may also apply to an activity of an entity because that activity is “governmental” in nature. Finally, the Charter may apply to a public official because “the limitations on statutory authority which are imposed by the Charter will flow down the chain of statutory authority and apply to” public officials.

In Nichols, the Supreme Court applied the test in Eldridge to marriage commissioners and held that marriage commissioners also play a public role as they are implementing a specific government scheme, such that the Charter applies to them. Based on the criteria expounded in these two cases, I do not think it would be likely that the Charter would apply to physicians privately. In the case that it did apply to physicians, then a woman who was refused service

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170 Ibid. at para. 51.
171 Ibid. at para. 44.
172 Ibid. at para. 21.
173 Nichols, supra note 92 at para. 52.
could bring a claim alleging that the physician violated her s. 7 or s. 15 Charter rights. However, women in that position would be better served to use the Human Rights Code, as discussed in the next Subsection.

4.1.2 Human Rights Codes

Health care providers’ right to freedom of religion is not only limited by the Charter, it is also limited by legislation such as the Ontario Human Rights Code. Section 1 of that Act provides that:

   Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability.\(^{174}\)

If this section applies to the provision of emergency contraception, which I will argue that it does, then it limits health care providers’ freedom of religion.

For s. 1 of the Human Rights Code to apply to this situation, first it must apply to physicians and pharmacists. The Human Rights Tribunal of Ontario applied the Human Rights Code to a physician in Finan v. Cosmetic Surgicentre (Toronto).\(^{175}\) Since the Code could apply to a physician and a private clinic, it should be able to apply to physicians in private practice and at hospitals, as well as to pharmacies and pharmacists.

Next, the section applies to “everyone,” including women requiring emergency contraception. Third, there must be a refusal of services or goods for there to be a claim based on this section. If a physician refused to prescribe emergency contraception, there would be a refusal of services. If a pharmacist refused to fill a valid prescription for emergency contraception, there would be a refusal of services and/or goods.

Finally, there must be discrimination on one of the named grounds in s. 1. The Supreme Court of Canada, in Brooks v. Canada Safeway Ltd., held that discrimination on the basis of pregnancy is discrimination on the basis of sex.\(^{176}\) Since emergency contraception is used to prevent

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\(^{174}\) Ontario HRC, supra note 55, s. 1.

\(^{175}\) Finan v. Cosmetic Surgicentre (Toronto), 2008 HRTO 47 (CanLII) [Finan].

unwanted pregnancy, it is likely that a refusal to provide emergency contraception would be found to be discriminatory on the basis of sex, a prohibited ground under s. 1 of the *Human Rights Code*.

In *Finan*, the Human Rights Tribunal appropriated the framework for dealing with a claim under s. 1 of the *Human Rights Code* articulated by the Supreme Court in *British Columbia (Public Service Employee Relations Commission) v. BCGSEU* (“*Meiorin*”), and followed in *British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights)* (“*Grismer*”).

The Supreme Court stated the test in *Grismer* as follows:

> Once the plaintiff establishes that the standard is *prima facie* discriminatory, the onus shifts to the defendant to prove on a balance of probabilities that the discriminatory standard is a BFOR [bona fide occupational requirement] or has a *bona fide* and reasonable justification. In order to establish this justification, the defendant must prove that:

1. it adopted the standard for a purpose or goal that is rationally connected to the function being performed;

2. it adopted the standard in good faith, in the belief that it is necessary for the fulfillment of the purpose or goal; and

3. the standard is reasonably necessary to accomplish its purpose or goal, in the sense that the defendant cannot accommodate persons with the characteristics of the claimant without incurring undue hardship.

The Tribunal in *Finan* then applied this test to the facts at hand. The Tribunal found that there was *prima facie* discrimination on the basis of sex because the respondent surgeon refused to perform the surgery on the complainants because they were transsexuals. The Tribunal then considered whether the refusal of services was justified, using the *Grismer* test. First, the Tribunal found that the surgeon’s reasoning for refusing the medical services was “based upon protecting the health and safety of patients” and met the first test. Second, the Tribunal found as


179 *Finan, supra* note 175 at para. 40.
a fact that the surgeon acted in good faith. Third, the Tribunal found as a fact that the surgeon’s evidence regarding the limits of his skills and his clinic were sufficient to meet the third test, that he was not qualified to perform the surgeries. The Tribunal then found that the accommodation which the complainants wanted, namely, for the surgeon to “obtain significant new qualifications and training and change the nature of his practice, would have amounted to undue hardship.” Accordingly, the respondent surgeon justified his refusal of services and the Tribunal found that he did not violate the Human Rights Code.

In Nichols v. M.J., the Saskatchewan Court of Queen’s Bench held that there is nothing in Saskatchewan’s human rights code that provides a person who refuses goods or services on the basis of a ground of discrimination “with a defense of bona fide justification based upon his religious beliefs.” The Court went on to say, “Mr. Nichols has a personal right to freedom of religion, but it is not a right enforceable against M.J. It is not M.J. who is interfering with his religious beliefs, but the duties imposed upon him by The Marriage Act.” Although there is no defense of bona fide justification based on religious beliefs explicitly stated in the Ontario Human Rights Code, the Ontario Human Rights Tribunal in Finan nonetheless adopted a general defence of bona fide justification, as seen above.

Therefore, the Ontario Human Rights Code could be used against physicians and pharmacists for refusing to provide emergency contraception to women. When applying the framework as set out in Grismer to a physician or pharmacist who refuses to prescribe or dispense emergency contraception, first the plaintiff patient who was denied the service must prove prima facie discrimination, then the onus shifts to the health care professional to justify the refusal of service. It is likely that prima facie discrimination would be found because the refusal was on the basis of sex: only women can get pregnant, so only women are in need of emergency contraception and only women are negatively affected if their request for emergency contraception is denied. The offending health care provider would then have to justify her refusal according to the Grismer test. By analogy to Nichols, religious belief is not a legitimate purpose for refusing to provide medical services, so she may not be able to justify her refusal.

180 Ibid. at paras. 43-45, 49.
181 Ibid. at para. 50.
182 Nichols, supra note 92 at para. 56.
183 Ibid. at para. 56.
However, a human rights tribunal may find that a health care provider who refused to provide emergency contraception but followed the protocols set out in Chapter 4, below, did not violate the *Human Rights Code*.

### 4.1.3 Professional Association Standards

Ontario’s professional colleges and associations have created policies on these very ethical issues. While not binding as law, their policies can shed some light on the appropriate balance to strike between health care providers’ rights and the rights of patients. In general, they take the position that the patient’s care is to be of first and foremost importance. They do, however, allow for some degree of refusal of service, under certain conditions.

The College of Physicians and Surgeons of Ontario (“CPSO”) published a policy relating to the Ontario *Human Rights Code* in 2008.\(^\text{184}\) The policy states the law – that a physician may violate the *Code* if he or she refuses to provide a service or refuses to accept a patient on the basis of a prohibited ground, even if it is on the basis of a moral or religious belief – but does not provide any explicit advice as to how courts and human rights tribunals will interpret this law. The CPSO policy then lists its expectations for physicians who limit their practice, refuse to accept patients, or end a physician-patient relationship on the basis of moral or religious belief. The physician must clearly communicate to the patient any treatments or procedures she does not provide because of religious beliefs; provide information about all clinical options that are available to the patient, even if providing these treatments would be against the physician’s beliefs; treat patients with respect when they are obtaining the treatment or procedure to which the physician objects; refrain from expressing personal judgments about beliefs, lifestyle, or characteristics of the patient; and advise patients that they can see another physician with whom they can discuss their circumstances.\(^\text{185}\) Failing to maintain these standards of practice may classify as acts of professional misconduct.\(^\text{186}\)

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\(^{185}\) *Ibid.* at 3-4.

\(^{186}\) *Professional Misconduct*, O. Reg. 856/93.
The Ontario College of Pharmacists (the “OCP”) has two documents that are relevant to this issue: the Code of Ethics and the Standards of Practice. These documents set out the College’s position on ethical issues facing pharmacists. Principle Four of the Code of Ethics provides that each pharmacist must respect “the autonomy, individuality and dignity of each patient and provide care with respect for human rights and without discrimination.” Further, pharmacists cannot deprive patients of access to pharmaceutical services because of the personal convictions or religious beliefs of the pharmacist; if such a situation occurs, the pharmacist must “refer the patient to a pharmacist who can meet the patient’s needs.”

Standard Two of the OCP’s Standards of Practice provides that pharmacists must comply with legal requirements and ethical principles. Operational Component 2.2 provides that pharmacists must uphold the ethical principle that the pharmacist’s primary duty is to the patient, with respect to the right of the patient to make his or her own choices.

These codes of ethics and standards of practice are significant in that they reaffirm the principle that health care providers have rights to their religious and moral beliefs, but these beliefs cannot interfere with a patient’s rights to access medical and pharmaceutical services. As a result, these policies impose a duty to refer the patient to another health care provider to provide the services. In some cases, the provider must disclose the limits of her practice to the patient at the beginning of the relationship.

4.2 United States

4.2.1 Jurisprudence

The jurisprudence associated with religious freedom protections and restrictions in the First Amendment was discussed in Subsection 3.4.1. The Supreme Court has limited freedom of religion in free exercise cases:

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189 OCP, Code of Ethics, supra note 187.

190 OCP, Standards of Practice, supra note 188 at Standard 2, Operational Component 2.2.
Free exercise does not mean *carte blanche* permission to do whatever one wants in the name of religion. Or, as Douglas put it in *Sherbert*, “the Free Exercise Clause is written in terms of what the government cannot do to the individual, not in terms of what the individual can exact from the government.”

Non-constitutional jurisprudence also shows a common theme that “religion is a private affair that should not play a role in public life.”

This can be seen in American jurisprudence relating to contraception and religion.

In *Shelton v. University of Medicine and Dentistry of New Jersey*, a nurse in the labour and delivery unit of a state hospital was terminated after refusing to participate in emergency situations because she considered them to be abortions. She sued the hospital for religious discrimination under Title VII of the *Civil Rights Act*, 42 U.S.C. §2000e and under the First Amendment. The Court of Appeal for the Third Circuit dismissed the First Amendment claim because she did not prove that the hospital was not neutral with respect to religion. The Court also held that the hospital reasonably accommodated the nurse’s religious beliefs and practices and the nurse’s Title VII suit was dismissed.

Title VII of the 1964 *Civil Rights Act* requires reasonable accommodation of employee’s religious beliefs, unless to do so would result in “undue hardship” to the employer. The Court in *Shelton* found that the nurse established a *prima facie* case of religious discrimination because she held a sincere religious belief that conflicts with a job requirement; she informed her employer of the conflict; and she was ultimately terminated because of the conflict. Because the nurse established a *prima facie* case of religious discrimination, the hospital had the burden of proving it provided reasonable accommodation or that reasonable accommodation would amount to undue hardship. The Court held that the hospital did provide reasonable accommodation.

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191 Murray, *supra* note 94 at 159.
193 *Shelton v. University of Medicine and Dentistry of New Jersey*, 223 F.3d 220 (3d Cir. 2000) [*Shelton*].
196 *Ibid.* at paras. 1-8. The hospital allowed the nurse to trade assignments, but twice she refused to assist in emergency situations. The hospital then offered to transfer her to the Newborn ICU or to another department in the hospital, but said finances did not allow her to continue refusing assignments in the Labour and Delivery Unit. The nurse refused these offers, and she was terminated.
accommodation by offering to transfer the nurse to another department in the hospital at the same salary and seniority level.\textsuperscript{198} Accordingly, there is statutory protection of health care providers’ religious rights in the United States, but these rights are not absolute, and can be limited if reasonable accommodation would amount to undue hardship, or if the health care provider refuses to accept the reasonable accommodation.

In \textit{Noesen v. Medical Staffing Network Inc.}, a Federal Court judge held that a pharmacy did not violate a pharmacist’s religious freedom rights when he was fired for refusing to fill prescriptions for contraceptives and failing to find another pharmacist to replace him.\textsuperscript{199} The pharmacy had accommodated Mr. Noesen by allowing him to refuse to fill such prescriptions, but required him to pass the prescription on to the other pharmacist on duty to deal with contraceptive matters. Mr. Noesen refused to do that and became disruptive, at which point he was terminated. He brought a suit under Title VII of the \textit{Civil Rights Act}, 1964, but the judge found that he did not establish \textit{a prima facie} case because he failed to show that he had been treated differently than non-Catholics. As well, the pharmacy had accommodated his religious beliefs and had legitimate non-discriminatory reasons for terminating Mr. Noesen.\textsuperscript{200} Therefore, while health care providers are entitled to accommodation of their religious beliefs, they are not entitled to ignore patients who require treatment or services with which the provider disagrees.

4.2.2 Legislation

A few states have passed legislation that requires pharmacists or pharmacies to fill all valid prescriptions, and some specifically mention emergency contraception. These states include California, Illinois, New Jersey and Washington.\textsuperscript{201} The relevant portions of these Acts are set out in Appendix A, below.

\textsuperscript{198} \textit{Ibid}. at paras. 25 and 31.


\textsuperscript{200} \textit{Ibid}.

\textsuperscript{201} Guttmacher Institute, “Refusal of Services,” \textit{supra} note 113 at 2.

Cal. Bus. & Prof. code § 733 [Cal. Code].

Ill. admin. code tit. 68, § 1330.91(j) and (k) (2007) [Ill. Admin. Code].

\textit{Health Care Right of Conscience Act}, 745 Ill. Comp. Stat. § 70/1-14, s. 6 [Ill. HCRCA].
California’s law imposes a duty on pharmacists and pharmacies to dispense drugs that are validly prescribed; however, a pharmacist may refuse to fill certain prescriptions on ethical, moral or religious grounds, if certain conditions are met. Further, it constitutes unprofessional conduct for a pharmacist to obstruct a patient from obtaining a prescription drug that has been validly prescribed. No other state has imposed such duties directly on the individual pharmacist; the other states impose the duty on the pharmacy.

Illinois, for example, brought a law into effect on April 16, 2008 that provides that a public retail pharmacy must dispense the contraceptive when presented with a valid prescription. Individual pharmacists are allowed to object to filling prescriptions for contraceptives, but if they do, the pharmacy must follow a particular protocol set out in the Act. Finally, every pharmacy must prominently display a notice setting out the patient’s rights with respect to contraception. However, as a counterbalance to the duty imposed on pharmacies, Illinois’ Health Care Right of Conscience Act provides that physicians are “under no duty to perform, assist, counsel, suggest, recommend, refer or participate in any way in any form of medical practice or health care service that is contrary to his or her conscience.” As well, physicians and health care personnel (which arguably could include pharmacists as “any other person who

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202 Cal. Code, supra note 201, § 733(b)(3). The conditions include: The pharmacist must notify her employer in writing of her objections and list the drugs to which she objects. The employer must be able to provide reasonable accommodation of the pharmacist’s objection, without creating undue hardship, for the pharmacist to be able to refuse to fill certain prescriptions. Finally, the employer must establish protocols that ensure that the patient has timely access to the medication despite the pharmacist’s refusal.

203 Ibid., § 733(a).

204 Ill. Admin. Code, supra note 201, § 1330.91(j)(1).

205 Ibid., § 1330.91(j)(3) and (4). The protocol involves requesting non-objecting pharmacists in the dispensing pharmacy to fill the prescription, or if there is no non-objecting pharmacist available, any other pharmacy can perform “remote medication order processing” (“RMOP”), which is essentially an electronic means to have another pharmacy fill the prescription. As well, pharmacies must ensure either that there is a non-objecting pharmacist scheduled at all times the pharmacy is open, or that there is a non-objecting pharmacist available at another pharmacy who can perform RMOP at any time when there is no non-objecting pharmacist at the dispensing pharmacy.

206 Ibid., § 1330.91(k).

207 Ill. HCRCA, supra note 201, s. 6.
furnishes … health care services”) are not liable to any person for refusing to perform, assist, recommend or refer any health care service on the grounds of conscience.\textsuperscript{208}

As another example, the Washington State Board of Pharmacy adopted two rules by unanimous vote on April 12, 2007. The first rule, an amendment to Washington Administrative Code section 246-863-095, provides that pharmacists may be subject to professional discipline for “destroying or refusing to return an unfilled lawful prescription, violating a patient’s privacy, or unlawfully discriminating against, or intimidating or harassing a patient.”\textsuperscript{209} However, pharmacists are not required to dispense medication if they object to it. The second rule, Washington Administrative Code section 246-869-010, requires pharmacies to dispense validly prescribed drugs in a timely manner, and apart from certain exceptions, a pharmacy cannot refuse to dispense lawfully prescribed medications.

A Washington pharmacy sought an injunction against the enforcement of the second of these new rules.\textsuperscript{210} The pharmacy challenged the rules on the basis that they interfere with their constitutional right of free exercise of religion because the rule forces them to choose between their religious beliefs and their livelihood.\textsuperscript{211} The owner of the pharmacy in question, Stormans, believes that life begins at fertilization, and because Plan B can prevent a fertilized egg from implanting, he will not sell Plan B.\textsuperscript{212} On November 8, 2007, the District Court found that the rules violated the pharmacies’ free exercise rights under the First Amendment and issued an order granting a preliminary injunction against the enforcement of the rule.\textsuperscript{213} The decision was appealed and the Court of Appeal held that the rule was a “neutral rule of general applicability.” The Court of Appeal stated:

That the rules may affect pharmacists who object to Plan B for religious reasons does not undermine the neutrality of the rules. The Free Exercise Clause is not

\textsuperscript{208} Ibid., ss. 3 and 4.
\textsuperscript{209} Stormans, Inc. v.Selecky, 586 F.3d 1109 (9th Cir. 2009), rev’g 524 F.Supp.2d 1245, 1250 (W.D. Wash. 2007) at 8446 [Selecky, cited to 9th Cir.]. Washington Administrative Code section 246-869-010 imposes the same duty on pharmacies as the first rule does on pharmacists to not destroy or refuse to return prescriptions, violate patients’ privacy, or discriminate against or intimidate or harass patients.
\textsuperscript{210} Ibid.
\textsuperscript{211} Ibid. at 1117.
\textsuperscript{212} Ibid. at 1117.
\textsuperscript{213} Ibid. at 1118.
violated even though a group motivated by religious reasons may be more likely to engage in the proscribed conduct.  

The Court of Appeal sent the case back to the District Court to determine whether the rules are rationally related to a legitimate government purpose. As well, the preliminary injunction was reversed, except to apply to the parties to the litigation.

The United States Congress has also, unsuccessfully, attempted to pass legislation establishing duties for pharmacies when pharmacists refuse to fill valid prescriptions such as those for emergency contraception on grounds of their personal beliefs. The Bill would have added section 249 to Part B of title II of the Public Health Service Act. Section 249 would have provided pharmacists with the right to refuse “on the basis of a personal belief to fill a valid prescription” as long as the pharmacy ensures that the prescription is filled without delay by another pharmacist employed by the pharmacy. As well, pharmacists would be prohibited from refusing to return the prescription to the patient, to transfer the prescription information to another pharmacy if requested, and subjecting the patient to humiliating treatment. The provisions were to be enforced by a civil penalty and the right of a private action.

These American legislative provisions balance the rights of health care providers to refuse to provide certain health care services, while ensuring that patients obtain appropriate care, by placing the duty on the pharmacy, rather than on the pharmacist. I will incorporate these legislative initiatives in my proposals in Chapter 4.

4.2.3 Professional Association Standards

The United States’ professional colleges and associations, like Canada’s, have created policies on these ethical issues. The non-binding policies differ somewhat from those in Canada, but are

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214 Ibid. at 1131.
215 Ibid. at 1138. The District Court’s new decision is pending as of May 2010.
216 Ibid. at 1142.
218 Ibid.
219 Ibid. at proposed 42 U.S.C. 238, s. 249(a)(1).
220 Ibid. at proposed 42 U.S.C. 238, s. 249(a)(3).
221 Ibid. at proposed 42 U.S.C. 238, s. 249(c).
largely similar, allowing for some degree of refusal of services, while maintaining the importance of the patient’s care.

The Code of Ethics of the American Pharmacists’ Association (“APA”) provides that a pharmacist must be “dedicated to protecting the dignity of the patient” and serve the patient with a “caring attitude and a compassionate spirit.” Accordingly, pharmacists must not humiliate patients if they are refusing to provide emergency contraception. As well, pharmacists must avoid “discriminatory practices, behavior or work conditions that impair professional judgment, and actions that compromise dedication to the best interests of patients.” Finally, pharmacists are recommended to refer patients to another pharmacist or health professional, where appropriate. According to the Code of Ethics, pharmacists may be able to refuse to provide emergency contraception to patients, but they must do so in a kind and respectful manner, and refer the patient to another pharmacist.

The American Medical Association (“AMA”) has also published a Code of Medical Ethics, based on a number of Principles of Medical Ethics. While physicians have the right to choose whom to serve, they cannot refuse to care for patients on the basis of “race, gender, sexual orientation” or other grounds of discrimination. Nonetheless, it may be ethically permissible for physicians to decline a potential patient when “a specific treatment sought by an individual is incompatible with the physician’s personal, religious, or moral beliefs.” However, once a physician-patient relationship has begun, the physician must not neglect the patient, and can only withdraw from a case if she gives notice to the patient, relatives or

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223 Ibid., s. IV.
224 Ibid., s. VI.
226 Ibid. at Opinion 10.05(1), (2)(b), (3)(c).
responsible friends sufficiently in advance for the patient to obtain another physician.\textsuperscript{227} As well, patients have the right receive information about treatment and procedural options from physicians, even if those options go against the physicians’ beliefs. Patients have the right to courtesy, respect, dignity, timely attention to their needs, and to have their autonomy respected.\textsuperscript{228} According to the Code of Medical Ethics, physicians may be able to refuse certain services or treatments to patients on the grounds of religious belief, but they must make the refusal known in a respectful manner, provide information about the treatment, and cannot withdraw from the physician-patient relationship without sufficient notice.

In the specialty of obstetrics and gynecology, there has been some debate over the limits of conscientious objections. The American College of Obstetricians and Gynecologists (“ACOG”) came out with an opinion on the limits of conscientious objection in 2007.\textsuperscript{229} The Opinion identifies four criteria to determine the limits of conscientious objections: potential for imposition of the physician’s beliefs on the patient, and denigrating respect for patient autonomy; effect on the patient’s health and the potential to do harm; lack of scientific evidence supporting the rationale behind the conscientious objection; and potential for discrimination.\textsuperscript{230} The Opinion recommends that conscientious objections be accommodated only if the primary duty to the patient’s well-being is fulfilled, which means that physicians may have to provide services against their beliefs in an emergency situation. As well, physicians must provide all scientifically relevant medical information to the patient, and give prior notice to patients about their refusal of certain services, while referring them to another provider in a timely manner, ensuring that their refusals do not limit women’s access to those services.\textsuperscript{231}

In 2008, the American Association of Pro-Life Obstetricians and Gynecologists (the “AAPLOG”) came out with a letter responding to this policy.\textsuperscript{232} The AAPLOG argues that

\begin{footnotes}
\item[227] Ibid. at Opinion 8.11, 8.115.
\item[228] Ibid. at Opinion 9.123, Opinion 10.01(1), (3), (5), 10.02.
\item[230] Ibid. at 3-4.
\item[231] Ibid. at 7.
\item[232] American Association of Pro-Life Obstetricians and Gynecologists, “AAPLOG response to the ACOG Ethics Committee opinion #385: The limits of conscientious refusal in reproductive medicine” (Holland, Michigan: AAPLOG, 2008), online: AAPLOG \url{http://www.consciencelaws.org/Examining-Conscience-Ethical/Ethical79c.htm} [AAPLOG Response].
\end{footnotes}
ACOG should consider the potentially controversial medical evidence that abortions may lead to complications in future pregnancies, as a balance to ACOG’s position. Further, the AAPLOG argues that ACOG’s stance that patient autonomy should take precedence over all other medical ethical principles is an unbalanced approach. Rather, AAPLOG states that where opinions differ, the patient is free to seek a second opinion.\(^{233}\) As can be seen from these two documents, professional opinions regarding reproductive services and the limits of conscientious objections are deeply engrained and at odds with each other. I will take into consideration some of the recommendations and arguments put forth by both groups in Sections 5 and 6, below.

### 4.3 Arguments against American Style Refusal Clauses

Just as there are valid reasons to have conscientious objections, there are also valid reasons why conscientious objections should not be worded too broadly. A number of scholars have argued against the American style refusal clause as set out in some states’ conscientious objection legislation on the grounds that they lean too far on the side of health care professionals’ rights, potentially harming women.

Bernard Dickens argues that some conscientious objection clauses abuse the principle of anti-discrimination by reversing the usual roles. Anti-discrimination laws are intended to protect “less powerful people from oppression by the more powerful.” However, conscientious objection legislation is designed to protect physicians and health care providers, typically those in a more powerful relationship vis-à-vis their patients, from being discriminated against because of their religious beliefs, and “to exploit the dependency and inferior status of patients, primarily women, who want access to reproductive health services.” Dickens goes on to write: “Enactment of laws to empower individuals to subordinate others to their preferences by denial of medically indicated care, especially which they enjoy a legal monopoly to provide is an abuse of the anti-discrimination principle.”\(^{234}\)

Elizabeth Fenton and Loren Lomasky set out a number of arguments and counterarguments against conscientious objections for pharmacists. First, pharmacists are not judges or ethical

\(^{233}\) *Ibid.*

committee members, so they should not judge patients who come in to have their prescriptions filled. On the other hand, pharmacists are professionals, and like physicians, they have the ability to choose whom to serve. However, some argue that pharmacists are not professionals, but merely technicians doling out drugs. On that view, pharmacists do not exercise independent judgment and should not be allowed to refuse on moral or religious grounds. Second, the pharmacy profession is like a guild, as pharmacists are protected from competition from non-pharmacists. Physicians, too, have a legal monopoly over certain medical services. If physicians or pharmacists withhold services, their patients may be harmed, if they have nowhere else to turn.

Professor Charo expands on the notion of health care professions as guilds. She argues that the public licensing systems of physicians and pharmacists complicates the claim for conscientious objections: “such a claim would be easier to make if the states did not give these professionals the exclusive right to offer such services.” She goes on to write: “Claiming an unfettered right to personal autonomy while holding monopolistic control over a public good constitutes an abuse of the public trust.”

Sarah Tomkowiak argues that some conscientious clause legislation strikes the wrong balance between patients’ rights and health care professionals’ rights. For example, some legislation allows health care providers the right to refuse on the basis that they “believe” the treatment “might cause an abortion.” Others, such as Mississippi’s legislation, lack the duty to refer to another professional for the treatment. Mississippi’s health care conscientious objection legislation does not prevent discrimination on the basis of marital status, nor does it require pharmacists to transfer prescriptions to another pharmacy or pharmacist if they object to the prescribed medication. When pharmacists refuse to transfer prescriptions, and legislation condones these refusals, pharmacists are violating the American Pharmacists Association’s

235 Fenton, supra note 4 at 581-582.
237 Fenton, supra note 4 at 586.
Code of Ethics, by putting the pharmacist’s beliefs ahead of the patient’s rights. Some conscience clauses that allow pharmacists to refuse to dispense emergency contraception do not impose a duty on the pharmacist to transfer the prescription or refer to another pharmacist; they do not require that the patient receive advance notice of the pharmacist’s refusal; and they do not have an exception for women who are sexually assaulted. These conscientious objection clauses equate to sexual discrimination because only women can get pregnant, only women will need to go back to the physician to get a new prescription if a pharmacist refuses to return it, and only women are humiliated when they are turned away. One hundred percent of patients directly affected by refusal clauses are women. Tomkowiak argues that a duty to transfer may not be sufficient, as it assumes there is always another pharmacist on duty and available; however, there may not be alternatives near by, particularly in rural and low-income areas.

Julie Cantor and Ken Baum list a number of arguments against a pharmacist’s right to object. First, pharmacy is a profession bound by fiduciary duties. Professional codes of ethics provide that pharmacists will put the patient’s needs above their own. The same can be said for physicians. Both know that they will be bound by these fiduciary duties when they enter the profession. Second, they argue that emergency contraception is not an abortifacient. This may be the case, particularly for Plan B, but does not hold true for abortifacient drugs. Third, pharmacists’ objections can significantly affect patients’ health. A refusal to provide emergency contraception may lead to a woman having to resort to abortion to terminate an unwanted pregnancy. As well, in rural or low-income areas, women may not have any other options, if a pharmacist refuses to provide them with emergency contraception. This is all the more important when one considers that Plan B must be taken within 72 hours of intercourse to be effective.

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240 Ibid. at 1345.
241 Grealis, supra note 236 at 1723.
242 Tomkowiak, supra note 239 at 1346-1347.
243 Ibid. at 1348.
244 Cantor, supra note 129 at 2009.
245 Ibid. at 2009.
247 Cantor, supra note 129 at 2009-2010.
As we have just seen, there are many arguments against refusal clause legislation, although most of these objections are raised against legislation that does not adequately protect women’s rights to health care services. This Chapter has emphasized that the rights of health care providers and of female patients do conflict, and legislatures and professional associations have taken different routes to attempt to balance these rights. The next Chapter will consider ways to reconcile these conflicting rights.
Chapter 4
Reconciling Freedom of Religion with Reproductive Rights

Although there is an undeniable conflict between health care providers’ right to freedom of religion and the rights of women to access emergency contraception in a timely manner, the conflict is not insurmountable. In this Chapter, I propose one solution in which the rights of health care providers and women can be reconciled. I begin the Chapter with a discussion of the analogous situation of marriage commissioners and same-sex marriage ceremonies. In Section 5, I discuss the possibility of establishing a duty of prior disclosure, a duty to refer, and a limited duty to prescribe or dispense in rare circumstances. In Section 6, I discuss practical issues relating to the establishment of a delivery system of emergency contraception so as to protect health care providers’ right of refusal.

The problem of balancing health care providers’ freedom of religion with women’s rights to access emergency contraception in a timely manner is similar to the situation facing marriage commissioners after the legalization of same-sex marriage. Marriage commissioners in Manitoba, Saskatchewan and Newfoundland were told that they had to resign if they were not prepared to perform same-sex civil marriages on religious grounds. They filed human rights complaints in Manitoba and Saskatchewan but their complaints were dismissed without a hearing.248 Orville Nichols is one such marriage commissioner; his appeal to the Court of Queen’s Bench of Saskatchewan was also dismissed.249 However, the Saskatchewan Government has proposed two versions of a bill amending the Marriage Act to allow for a right of religious refusal to performing same-sex marriage ceremonies: one version gives the right only to those marriage commissioners appointed before same-sex marriage was legalized, the other to all marriage commissioners.250 The Government of Saskatchewan referred the question

248 Ryder, supra note 66 at 100.
249 Nichols, supra note 92.
250 Marriage Act Reference, supra note 168, Sched. A and B.

Schedule A: An Act to Amend The Marriage Act, 1995, s. 4, which adds a new section 28.1 to the Act. The relevant portion reads:

28.1(1) Notwithstanding The Saskatchewan Human Rights Code, a marriage commissioner who was appointed on or before November 5, 2004 is not required to solemnize a marriage if:
(a) to do so would be contrary to the marriage commissioner’s religious beliefs; and
(b) the marriage commissioner has filed the notice mentioned in subsection (2) within the period mentioned in that section.
of whether one or both versions of the proposed bill are consistent with the Charter to the Saskatchewan Court of Appeal on June 30, 2009. The Court of Appeal heard oral arguments on May 13 and 14, 2010, and the decision is currently reserved.

Bruce Ryder summarized the problem as follows: “Religious public servants…are being asked to choose between keeping their jobs and acting in accordance with their religious beliefs.” Ryder argues that there need not be such a stark choice. He proposes that the religious rights of public servants and the rights of same-sex couples to have equal access to civil marriage can both be affirmed by providing a right of religious refusal and ensuring that same-sex couples obtain their marriage ceremony without undue delay or inconvenience. This could be done by having the refusal right apply only to those already appointed as marriage commissioners prior to the legalization of same-sex marriage. Moving forward, governments could appoint only those who do not oppose same-sex marriage. However, if a right of religious refusal cannot be exercised without compromising equal access to civil marriage, then marriage commissioners could be compelled to perform same-sex civil marriage ceremonies because “freedom of religion does not extend to violating the equality rights of others.”

Just as there can be compromise to reconcile the rights of religious marriage commissioners with those of same-sex couples wishing to marry, there can be compromise to reconcile the rights of religious health care providers with the rights of women. In the following sections, I propose a set of duties and practical delivery system to achieve this reconciliation.

Schedule B: An Act to Amend The Marriage Act, 1995, s. 4, which adds a new section 28.1 to the Act. The relevant portion reads:

28.1 Notwithstanding The Saskatchewan Human Rights Code, a marriage commissioner is not required to solemnize a marriage if to do so would be contrary to the marriage commissioner’s religious beliefs.

251 Marriage Act Reference, supra note 168.
253 Ryder, supra note 66 at 100.
254 Since O’Malley, employees have had the right “to object to the performance of job duties on religious grounds, and employers have an obligation to accommodate them if they can do so without undue hardship.” Ryder, supra note 66 at 101, referring to O’Malley, supra note 90.
255 Public employees already appointed as marriage commissioners “are not required to leave their faith at home simply because they are working for the ‘secular’ state.” Ryder, supra note 66 at 102.
256 Ibid. at 101.
5  Duty of Disclosure and Duty of Referral

I propose that the ideal solution to reconcile freedom of religion with reproductive health rights is to allow health care practitioners to object to providing emergency contraception as long as they disclose this objection before taking on patients, disclose all possible treatments to their patients, and refer patients to another nearby practitioner. Employers have a duty to accommodate their objecting employees. In certain rare circumstances, such as in isolated geographical areas, the right of refusal will not be allowed. Physicians and pharmacists must continue caring for the patient, if they are already in a patient-provider relationship, regardless of whether the patient undergoes certain treatments to which the provider objects. This solution strikes a balance between the two conflicting rights, comes from the experiences of the American conscientious objection legislation, is in line with constitutional rights and freedoms, and is largely supported by the many scholars who have written on this subject, in particular, Rebecca Cook and Bernard Dickens in Canada, and Catherine Grealis in the United States.

My recommendation treats the duty of prior disclosure and the duty to refer as ethical duties, but to be sufficiently effective at protecting the rights of health care providers and the rights of women, they should be enacted as law. These duties will be discussed in the context of emergency contraception, but can be expanded to include abortion, sterilization procedures, in vitro fertilization procedures, euthanasia, and other controversial medical practices.

Catherine Grealis recently proposed a new version of conscientious objection legislation, relating specifically to pharmacies and pharmacists. I set out her proposal in full in Appendix A. The general provision allows the pharmacist the right to not dispense any prescription drug that violates her beliefs, as long as the refusal is not based on a prohibited ground of discrimination. The next provision sets out the obligations of the pharmacist-employee to report her intention to the state pharmacy board and her employer. If a non-objecting pharmacist is not available at the time, the objecting pharmacist must either transfer the prescription to another pharmacy or refer the patient to another pharmacy. The third provision sets out the obligations

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of the pharmacy-employer to provide notice to patients if it chooses not to stock certain medications. The final provision sets out the obligations of state pharmacy boards to provide a list of pharmacies that do carry emergency contraception to physicians and health care providers in the state, so physicians can provide that information to patients when prescribing the medication.\textsuperscript{259}

This proposed legislation strikes a balance between pharmacists’ right of conscience and patients’ rights to emergency contraception. An analogous provision could be drafted for physicians who refuse to prescribe emergency contraception, where a prescription is needed, and abortifacient drugs. There could also be a limited duty to dispense provision, which would require pharmacies (and potentially pharmacists) within limited geographical areas that lack sufficient pharmacists to whom patients could be referred.

These duties should be enacted as law because there will be health care providers who will not abide by them if they are merely ethical duties. An American study has shown that 86% of physicians who objected to a procedure on moral or religious grounds believe that physicians are obligated to present the legal medical procedure, even if they object, and 71% believe that they must refer the patient to a non-objecting provider.\textsuperscript{260} According to this study, 14% of American patients are being treated by physicians who do not believe they must disclose all treatments, and 29% of American patients are being treated by physicians who do not believe they must refer their patients to a non-objecting provider. To protect this substantial portion of the population, it would be ideal to make the duties of disclosure and referral legal obligations.

Physicians, pharmacists and patients can avoid having to meet these duties through mutual accommodation: physicians and pharmacists have the right to choose whom to treat, excepting emergencies, and patients have the right to choose whom to see for treatment. However, even if selecting patients, practitioners still owe a duty to disclose to potential patients the services and treatments to which the practitioner objects.\textsuperscript{261} The following duties are required so as to give

\textsuperscript{259} Grealis, \textit{supra} note 236 at 1734-1735.
\textsuperscript{261} Cook and Dickens, “Growing Abuse,” \textit{supra} note 246 at 337.
priority to the patient’s well being.\textsuperscript{262} Also, if health care practitioners require respect for their rights and freedoms, they must respect the rights and freedoms of others, including their patients and potential patients.\textsuperscript{263} Accordingly, health care practitioners must treat everyone who comes to see them with respect and without judgment. Respect for both parties’ rights can be attained through the ethical and legal duties of prior disclosure and referral.

### 5.1 Duty of Disclosure

The duty of disclosure consists of two duties. First, health care providers must tell prospective patients the services to which they object. Second, health care providers must disclose all possible treatments and procedures, even those to which they object, to their current patients.

In more concrete terms, physicians must tell prospective patients that they will not prescribe emergency contraception such as abortifacient drugs, and pharmacies must post notices that they do not stock emergency contraception. Pharmacists must tell their employers, in writing, that they object to filling prescriptions for emergency contraception. Health care providers must disclose all potential treatments and medications, even if the treatments are contrary to the providers’ beliefs.\textsuperscript{264}

This duty is in line with the College of Physicians and Surgeons of Ontario Code of Ethics and with a number of scholarly articles. Prior knowledge of limitation of practices is accepted in medical circles, as pediatricians are not expected to provide geriatric care, and geriatricians are not expected to give pediatric care.\textsuperscript{265} Accordingly, physicians should make it known before they accept responsibility for a patient that they will not prescribe emergency contraception.

Pharmacies should give clear notice that they do not stock emergency contraception, and pharmacists should give notice to their employers.\textsuperscript{266} Pharmacies can give notice by ensuring there is a prominently displayed sign in the front window and at the prescription counter that says:

\begin{quote}
\end{quote}

\textsuperscript{262} Dickens, “Legal Protection,” \textit{supra} note 234 at 345.
\textsuperscript{264} Cook, “Health Care Responsibilities,” \textit{supra} note 257 at 251.
\textsuperscript{265} Cook and Dickens, “Growing Abuse,” \textit{supra} note 246 at 337.
\textsuperscript{266} Tomkowiak, \textit{supra} note 239 at 1359.
We do not provide emergency contraception. Please call the Canadian Federation for Sexual Health (Planned Parenthood) national emergency contraception toll-free line at 1-888-270-7444 or visit the Emergency Contraception Web site at http://www.cfsh.ca/ or www.not-2-late.com for assistance.\textsuperscript{267}

The first website answers questions on emergency contraception and provides links to Planned Parenthood and sexual health organizations across Canada. The second site is American but provides friendly advice regarding emergency contraception. Because there is a narrow time frame of 72 hours in which a woman must take Plan B, simply providing such general information may not be enough. It would be preferable for each objecting pharmacy to tailor its notice so as to provide the contact information for the local Planned Parenthood organization as well as the nearest non-objecting pharmacies. In addition, in remote areas where the main or only pharmacy objects to emergency contraception, non-objecting physicians could dispense Plan B to women in advance, and prioritize appointments for women who need to obtain Plan B. The names and contact information of such physicians should also be listed on objecting pharmacies’ notices.

This ethical duty of prior disclosure is based on respect for the patient’s dignity as a person and the patient’s autonomy, by providing her with the information she needs to choose a physician and a pharmacist.\textsuperscript{268}

5.2 Duty of Referral

The second duty health care providers must fulfill if they object to emergency contraception on religious or moral grounds is the duty to refer in good faith. After a physician has formed a relationship with a patient, she is obligated to refer the patient to another, non-objecting, practitioner if she objects to a treatment that the patient wants.\textsuperscript{269} After a patient has approached a pharmacist for emergency contraception, the pharmacist is required to refer her. Pharmacy owners can refer to another nearby pharmacy; pharmacist employees can ask a colleague to fill the prescription.\textsuperscript{270} In all cases, the referral must be within certain geographical restrictions, taking into account the patient’s convenience.

\textsuperscript{267} Cantor, supra note 129 at 2011.
\textsuperscript{268} Dickens, “Legal Protection,” supra note 234 at 345.
\textsuperscript{269} Cook and Dickens, “Growing Abuse,” supra note 236 at 337.
\textsuperscript{270} Dickens, “Legal Protection,” supra note 234 at 344.
Some health care providers may oppose the duty to refer on the ground that they will be complicit in the actions following the referral. Rebecca Cook and Bernard Dickens argue against this position: just as the referring physician does not share in the referred physician’s fees or negligence, she does not share in the referred physician’s provision of emergency contraception. 271 F.A. Chervenak and L.B. McCullough also argue against the position that referral necessarily makes the referring physician complicit in the action. They create a distinction between active referral and passive referral. Active referral requires the physician to ensure that the patient receives prompt care. 272 Passive referral only requires the physician to give the patient the referral information. 273 Active referral is required when medical treatment is beneficence-based, meaning treatment is required by “evidence-based clinical judgment.” Such is the case in a situation where a patient shows the symptoms of appendicitis, or where the continuation of a pregnancy poses a grave threat to the woman’s life or physical health. 274 Passive referral is required when there are autonomy-based indications. In other words, medical treatment is not beneficence-based but is clinically safe and appropriate to achieve the patient’s goals. This includes cosmetic surgery and elective abortions. Because there is no clinical evidence for the physician to determine whether a pregnant woman should nurture or terminate the pregnancy, the only criterion is the woman’s choice. The woman makes her choice based on fundamental beliefs, so the physician cannot discriminate on the basis of these beliefs and must treat them with respect. The physician’s only fiduciary obligation is to “empower the exercise of autonomy by the patient, by giving the patient referral information, without taking any additional steps to ensure the referral actually occurs.” 275 Accordingly, the physician only has to provide referral information to competent organizations, such as Planned Parenthood. The physician is not being complicit when giving indirect referrals, because whether the patient undergoes the procedure or not is the patient’s choice, an exercise of her autonomy. 276

271 Cook and Dickens, “Growing Abuse,” supra note 246 at 337.
273 Ibid. at 232.e2.
274 Ibid. at 232.e1.
275 Ibid. at 232.e2.
276 Ibid. at 232.e2.
Therefore, conscientious objection legislation that does not include the duty of referral violates a basic medical ethic of respecting the patient’s autonomy. All professional association codes of ethics that were discussed above require health care providers to refer patients to another practitioner if they object to the treatment. By following the duty of referral, health care providers would also be complying with human rights laws in Ontario.

5.3 Limited Duty to Dispense or Prescribe

While in most cases, the right of refusal exists subject only to the duties of disclosure and referral, in certain areas and circumstances, such a right will not exist. In other words, I propose a duty to dispense or prescribe emergency contraception such as Plan B in rural or isolated communities. This duty exists at the institutional level, so if a pharmacy or hospital has at least one non-objecting provider available, an objecting provider still has a right of refusal.

If, however, there were only one health care provider in a given rural or isolated area, that provider would have to dispense the emergency contraception, even if she objects to it.

Duties to dispense are already in place in some state legislation. Conscientious objection legislation in New Jersey and Illinois place a duty to dispense on all pharmacies, and California’s legislation places the duty to dispense on all pharmacists.

However, I do not propose a blanket duty to dispense on all pharmacists, or even all pharmacies and hospitals, but only those pharmacies and hospitals in rural or isolated areas where referrals would not be sufficient to protect women’s rights. A blanket duty to dispense is unnecessary because there are very few areas where there would not be another option available, and the religious rights of the providers ought to be infringed as minimally as possible. As well, the limited duty will minimize the negative economic effect on small pharmacies, as they may need to hire more pharmacists and keep medications in stock that they would not normally carry.

277 Cook and Dickens, “Growing Abuse,” supra note 246 at 339.
278 See Section 4.1.3 and 4.2.3 above.
279 See Section 4.1.2 above.
280 This discussion applies only to Plan B. For a discussion on the possibility of a duty to prescribe abortive pills, and why I do not propose such a duty, please see page 62 below.
281 Tomkowink, supra note 239 at 1350-1352, 1355.
282 See Section 4.2.2 above.
283 Cantor, supra note 129 at 2010-2011.
284 Grealis, supra note 236 at 1733.
Accordingly, the duty is a geographically limited policy of compulsion, only in areas where women would suffer significant hardship if pharmacists were not compelled to provide emergency contraception.\textsuperscript{285}

Imposing a duty on institutions such as pharmacies and hospitals may spare objecting pharmacists who work with non-objecting pharmacists; however, it may cause a problem for small pharmacies owned by those with moral or religious objections to emergency contraception and for Catholic or other religious hospitals. On the other hand, as Bernard Dickens argues, pharmacies and hospitals are institutions without souls, unlike the physicians and pharmacists who staff them. Accordingly, since institutions cannot have religious beliefs, they cannot object on an institutional level to procedures based on religious belief.\textsuperscript{286}

A benefit of imposing a duty to dispense only on institutions in rural or isolated areas is the low number of pharmacists and physicians who would actually be compelled to dispense or provide emergency contraception against their will. Those who enter the profession after a geographically limited duty to dispense is in place will know which areas are subject to the duty and can choose to work in a different area.\textsuperscript{287} For those who work in those areas prior to the enactment of the duty to dispense, a grandfather clause could grant them the right to refuse.

However, even without a grandfather clause, it is not unreasonable to infringe on a small number of pharmacists and physicians’ religious rights by compelling them to provide emergency contraception when there is no other option available. Physicians take the Declaration of Geneva, the modern Hippocratic Oath, promising that, “The health of my patient will be my first consideration.”\textsuperscript{288} As well, health care providers have a history of sacrificing themselves in the pursuit of treating patients. A physician or pharmacist putting a patient’s rights before her own religious rights is no different than a physician or pharmacist putting her physical health in danger while treating SARS patients or lepers. To do otherwise would be to treat patients as an instrumentality in reaching the physician’s own goals of spiritual

\textsuperscript{285} Fenton, \textit{supra} note 4 at 589.
\textsuperscript{286} Dickens, “Professionalism, \textit{supra} note 263 at 99.
\textsuperscript{287} Fenton, \textit{supra} note 4 at 589.
\textsuperscript{288} Cook and Dickens, “Growing Abuse,” \textit{supra} note 246 at 337.
More specifically, requiring physicians to prescribe and pharmacists to dispense Plan B as a last resort is morally upsetting for one who objects to it because of the possibility that it prevents implantation. However, such a duty is a far smaller imposition than requiring physicians to perform abortions, which could become necessary should a woman be prevented from obtaining Plan B. Accordingly, a limited duty to prescribe and dispense Plan B minimally impairs the rights of health care providers, while protecting women’s right of access to health care.

Different considerations apply with respect to a duty to prescribe abortifacient drugs. Although it seems at first glance that such a duty requires no more than writing a prescription, a duty to provide abortifacient drugs is a greater imposition than a duty to provide Plan B and is closer to a duty requiring the provision of a surgical abortion. First, being an accomplice to a medical abortion by prescribing the drugs may weigh heavily on a physician’s conscience. Second, and more seriously, imposing a duty on a physician to prescribe abortifacient drugs is tantamount to imposing a duty on a physician to perform a surgical abortion. That is, if the abortifacient drugs do not completely terminate the pregnancy, a physician must perform a surgical abortion to prevent complications for the woman. Physicians who object to abortions on religious grounds likely will not be trained to perform abortions. This is not a problem in a community where there are sufficient physicians trained in such procedures, but in a small community, the objecting physician who was required to prescribe the abortifacient drugs may be the only physician available to perform a surgical abortion. This would cause moral and ethical problems for the conscientious objecting physician, who would have to perform a procedure that she objects to and is not competent to provide, as well as for the woman, who has the right to competent medical treatment. If there were a medical emergency requiring immediate termination of a pregnancy, a surgical abortion would be quicker and more appropriate than a medical abortion, and a woman in a small or isolated community would need to be transported to the appropriate facility as quickly as possible. For these reasons, I would not impose a duty on a conscientious objecting physician to prescribe abortifacient drugs in any circumstance.

5.4 Employment Related Obligations

In addition to the previously mentioned duties, there are certain obligations on employees and employers. Employee pharmacists must give written notice to their employer that they object to dispensing emergency contraception on moral and religious beliefs. Employers of objecting employees have a duty to reasonably accommodate the religious beliefs of the objecting employees. This can be done by having one non-objecting pharmacist on duty at all times, so that the objecting pharmacist can refer patients to her colleague to assist with emergency contraception. However, employers can also make non-objecting to emergency contraception a bona fide occupational requirement when hiring future pharmacists.

6 Access to Emergency Contraception: Practical Issues

In order to protect a health care provider’s right to refuse, there must be an adequate delivery system to ensure that a woman’s right to access health care services is not compromised. There are several components to this problem, each with its own practical issues. The first component is the location of the woman; the experience of rural women is different than the experience of urban women. The second component is the provision of Plan B, and as a corollary, the availability of pharmacists or dispensing facilities (as prescriptions are not needed in most of Canada). The third component is the provision of abortifacient drugs, and the availability of physicians to prescribe and supervise the use of the pills. The solutions in this Section are better suited for Plan B than abortifacient drugs because of the additional care and supervision required for abortifacient drugs, but where appropriate, I note the applicability of a solution to abortifacient drugs. Finally, there is the issue of a woman’s psychological ability to request emergency contraception again after having been rejected before, particularly if she had been humiliated in the process. These issues are important to consider because of Beetz J.’s admonition in Morgentaler: “A pregnant woman's person cannot be said to be secure if, when her life or health is in danger, she is faced with a rule of criminal law which precludes her from obtaining effective and timely medical treatment.”

290 Tomkowiak, supra note 239 at 1359.
292 Tomkowiak, supra note 239 at 1360.
293 Dickens, “Legal Protection,” supra note 234 at 344.
294 Morgentaler, supra note 47 at 90, Beetz J.
sanction here, an analogy can be drawn between the state precluding access to abortion by way of criminal law and the state precluding access to emergency contraception by allowing health care providers to refuse to provide such treatment, both resulting in a violation of a woman’s security of the person. The solutions proposed below include the use of Community Health Centres, remote dispensing, and other methods of improving access to emergency contraception.

### 6.1 Background

The first component is the location of the woman. There is a disparity in access to pharmacists and physicians between rural Ontario and urban Ontario, and Northern Ontario and Southern Ontario. In 2007, there were 76 pharmacists and 85 general or family physicians for every 100,000 people in Ontario. These numbers are not broken down into north and south, urban and rural populations.

However, two anecdotes may suffice as examples. Moosonee, Ontario is a rural town of approximately 3,500 people on James Bay that is not connected to the road system. It has one local pharmacy with four pharmacists. Nearby Moose Factory has two pharmacies, including one in the local hospital, with a total of four pharmacists. On the other hand, in my

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297 The Ontario Ministry of Agriculture, Food, and Rural Affairs (“OMAFRA”) defines “rural Ontario” as the area of the province that is outside of the City of Greater Sudbury, the City of Hamilton, the City of London, the City of Ottawa, the City of Thunder Bay, the City of Windsor, the Greater Toronto Area, the Region of Niagara, the Region of Waterloo, and those municipalities within those urban areas with a population of less than 100,000. Rural Ontario makes up 40% of Ontario’s population, while urban Ontario makes up the majority at 60%. Southern Ontario makes up 93% of Ontario’s population, 62% of which is urban and 38% rural. Northern Ontario makes up just 7% of Ontario’s population but 66% of those living in Northern Ontario are in rural areas, and 34% in urban centres.
298 Canadian Institute for Health Information, Health Indicators 2009 (Ottawa, Ont.: CIHI, 2009), online: <http://www.cihi.ca/cihiweb/products/Healthindicators2009_en.pdf> at 82, 124 and 125 [Health Indicators 2009].
downtown Toronto neighbourhood, there are at least three pharmacies in a 0.11 km\(^2\) block, with a total of 19 pharmacists.\(^{300}\) If a hypothetical woman in Moosonee, Ontario and I in Toronto each came across a pharmacist who refused to provide us with Plan B, I would have more options nearby than the Moosonee woman.

Likewise, physicians are much harder to come by in rural or northern areas than in southern urban areas. In the urban area of Toronto Central Local Health Integration Unit ("LHIN"), there were approximately thirteen physicians for every square kilometer, or 1,300 physicians per 100 km\(^2\).\(^{301}\) Contrast that with the rural area of the Erie St. Clair LHIN, where there were approximately five physicians for every 100 km\(^2\).\(^{302}\) In the northern area of the North East LHIN, which includes Moosonee, there were approximately 503 physicians in the area covering 400,000 km\(^2\).\(^{303}\) This means that while those who live in the concentrated areas of these LHINs may have relatively easy access to a family physician, those in the more remote communities may not be so fortunate. In fact, the Community Information Database indicates that in much of Northern Ontario, 79% to 88% of the population aged 12 and over had a regular medical doctor, whereas, in much of Southern Ontario, 84% to 98.8% of the population aged 12 and over had a regular medical doctor in 2008.\(^{304}\)

There are a number of public health services located throughout Ontario. There are 211 general hospital sites, which provide numerous services. However, some of the hospitals are Catholic-

\(^{300}\) As of July 2010, there are two Shoppers Drug Mart pharmacies and a Pharma Plus pharmacy in the area bordered by Yonge Street, Bloor Street, Bay Street and St. Mary Street.

\(^{301}\) Health Indicators 2009, supra note 296 at 82.

Toronto Central LHIN, “The LHINs that make up the City of Toronto” Toronto Central Local Health Integration Unit (Toronto: Toronto Central LHIN, 2006), online: <http://www.torontocentrallhin.on.ca/uploadedFiles/Home_Page/About_Our_LHIN/TCLHINCityofTorontoBaseMapv3.pdf>.

\(^{302}\) Health Indicators 2009, supra note 296 at 82 and 124.


\(^{303}\) Health Indicators 2009, supra note 296 at 82 and 124. This works out to be approximately one physician for every 1,000 km\(^2\), although they are likely concentrated in several main areas.

North East LHIN, “About Our LHIN” North East LHIN (Toronto: Queen’s Printer for Ontario, 2008), online: <http://www.nellhin.on.ca/page_about.aspx?id=108&ekmensel=e2f22c9a_72_184 btnlink>.


sponsored, and may have difficulty in providing certain sexual health services because of their values and mission statement.\textsuperscript{305} According to their Catholic faith, some, if not all, of these hospitals may refuse to perform abortions, provide regular or emergency contraception, or provide other reproductive and sexual health related services.

The previous information creates a backdrop demonstrating the potential problems of access if pharmacists and physicians are allowed to refuse to prescribe and dispense emergency contraception.

6.2 Problematic Scenarios with the Right of Refusal

There are a number of potential scenarios in which a right of refusal may impede a woman’s access to emergency contraception. These scenarios could occur in Northern or Southern Ontario, urban or rural centres. However, as we have seen in the Background section above, rural women, particularly Northern rural women, have fewer options when it comes to health care providers.

Women may face a number of obstacles to obtaining emergency contraception, such as lacking access to a vehicle, needing time off work, needing time away from her family, keeping it secret from her family and friends, and prohibitively high costs of traveling. Chief Justice Dickson acknowledged in \textit{Morgentaler} the “enormous emotional and financial burden placed upon women who must travel long distances from home to obtain an abortion,” or, in this case, emergency contraception.\textsuperscript{306} If she is able to overcome these obstacles and burdens, only to be refused emergency contraception by a health care provider, she may not have a second opportunity to obtain it. The woman may need to travel great distances for an abortion, attempt a medically unsafe abortion, have difficulties in pregnancy or labour, or give birth to the child in a situation in which she could not care for it properly.

The first set of refusal scenarios involves a woman who requires Plan B in a province in which a prescription is not needed. She does not have access to a vehicle. She may be married or she

\textsuperscript{305} Catholic Health Association of Ontario, “Catholic Health Care in Ontario: About Us” Catholic Health Association of Ontario (Oakville: CHAO, 2010), online: <http://www.chaont.ca/aboutus/whoweare.php>. The Catholic Health Association of Ontario includes 15 hospitals that offer “all Ontario residents whatever their origin, religion, socio-economic status or culture, a faith-based approach to the provision of health care.”

\textsuperscript{306} \textit{Morgentaler, supra} note 47 at 71, Dickson C.J.
may be a teenager living with her parents or she may not want anyone to know that there had been a contraception failure. She walks to the nearest pharmacy, gathers her courage, and requests Plan B from the pharmacist. The pharmacist may refuse kindly, or she may berate the woman for not being more careful or otherwise humiliate her. The woman who lives in an urban centre, if she still has the courage to ask again after being refused and possibly humiliated, can walk a few hundred metres to the next pharmacy and try again. However, the woman who lives in a rural area may not have another pharmacy within walking distance or accessible via public transit. Alternatively, there could be another pharmacy, but other reasons may prevent the woman from using that pharmacy. For example, she could be too embarrassed to ask the pharmacist because she is a close family friend. The woman may wait until another pharmacist is on duty, if there is a second pharmacist who works at the pharmacy, but because there is only a short, 72-hour window in which she can take Plan B, there may not be time to wait. Finally, she could try the emergency room at the local hospital or the local branch of the Public Health Unit, if those are within walking distance or accessible via public transport.

The second set of refusal scenarios involves a woman who requires abortifacient drugs or lives in a province where a prescription is needed for Plan B. Not only does this woman have to deal with the potential occurrence of the first set of scenarios, she also faces the possibility that her physician will refuse. In addition, she may be too embarrassed to ask her family physician because she is a family friend and has been her doctor and her family’s doctor for many years. If her physician does refuse to prescribe abortifacient drugs, she will need to find another physician who will do so. In a small community, there may only be a few practicing physicians and there may be long waiting lists for appointments. She could try her local emergency room, urgent care clinic or walk-in clinic, but she may have to wait a long time to be seen.\textsuperscript{307} Also, patients using abortifacient drugs require three appointments with a physician. Emergency room doctors may find these sorts of appointments interfere with more immediate emergencies. Furthermore, the medications needed for a medical abortion may not be available locally in some small remote communities.

\textsuperscript{307} North Simcoe Muskoka LHIN “Fast Facts” North Simcoe Muskoka LHIN (Toronto: Queen’s Printer for Ontario, 2006), online: <http://www.nsmlhin.on.ca/Page.aspx?id=4118&ekmensel=e2f22e9a_72_300_4118_1>. For example, in North Simcoe Muskoka LHIN, 90% of ER patients are treated within 7.7 hours from triage to discharge.
The final set of refusal scenarios involves a woman in a community in the north, such as Moosonee, that is only accessible via plane or train. In Southern Ontario, even in rural areas, if a woman has access to a vehicle, she is likely able to drive to a town or urban area with a pharmacy or a physician within a reasonable amount of time. However, a woman in Northern Ontario may not be able to drive to a neighbouring community, even with access to a vehicle.

This issue is further complicated for Aboriginal women. Not only are they isolated geographically, they are also isolated socially and culturally. Because of the social and cultural history of colonization, Aboriginal communities have an overall quality of health that is lower than the rest of Canadians. In addition, Aboriginal women seeking contraception, emergency contraception or abortion often face a lack of confidentiality and privacy in their communities, lack of access to birth control methods, a cultural stigma surrounding contraception and abortion, the need for a translator outside their community, and direct and indirect racism. All these factors make it that much more difficult for Aboriginal women to exercise their right to reproductive health care.

In some ways, the issue of access to emergency contraception in isolated areas is no different than access to other health care. Women in isolated areas often need to travel for medical care in an ordinary situation. However, even in isolated areas, there are usually local hospitals or hospital sites. The problem arises when a health care practitioner in an isolated area refuses to provide access to emergency contraception, potentially requiring the woman to travel a great deal further to obtain emergency contraception, or potentially preventing her from obtaining it in the necessary timeframe. If we are to reconcile the right of refusal with the right to health care, we must avoid this problem and the others discussed above.

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Native Women’s Association of Canada, “The Native Women’s Association of Canada Background Document on Aboriginal Women’s Health For the Health Sectoral Session, Following up to the Canada-Aboriginal Peoples Roundtable” (Ottawa: Native Women’s Association of Canada, October 2004) at 3, online: Native Women’s Association of Canada <http://www.aboriginalroundtable.ca/sect/hlth/bckpr/NWAC_BgPaper_e.pdf>.
6.3 Potential Solutions to Provide Access

Although these scenarios are extreme examples, for some women, they are reality. To avoid the potential problems associated with a right of refusal, I offer a few proposals to create a fast, reliable, private delivery system that provides women with access to emergency contraception while protecting health care providers’ religious rights.

Ideally, the duties discussed in Section 5 would adequately protect both sets of rights. Health care providers could refer patients to emergency rooms of local hospitals, urgent care clinics and walk-in clinics if Plan B and abortifacient drugs were available there. In addition, the use of Community Health Centres, Public Health Units, and remote dispensing, proposed in the sections that follow, should ensure that no woman is denied access to emergency contraception.

6.3.1 Community Health Centres and Public Health Units: Dedicated Clinics

The first proposal makes use of Community Health Centres (“CHC”) and Public Health Units (“PHU”). CHCs are located in the 14 Local Health Integration Units (“LHIN”) in Ontario, and are non-profit organizations that provide health promotion programs, including those on healthy sexuality.310 Ontario is divided into 36 PHUs, each of which has a number of branches throughout its area that provide primary health promotion programs.311

Every Public Health Unit or LHIN could set up at least one clinic dedicated to sexual health care with the ability to handle incomplete abortions resulting from abortifacient drugs. These branches would distribute condoms, oral and other contraceptives, Plan B, and abortifacient drugs. Women could visit these branches on occasion when in the area and stock up on contraceptives and Plan B, after having been informed of their uses and instructed when to use them by the staff. Ideally, these clinics would be located in such a manner that it would not be more than a day’s return trip for women requiring abortifacient drugs, as they do require three visits. However, a woman in that situation may wish to have a surgical abortion at the clinic rather than having a medical abortion because it requires only one visit. To be more cost

311 Ontario Ministry of Health and Long-Term Care, “Health Services in Your Community” (Toronto: Queen’s Printer for Ontario, 2009), online: <http://www.health.gov.on.ca/english/public/contact/contact_mn.html>.
effective, the physician may come into the clinic only once a week to prescribe abortifacient drugs and handle the follow-up appointments.

By utilizing the infrastructure already in place in LHINs and PHUs, emergency contraception could be made more readily available to women who lack family physicians or whose local pharmacists object to emergency contraception. In addition, these clinics provide certainty to a woman in an isolated area whose alternative would be to travel to another town where she would face possible refusal. Finally, the dedicated clinics are probably the best solution for those who wish to have medical abortions, as they will be staffed by fully trained, non-objecting physicians and pharmacists who can provide women with abortifacient drugs and the necessary follow-up, including a surgical abortion should that be necessary. Women may still need to travel, perhaps more than they would like, to the dedicated clinics to obtain abortifacient drugs, but given the potentially more complicated follow-up, abortifacient drugs cannot be made as readily available as oral contraceptives or Plan B.

6.3.2 Remote Dispensing

Remote dispensing offers an ideal solution for the provision of Plan B, although not for abortifacient drugs. Amendments to the Drug and Pharmacies Regulation Act, assented to on December 15, 2009, but not yet in force, provide for remote dispensing.312 Among the changes are amendments to the definition of “pharmacy” and an exemption to the requirement that a pharmacist be physically present. The definition of “pharmacy” will be amended so that it includes a remote dispensing location, which is defined in the regulations.313 Section 146(1)(a) of the Drug and Pharmacies Regulation Act currently states that a pharmacy cannot operate unless it is under the “supervision of a pharmacist who is physically present” and is managed by a designated manager.314 In order for remote dispensing locations to be exempt from the requirement for a pharmacist to be physically present, there must be a certificate of accreditation issued that permits the operation of the remote dispensing location; and the remote dispensing

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313 Regulated Health Professions Statute Law Amendment Act, 2009, S.O. 2009, c. 26, ss. 8(1) and 8(2) [Regulated Health Professional Amendment].
314 Drug and Pharmacies Regulation Act, R.S.O. 1990, c. H.4, s. 146(1)(a).
location must be operated in accordance with the regulations.\textsuperscript{315} Currently, there are no regulations in place relating to remote dispensing locations.

Acknowledging that it will eventually be a reality, the Ontario Pharmacists’ Association (“OPA”) presented four concerns about remote dispensing in May 2009.\textsuperscript{316} First, the OPA stated that remote dispensing would only be able to offer a limited range of services.\textsuperscript{317} Second, while recognizing that “in remote or underserviced regions of the province, communication by phone or video may be preferable to no interaction at all,” the OPA stated that remote dispensing locations could not provide the same level of service as that provided by a pharmacist who is physically present. Further, according to OPA survey results, “more than 90 per cent of respondents indicated that there is no problem related to access to pharmacy services in their areas.”\textsuperscript{318} Third, the OPA was concerned about patient care and patient safety. Remote dispensing may limit the pharmacist from being able to promptly counsel patients on medications and the use of devices, answer drug-related questions, help select over-the-counter drug products and counsel on Schedule II drugs.\textsuperscript{319} Finally, the OPA was concerned with public safety, including access to the area, the “safety of medications within the remote dispensing area,” and the potential for forgeries to go unrecognized by the machine.\textsuperscript{320} With these concerns in mind, there are two applications of remote dispensing that could prove very useful for accessibility to emergency contraception: kiosks in conjunction with direct links to pharmacists, and Mail Order dispensing.

6.3.2.1 Kiosks and TeleHealth

The legislation providing for remote dispensing envisions kiosks or booths that would dispense drugs. Combining these booths with TeleHealth or a webcam would allow women to have timely access to emergency contraception with the necessary interaction with a pharmacist, without fearing refusal or humiliation.

\textsuperscript{315} Regulated Health Professions Amendment, supra note 313, s. 8(5).
\textsuperscript{316} Letter from the Ontario Pharmacists’ Association to David Caplan, the Minister of Health and Long-Term Care for Ontario (27 April 2009), online: Ontario Pharmacists’ Association <http://www.opatoday.com/documents/RemoteDispensing/Letter_Minister%20Caplan-Remote_Dispensing_April_2009.pdf> [OPA Letter].
\textsuperscript{317} Ibid. at 2.
\textsuperscript{318} Ibid. at 2.
\textsuperscript{319} Ibid. at 2.
\textsuperscript{320} Ibid. at 3.
The creation of these kiosks, or drug vending machines, is already in the works. The Ontario Hospital Association and PharmaTrust Inc. are partnering to install kiosks in hospitals across Ontario. These kiosks are designed to be able to scan prescriptions, so abortifacient drugs could be dispensed, but they can work without prescriptions for items like Plan B. The kiosks are connected via a handset or touch screen to a remote-based pharmacist who is available seven days a week, 24 hours a day, and who authenticates the prescription, runs a series of checks on the prescribed dose, and provides advice to the patient. The kiosks can carry up to 2,400 different drugs, so female patients needing emergency contraception would not feel conspicuous using these machines. Patients can pay using cash, debit or credit card. As well, the patient can receive a phone call or electronic reminder in the future when then prescription is due to be refilled. This feature could be used in the context of abortifacient drugs to remind patients when to take the second dose or visit the physician for a follow-up appointment.\textsuperscript{321}

These kiosks are already designed to have a connection to a pharmacist, 24 hours a day, seven days a week. The pharmacist on the line would necessarily have to be someone who does not object to emergency contraception. In addition, or as an alternative, to the connection to a pharmacist, TeleHealth could be used in these kiosks. TeleHealth Ontario is a service provided by the Ontario Ministry of Health and Long-Term Care, in which any resident of Ontario can call and reach a registered nurse for free, 24 hours a day, 7 days a week. The service is free and confidential and provides residents with health advice or general health information.\textsuperscript{322} Access to TeleHealth in the kiosk would allow women to discuss their issues with a registered nurse and could be useful in connection with dispensing abortifacient drugs.

Plans are currently underway to place these kiosks in hospitals. They could also be placed in many other locations, such as pharmacies, police stations, post offices, high schools, physicians’ offices, walk-in clinics, supermarkets, Walmarts, major shopping centres, and government offices of all levels: federal, provincial, municipal and city hall. If the kiosk dispenses other medications, it could be placed in a fairly prominent spot in the building. If it dispenses only

oral and emergency contraceptives, ideally it would be placed in the ladies’ washroom, to provide women with the maximum amount of privacy.

6.3.2.2 Mail Order

Another option to provide Plan B to isolated communities is mail order or courier. Women could order it over the phone or the Internet, after answering a few automated questions created by a pharmacist. Then Plan B would be sent via express post or courier. The most serious potential problem associated with this option is the timeframe. Plan B must be taken within 72 hours, or 3 days, of intercourse. A woman may not know about Plan B for a day, may not know to call or order online for another day, and it may take more than a day for the mail to arrive. Also, this option lacks the face-to-face interaction with a pharmacist that occurs in a pharmacy. However, despite these concerns, a benefit of the mail order solution is that no woman would be refused or humiliated for requesting Plan B.

The idea of mailing Plan B to remote and isolated communities is similar to a program called the Food Mail Program, or Northern Air Stage Program, which is a joint effort of Indian and Northern Affairs Canada (“INAC”), Canada Post and Health Canada. INAC provides funding to Canada Post for transporting perishable foods and other necessary items to isolated communities by air at a reduced postage rate. All isolated northern communities that do not have year-round access by surface transportation are eligible, except those where surface transportation is not available only for brief periods during freeze-up and breakup. A similar program could be set up for Plan B, or Plan B could be added to the list of essential items that are flown to these remote communities. Dated non-prescription drugs are eligible for subsidy rates for shipping to isolated Northern communities, even under the new Northern Nutrition

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323 Indian and Northern Affairs Canada, “Food Mail Program” (Ottawa: Government of Canada, 2010), online: INAC <http://www.aicn-inac.gc.ca/nth/fon/fm/index-eng.asp>. Indian and Northern Affairs Canada, “Food Mail Program Information Sheet” (Ottawa: Government of Canada, 2010), online: INAC <http://www.aicn-inac.gc.ca/nth/fon/fm/pubs/inf/inf-eng.asp>. About 135 communities - roughly 100,000 people - are eligible for the reduced postage rate of $0.80 per kg plus $0.75 per parcel. Most of these are Aboriginal communities located in the three territories and in Labrador and northern portions of Quebec, Ontario, Manitoba, Saskatchewan and Alberta. Indian and Northern Affairs Canada, “Nutrition North Canada” (Ottawa: Government of Canada, 2010), online: INAC <http://www.aicn-inac.gc.ca/nth/fon/nm/index-eng.asp>. The Food Mail Program is being phased out and being replaced with the Northern Nutrition Program on April 1, 2011.
Program.\textsuperscript{324} The Food Mail and Northern Nutrition Programs run throughout the year but extreme weather conditions, particularly in the winter months, often prevent Canada Post from normal delivery operations in some remote locations and aboriginal reserves.\textsuperscript{325} Further, these sorts of mail delivery programs would not run frequently enough to ensure that a woman would receive Plan B within 72 hours of having unprotected sexual intercourse. In remote communities, women may want to order Plan B in advance to keep on hand in case of contraceptive failures.

### 6.3.3 Additional Solutions

Other solutions to the access issue can be used in conjunction with the ideas proposed above. First, an educational campaign could be undertaken as a joint initiative between Health Canada, provincial ministries of health, and the makers of emergency contraceptives to educate teenage girls and young women about the availability of emergency contraception. It could include radio and television ads, a website, and posters or billboards across the country. Speakers could visit schools, or alternatively, information about emergency contraception could be added to the high school health class curriculum.

Second, Plan B, but not abortifacient drugs, could be made Schedule III drugs in all provinces, so that they could be kept on the shelves in pharmacies. This would eliminate the need for direct interaction with a pharmacist. There are two problems with this proposal, both relating to the lack of advice from a pharmacist. First, women might take Plan B when they do not need it, perhaps because they are mistaken about there having been a contraceptive failure. Second, there is the concern that women will take Plan B as their “Plan A” and make it a regular occurrence. Although there is no medical knowledge that doing so will cause harm to the woman, Plan B was not designed to be a primary form of birth control.\textsuperscript{326} These problems can be solved by having pamphlets with that information with the medication, and by prominently


displaying the telephone number for TeleHealth and/or to another pharmacy staffed by those who do not object to emergency contraception.

Third, Catholic hospitals or small communities where the local physicians object to emergency contraception may need to bring in a non-objecting physician once a week, for example, to prescribe abortifacient drugs and follow up with such patients. She can also bring samples of Plan B to distribute to local women to have on hand in case of a contraceptive failure. This proposal may not be financially feasible for many communities or hospitals, but would be worthwhile to examine.

Finally, as a last resort, as discussed in Section 5.3 above, if none of the other delivery system proposals are effective, health care providers may be required to provide emergency contraception, such as Plan B but not abortifacient drugs, over their own objections. This limited duty to prescribe and dispense is necessary only in rare circumstances to ensure that women are able to access emergency contraception in a timely manner.

6.4 Conclusion

If these proposals are followed and a delivery system is put in place that is quick, safe, reliable and private, there should be very few situations in which a health care provider would be compelled to act against her religious convictions by being compelled to prescribe or dispense emergency contraception. Accordingly, the health care provider’s freedom of religion is only minimally impaired in such situations. The same can be said of a woman’s rights to sexual health care. As long as there is an appropriate delivery system in place and everything is done to protect her rights, if there is ever a rare situation in which a woman cannot obtain access to emergency contraception, her rights will have been only minimally impaired.
Chapter 5
Conclusion

7 Conclusion

Although the conflict between the right of physicians and pharmacists to refuse on conscientious grounds and the right of women to access emergency contraception seems insurmountable, the competing rights can in fact be reconciled. Reconciliation requires a certain degree of compromise and toleration on the part of both groups, but if the proposals set out in this thesis are followed, the impairment to either group’s rights will be minimal.

The Canadian Charter of Rights and Freedoms guarantees freedom of religion to everyone; physicians and pharmacists therefore have a constitutional right to act in accordance with their religious beliefs. Health care providers also have a statutory right in human rights codes not to be discriminated against on the basis of their religion. However, religious conduct is not an absolute right and can be limited by justifiably reasonable limitations. For one, health care providers cannot refuse to provide health care services to patients on prohibited grounds such as race, religion and sex. For another, the duties proposed in this thesis require health care providers to disclose to their patients and employers those services that they do not provide, and to refer their patients to a non-objecting provider. In certain rare cases, providers may be required to prescribe or dispense Plan B, but not abortifacient drugs. The foregoing duties are in line with some American conscientious objection legislation, Canadian and American professional association codes of ethics, and many scholarly articles. These limitations are necessary so as to protect women’s rights to access health care. Nonetheless, any limitations on health care providers’ rights must be structured so as to minimally impair those rights. At the same time, in structuring health care providers’ right to refuse to provide emergency contraception, women’s rights to health care must also be only minimally impaired.

In order to ensure that both group’s rights are protected and only minimally impaired by limitations, this thesis proposes a fast, reliable and private delivery system to provide emergency contraception to women. The proposed ideas are inspired by infrastructure already in place in Canada, as well as some scholarly articles. They include making use of existing Public Health Units and Community Health Centres to provide dedicated clinics for abortifacient drugs,
placing drug vending machines in a number of easily accessible areas filled with Plan B, regulating Plan B as an “on the shelf” drug, and potentially using air mail to deliver Plan B to isolated areas. Further, in certain rare occasions or in geographically limited areas, pharmacists will be required to dispense emergency contraception over their religious objections. These delivery proposals ensure that health care providers can maintain their right to object, except in rare circumstances, while protecting women’s right to access emergency contraception, also except in rare circumstances. In either case, the group’s rights are protected, and to the extent they are limited, the rights are only minimally impaired.

In a religiously pluralistic society like Canada, it is important to protect the religious freedoms of its citizens. However, it is equally important to protect the rights of its citizens to obtain necessary health care, particularly if that health care is related to sexual and reproductive health, as is emergency contraception. The Charter requires the state to protect both rights, but doing so requires creativity to reconcile the conflicting rights. It would be worthwhile for legislatures to consider enacting the proposed duties as part of conscientious objection legislation, and to examine the delivery system ideas in this thesis, to adequately protect and reconcile both sets of rights.
Bibliography

LEGISLATION

Canadian Legislation


*Criminal Code*, S.C. 1953-54, c. 51, s. 150(2)(c).


*Food and Drug Regulations*, C.R.C. c. 870, Sch. F.


*Professional Misconduct*, O. Reg. 856/93.


S.C. 1968-1969, c. 41, s. 2.

United States Legislation

Cal. Bus. & Prof. code § 733.


Ill. admin. code tit. 68, § 1330.91(2007).


U.S. Const. amend. I.
JURISPRUDENCE

Canadian Jurisprudence

Finan v. Cosmetic Surgicentre (Toronto), 2008 HRTO 47 (CanLII).

United States Jurisprudence

The Civil Rights Cases, 109 U.S. 3 (1883), Harlan J., dissenting, in discussion of Rex v. Ivens, 7 Carrington & Payne, 213, 32 E.C.L. 495, Coleridge J.
Reynolds v. United States, 98 U.S. 145 (1879).
Stormans, Inc. v. Selecky, 586 F.3d 1109 (9th Cir. 2009), rev’g 524 F.Supp.2d 1245, 1250 (W.D. Wash. 2007).

SECONDARY MATERIAL: MONOGRAPHS


SECONDARY MATERIAL: ARTICLES


SECONDARY MATERIAL: MISCELLANEOUS

Government Documents

Canada


United States


Professional Associations and Governing Bodies

Canada


United States


Encyclopedias and Digests


News Sources


Not-For-Profit Organizations


North East LHIN. “About Our LHIN” North East LHIN (Toronto: Queen’s Printer for Ontario, 2008), online: <http://www.nelhin.on.ca/page_about.aspx?id=108&ekmensel=e2f22c9a_72_184_btnlink>.


Toronto Central LHIN. “The LHINs that make up the City of Toronto” Toronto Central Local Health Integration Unit (Toronto: Toronto Central LHIN, 2006), online: <http://www.torontocentrallhin.on.ca/uploadedFiles/Home_Page/About_Our_LHIN/TC_LHINCityofTorontoBaseMapv3.pdf>.

Other


Native Women’s Association of Canada. “The Native Women’s Association of Canada Background Document on Aboriginal Women’s Health For the Health Sectoral Session, Following up to the Canada-Aboriginal Peoples Roundtable” (Ottawa: Native Women’s Association of Canada, October 2004), online: Native Women’s Association of Canada <http://www.aboriginalroundtable.ca/sect/hlth/bckpr/NWAC_BgPaper_e.pdf>.


Women’s Health Centre. “Abortion” (Toronto: Women's College Hospital and the Women’s College Research Institute, 2008), online: Women’s Health Centre <http://www.womenshealthmatters.ca/centres/sex/abortion/abortion.html>.


Women’s Health Centre. “Medical Abortion” (Toronto: Women's College Hospital and the Women’s College Research Institute, 2008), online: Women’s Health Centre <http://www.womenshealthmatters.ca/centres/sex/abortion/medicalab.html>.

Appendix A: Legislation

Freedom of Religion

Congress


Section 1:

(a) Government shall not substantially burden a person’s exercise of religion even if the burden results from a rule of general applicability, except as provided in subsection (b) of this section.

(b) Government may substantially burden a person’s exercise of religion only if it demonstrates that application of the burden to the person—

   (1) is in furtherance of a compelling governmental interest; and

   (2) is the least restrictive means of furthering that compelling governmental interest.

(c) Judicial relief

A person whose religious exercise has been burdened in violation of this section may assert that violation as a claim or defense in a judicial proceeding and obtain appropriate relief against a government. Standing to assert a claim or defense under this section shall be governed by the general rules of standing under article III of the Constitution.
Conscientious Objection Legislation

California

Cal. Bus. & Prof. code § 733.

733.

(a) No licentiate shall obstruct a patient in obtaining a prescription drug or device that has been legally prescribed or ordered for that patient. A violation of this section constitutes unprofessional conduct by the licentiate and shall subject the licentiate to disciplinary or administrative action by his or her licensing agency.

(b) Notwithstanding any other provision of law, a licentiate shall dispense drugs and devices, as described in subdivision (a) of Section 4024, pursuant to a lawful order or prescription unless one of the following circumstances exists:

(1) Based solely on the licentiate's professional training and judgment, dispensing pursuant to the order or the prescription is contrary to law, or the licentiate determines that the prescribed drug or device would cause a harmful drug interaction or would otherwise adversely affect the patient's medical condition.

(2) The prescription drug or device is not in stock. If an order, other than an order described in Section 4019, or prescription cannot be dispensed because the drug or device is not in stock, the licentiate shall take one of the following actions:

(A) Immediately notify the patient and arrange for the drug or device to be delivered to the site or directly to the patient in a timely manner.

(B) Promptly transfer the prescription to another pharmacy known to stock the prescription drug or device that is near enough to the site from which the prescription or order is transferred, to ensure the patient has timely access to the drug or device.

(C) Return the prescription to the patient and refer the patient.

The licentiate shall make a reasonable effort to refer the patient to a pharmacy that stocks the prescription drug or device that is near enough to the referring site to ensure that the patient has timely access to the drug or device.

(3) The licentiate refuses on ethical, moral, or religious grounds to dispense a drug or device pursuant to an order or prescription. A licentiate may decline to dispense a prescription drug or device on this basis only if the licentiate has previously notified his or her employer, in writing, of the drug or class of drugs to which he or she objects, and the licentiate's employer can, without creating undue hardship, provide a reasonable accommodation of the licentiate's objection. The licentiate's employer shall establish protocols that ensure that the patient has timely access to the prescribed drug or device despite the licentiate's refusal to dispense the prescription or order. For purposes of this section, "reasonable accommodation" and "undue hardship" shall have the same meaning as applied to those terms pursuant to subdivision (l) of Section 12940 of the Government Code.

...
Illinois

Health Care Right of Conscience Act, 745 Ill. Comp. Stat. § 70/1-14, s. 6.

Sec. 1. Short title. This Act may be cited as the Health Care Right of Conscience Act.

Sec. 2. Findings and policy.

The General Assembly finds and declares that people and organizations hold different beliefs about whether certain health care services are morally acceptable. It is the public policy of the State of Illinois to respect and protect the right of conscience of all persons who refuse to obtain, receive or accept, or who are engaged in, the delivery of, arrangement for, or payment of health care services and medical care whether acting individually, corporately, or in association with other persons; and to prohibit all forms of discrimination, disqualification, coercion, disability or imposition of liability upon such persons or entities by reason of their refusing to act contrary to their conscience or conscientious convictions in refusing to obtain, receive, accept, deliver, pay for, or arrange for the payment of health care services and medical care.

Sec. 3. Definitions.

As used in this Act, unless the context clearly otherwise requires:

(a) "Health care" means any 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;

(b) "Physician" means any person who is licensed by the State of Illinois under the Medical Practice Act of 1987;

(c) "Health care personnel" means any nurse, nurses' aide, medical school student, professional, paraprofessional or any other person who furnishes, or assists in the furnishing of, health care services;

(d) "Health care facility" means any public or private hospital, clinic, center, medical school, medical training institution, laboratory or diagnostic facility, physician's office, infirmary, dispensary, ambulatory surgical treatment center or other institution or location wherein health care services are provided to any person, including physician organizations and associations, networks, joint ventures, and all other combinations of those organizations;

(e) "Conscience" means a sincerely held set of moral convictions arising from belief in and relation to God, or which, though not so derived, arises from a place in the life of its possessor parallel to that filled by God among adherents to religious faiths; and

(f) "Health care payer" means a health maintenance organization, insurance company, management services organization, or any other entity that pays for or arranges for the payment of any health care or medical care service, procedure, or product. The above definitions include not only the traditional combinations and forms of these persons and organizations but also all new and emerging forms and combinations of these persons and organizations.
Sec. 4. Liability.

No physician or health care personnel shall be civilly or criminally liable to any person, estate, public or private entity or public official by reason of his or her refusal to 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.

Sec. 5. Discrimination.

It shall be unlawful for any person, public or private institution, or public official to discriminate against any person in any manner, including but not limited to, licensing, hiring, promotion, transfer, staff appointment, hospital, managed care entity, or any other privileges, because of such person's conscientious refusal to receive, obtain, accept, perform, assist, counsel, suggest, recommend, refer or participate in any way in any particular form of health care services contrary to his or her conscience.

Sec. 6. Duty of physicians and other health care personnel. Nothing in this Act shall relieve a physician from any duty, which may exist under any laws concerning current standards, of normal medical practices and procedures, to inform his or her patient of the patient's condition, prognosis and risks, provided, however, that such physician shall be under no duty to perform, assist, counsel, suggest, recommend, refer or participate in any way in any form of medical practice or health care service that is contrary to his or her conscience. Nothing in this Act shall be construed so as to relieve a physician or other health care personnel from obligations under the law of providing emergency medical care.

Sec. 7. Discrimination by employers or institutions.

It shall be unlawful for any public or private employer, entity, agency, institution, official or person, including but not limited to, a medical, nursing or other medical training institution, to deny admission because of, to place any reference in its application form concerning, to orally question about, to impose any burdens in terms or conditions of employment on, or to otherwise discriminate against, any applicant, in terms of employment, admission to or participation in any programs for which the applicant is eligible, or to discriminate in relation thereto, in any other manner, on account of the applicant's refusal to receive, obtain, accept, perform, counsel, suggest, recommend, refer, assist or participate in any way in any forms of health care services contrary to his or her conscience.

Sec. 8. Denial of aid or benefits.

It shall be unlawful for any public official, guardian, agency, institution or entity to deny any form of aid, assistance or benefits, or to condition the reception in any way of any form of aid, assistance or benefits, or in any other manner to coerce, disqualify or discriminate against any person, otherwise entitled to such aid, assistance or benefits, because that person refuses to obtain, receive, accept, perform, assist, counsel, suggest, recommend, refer or participate in any way in any form of health care services contrary to his or her conscience.

…

Sec. 12. Actions; damages.

Any person, association, corporation, entity or health care facility injured by any public or private person, association, agency, entity or corporation by reason of any action prohibited by this Act may commence a suit therefor, and shall recover threefold the actual damages,
including pain and suffering, sustained by such person, association, corporation, entity or health care facility, the costs of the suit and reasonable attorney's fees; but in no case shall recovery be less than $2,500 for each violation in addition to costs of the suit and reasonable attorney's fees. These damage remedies shall be cumulative, and not exclusive of other remedies afforded under any other state or federal law.

…

**Illinois**

Ill. admin. code tit. 68, § 1330.91(j) and (k) (2007).

j) **Duty of Retail Pharmacy to Dispense Contraceptives**

1) Upon receipt of a valid, lawful prescription for a contraceptive, a retail pharmacy serving the general public must dispense the contraceptive, or a suitable alternative permitted by the prescriber, to the patient or the patient's agent without delay, consistent with the normal timeframe for filling any other prescription, subject to the remaining provisions of this subsection (j). If the contraceptive, or a suitable alternative, is not in stock, the pharmacy must obtain the contraceptive under the pharmacy's standard procedures for ordering contraceptive drugs not in stock, including the procedures of any entity that is affiliated with, owns, or franchises the pharmacy. However, if the contraceptive, or a suitable alternative, is not in stock and the patient prefers, the prescription must be transferred to a local pharmacy of the patient's choice under the pharmacy's standard procedures for transferring prescriptions for contraceptive drugs, including the procedures of any entity that is affiliated with, owns, or franchises the pharmacy. Under any circumstances an unfilled prescription for contraceptive drugs must be returned to the patient if the patient so directs.

2) Each retail pharmacy serving the general public shall use its best efforts to maintain adequate stock of emergency contraception to the extent it continues to sell contraception (nothing in this subsection (j)(2) prohibits a pharmacy from deciding not to sell contraception). Whenever emergency contraception is out-of-stock at a particular pharmacy and a prescription for emergency contraception is presented, the pharmacist or another pharmacy registrant shall attempt to assist the patient, at the patient's choice and request, in making arrangements to have the emergency contraception prescription filled at another pharmacy under the pharmacy's standard procedures for transferring prescriptions for contraceptive drugs, including the procedures of any entity that is affiliated with, owns or franchises the pharmacy.

3) **Dispensing Protocol** – In the event that a licensed pharmacist who objects to dispensing emergency contraception (an "objecting pharmacist") is presented with a prescription for emergency contraception, the retail pharmacy serving the general public shall use the following dispensing protocol:

A) All other pharmacists, if any, then present at the location where the objecting pharmacist works (the "dispensing pharmacy") shall first be asked to dispense the emergency contraception (any pharmacist that does not object to dispensing these medications is
referred to as a "non-objecting pharmacist").

B) If there is an objecting pharmacist and no non-objecting pharmacist is then available at the dispensing pharmacy, any pharmacy (the "remote pharmacy") or other non-objecting pharmacist shall provide "remote medication order processing" (RMOP) to the dispensing pharmacy. RMOP includes any and all services that a licensed pharmacist may provide, as well as authorizing a non-pharmacist registrant at the dispensing pharmacy, to dispense the emergency contraception to the patient under the remote supervision of a non-objecting pharmacist. For purposes of this subsection (j) and the Pharmacy Practice Act, a registered pharmacy technician is authorized to engage in RMOP involving emergency contraception.

4) A retail pharmacy that serves the general public is responsible for ensuring either that there is a non-objecting pharmacist scheduled at all times the pharmacy is open, or that there is a licensed pharmacist available to perform RMOP for emergency contraception at all times the pharmacy is open and no non-objecting pharmacist is available at the pharmacy.

5) For the purposes of this subsection (j), the term "contraceptive" shall refer to all FDA-approved drugs or devices that prevent pregnancy.

k) Notice of rights regarding the dispensing of contraceptives.

1) Each Division I pharmacy must prominently display the notice described in subsection (k)(2) of this Section and include information regarding how to file a complaint with the Division. The notice must be on 8.5 inch by 11 inch paper and otherwise conform with the format prescribed by subsection (k)(2). The notice must be clearly visible from the area at which the pharmacy intakes prescriptions. The Department's website shall provide a template for approved format of the notice and that template shall include required information regarding how to file a complaint with the Division, in accordance with the Department's administrative hearing rules located at 68 Ill. Adm. Code 1110. The licensee shall be accorded all process provided for in 68 Ill. Adm. Code 1110.

2) Form and text of notice:

IF YOU USE CONTRACEPTIVES KNOW YOUR RIGHTS.

If this pharmacy dispenses prescription contraceptives, then you have the following rights under Illinois law:

The pharmacy must dispense your prescribed contraceptives without delay, consistent with the normal timeframe for filling any other prescription.
When your contraceptive is out of stock, you have the following options: the pharmacy must cooperate with your doctor to determine a suitable alternative, order the contraceptive, or transfer the prescription to another pharmacy of your choice.

You can instruct the pharmacy to return the prescription slip to you at any time prior to dispensing.

You may file a complaint with the Department of Financial and Professional Regulation-Division of Professional Regulation through the Department's website http://www.idfpr.com.
Mississippi Health Care Rights of Conscience Act

§ 41-107-1. Title
This chapter may be known and cited as the "Mississippi Health Care Rights of Conscience Act."

§ 41-107-3 Definitions
As used in this Chapter:

(a) "Health-care service" means any phase of patient medical care, treatment or procedure, including, but not limited to, the following: patient referral, counseling, therapy, testing, diagnosis or prognosis, research, instruction, prescribing, dispensing or administering any device, drug, or medication, surgery, or any other care or treatment rendered by health-care providers or health-care institutions.

(b) "Health-care provider" means any individual who may be asked to participate in any way in a health-care service, including, but not limited to: a physician, physician's assistant, nurse, nurses' aide, medical assistant, hospital employee, clinic employee, nursing home employee, pharmacist, pharmacy employee, researcher, medical or nursing school faculty, student or employee, counselor, social worker or any professional, paraprofessional, or any other person who furnishes, or assists in the furnishing of, a health-care procedure.

(c) "Health-care institution" means any public or private organization, corporation, partnership, sole proprietorship, association, agency, network, joint venture, or other entity that is involved in providing health-care services, including, but not limited to: hospitals, clinics, medical centers, ambulatory surgical centers, private physician's offices, pharmacies, nursing homes, university medical schools and nursing schools, medical training facilities, or other institutions or locations where health-care procedures are provided to any person.

(d) …

(e) …

(f) "Participate" in a health-care service means to counsel, advise, provide, perform, assist in, refer for, admit for purposes of providing, or participate in providing, any health-care service or any form of such service.

(g) …

(h) "Conscience" means the religious, moral or ethical principles held by a health-care provider, the health-care institution or health-care payer. For purposes of this chapter, a health-care institution or health-care payer's conscience shall be determined by reference to its existing or proposed religious, moral or ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations or other relevant documents.

§ 41-107-5 Rights of Conscience of Health-Care Providers

(1) Rights of Conscience. A health-care provider has the right not to participate, and no health-care provider shall be required to participate in a health-care service that violates his or her conscience. However, this subsection does not allow a health-care provider to...
refuse to participate in a health-care service regarding a patient because of the patient's race, color, national origin, ethnicity, sex, religion, creed or sexual orientation.

(2) **Immunity from Liability.** No health-care provider shall be civilly, criminally, or administratively liable for declining to participate in a health-care service that violates his or her conscience. However, this subsection does not exempt a health-care provider from liability for refusing to participate in a health-care service regarding a patient because of the patient's race, color, national origin, ethnicity, sex, religion, creed or sexual orientation.

(3) **Discrimination.** It shall be unlawful for any person, health-care provider, health-care institution, public or private institution, public official, or any board which certifies competency in medical specialties to discriminate against any health-care provider in any manner based on his or her declining to participate in a health-care service that violates his or her conscience. For purposes of this chapter, discrimination includes, but is not limited to: termination, transfer, refusal of staff privileges, refusal of board certification, adverse administrative action, demotion, loss of career specialty, reassignment to a different shift, reduction of wages or benefits, refusal to award any grant, contract, or other program, refusal to provide residency training opportunities, or any other penalty, disciplinary or retaliatory action.

§ 41-107-7 Rights of Conscience of Health-Care Institutions

(1) **Rights of Conscience.** A health-care institution has the right not to participate, and no health-care institution shall be required to participate in a health-care service that violates its conscience. However, this subsection does not allow a health-care institution to refuse to participate in a health-care service regarding a patient because of the patient's race, color, national origin, ethnicity, sex, religion, creed or sexual orientation.

(2) **Immunity from Liability.** A health-care institution that declines to provide or participate in a health-care service that violates its conscience shall not be civilly, criminally or administratively liable if the institution provides a consent form to be signed by a patient before admission to the institution stating that it reserves the right to decline to provide or participate in a health-care service that violates its conscience. However, this subsection does not exempt a health-care institution from liability for refusing to participate in a health-care service regarding a patient because of the patient's race, color, national origin, ethnicity, sex, religion, creed or sexual orientation.

(3) **Discrimination.** It shall be unlawful for any person, public or private institution, or public official to discriminate against any health-care institution, or any person, association, corporation, or other entity attempting to establish a new health-care institution or operating an existing health-care institution, in any manner, including, but not limited to, any denial, deprivation or disqualification with respect to licensure, any aid assistance, benefit or privilege, including staff privileges, or any authorization, including authorization to create, expand, improve, acquire, or affiliate or merge with any health-care institution, because such health-care institution, or person, association, or corporation planning, proposing, or operating a health-care institution, declines to participate in a health-care service which violates the health-care institution's conscience.
(4) *Denial of Aid or Benefit.* It shall be unlawful for any public official, agency, institution, or entity to deny any form of aid, assistance, grants or benefits, or in any other manner to coerce, disqualify or discriminate against any person, association, corporation or other entity attempting to establish a new health-care institution or operating an existing health-care institution because the existing or proposed health-care institution declines to participate in a health-care service contrary to the health-care institution's conscience.

…

§ 41-107-11 Civil remedies

(1) A civil action for damages or injunctive relief, or both, may be brought for the violation of any provision of this chapter. It shall not be a defense to any claim arising out of the violation of this chapter that such violation was necessary to prevent additional burden or expense on any other health-care provider, health-care institution, individual or patient.

(2) *Damage Remedies.* Any individual, association, corporation, entity or health-care institution injured by any public or private individual, association, agency, entity or corporation by reason of any conduct prohibited by this chapter may commence a civil action. Upon finding a violation of this chapter, the aggrieved party shall be entitled to recover threefold the actual damages, including pain and suffering, sustained by such individual, association, corporation, entity or health-care institution, the costs of the action, and reasonable attorney's fees; but in no case shall recovery be less than Five Thousand Dollars ($5,000.00) for each violation in addition to costs of the action and reasonable attorney's fees. These damage remedies shall be cumulative, and not exclusive of other remedies afforded under any other state or federal law.

(3) *Injunctive Remedies.* The court in such civil action may award injunctive relief, including, but not limited to, ordering reinstatement of a health-care provider to his or her prior job position.
New Jersey


AN ACT concerning the dispensing of medications and supplementing P.L.2003, c.280 (C.45:14-40 et seq.).

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. a. A pharmacy practice site has a duty to properly fill lawful prescriptions for prescription drugs or devices that it carries for customers, without undue delay, despite any conflicts of employees to filling a prescription and dispensing a particular prescription drug or device due to sincerely held moral, philosophical or religious beliefs.

   b. If a pharmacy practice site does not have in stock a prescription drug or device that it carries, and a patient presents a prescription for that drug or device, the pharmacy practice site shall offer:

       (1) to obtain the drug or device under its standard expedited ordering procedures; or

       (2) to locate a pharmacy [of the patient’s choice] that is reasonably accessible to the patient and has the drug or device in stock, and transfer the prescription there in accordance with the pharmacy practice site’s standard procedures.

       The pharmacy practice site shall perform the patient’s chosen option without delay. If the patient so requests, the pharmacist shall return an unfilled prescription to the patient.

   c. If a pharmacy practice site does not carry a prescription drug or device, and a patient presents a prescription for that drug or device, the pharmacy practice site shall offer to locate a pharmacy that is reasonably accessible to the patient and has the drug or device in stock.

   d. A person who believes that a violation of this section has occurred may report the violation to the New Jersey State Board of Pharmacy.

2. This act shall take effect immediately.

Establishes pharmacy’s duty to fill prescriptions for in-stock drugs or devices without delay, notwithstanding sincerely held moral, philosophical or religious beliefs of pharmacist.
Tennessee


68-34-102 Chapter definitions

As used in this chapter, unless the context otherwise requires:

1. “Commissioner” means the commissioner of health;

2. “Contraceptive procedures” means any medically accepted procedure designed to prevent conception;

3. “Contraceptive supplies” means those medically approved items designed to prevent conception through chemical, mechanical or other means;

4. “Department” means the department of health; and

5. “Physician” means any doctor of medicine or doctor of osteopathy duly licensed to practice such physician's profession in Tennessee or the state in which such physician resides and lawfully practices such physician's profession.

68-34-104 Contraceptives — Availability — Information — Religious belief

It is the policy and authority of this state that:

1. All medically acceptable contraceptive procedures, supplies, and information shall be readily and practicably available to each and every person desirous of the same regardless of sex, race, age, income, number of children, marital status, citizenship or motive;

2. Contraceptive procedures, including medical procedures for permanent sterilization, when performed by a physician on a requesting and consenting patient, are consistent with public policy;

3. Nothing in this chapter shall inhibit a physician from refusing to furnish any contraceptive procedures, supplies or information where such refusal is for medical reasons;

4. Dissemination of medically acceptable contraceptive information by duly authorized persons in state and county health and welfare departments, in medical facilities at institutions of higher learning, and at other agencies and instrumentalities of this state is consistent with public policy;

5. No private institution or physician, nor any agent or employee of such institution or physician, shall be prohibited from refusing to provide contraceptive procedures, supplies, and information when such refusal is based upon religious or conscientious objection, and no such institution, employee, agent, or physician shall be held liable for such refusal; and

6. To the extent that family planning funds are available, each public health agency of this state and each of its political subdivisions shall provide contraceptive procedures, supplies, and information, including voluntary sterilization procedures for male or female persons eligible for free medical service as determined by rules and regulations promulgated by the commissioner. The same service shall be available to all others
who are unable to obtain the service privately, at a cost to be determined by rules and regulations promulgated by the commissioner.

68-34-107Contraceptives for minors

Contraceptive supplies and information may be furnished by physicians to any minor who is pregnant, a parent, or married, or who has the consent of the minor's parent or legal guardian, or who has been referred for such service by another physician, a clergy member, a family planning clinic, a school or institution of higher learning, or any agency or instrumentality of this state or any subdivision of the state, or who requests and is in need of birth control procedures, supplies or information.
Washington

Washington Administrative Code section 246-863-095: Pharmacist’s Professional Responsibilities

(1) A pharmacist’s primary responsibility is to ensure patients receive safe and appropriate medication therapy.

(4) It is considered unprofessional conduct for any person authorized to practice or assist in the practice of pharmacy to engage in any of the following:

(a) Destroy unfilled lawful prescription;
(b) Refuse to return unfilled lawful prescriptions;
(c) Violate a patient's privacy;
(d) Discriminate against patients or their agent in a manner prohibited by state or federal laws; and
(e) Intimidate or harass a patient.

Washington Administrative Code section 246-869-010: Pharmacies’ Responsibilities

(1) Pharmacies have a duty to deliver lawfully prescribed drugs or devices to patients and to distribute drugs and devices approved by the U.S. Food and Drug Administration for restricted distribution by pharmacies, or provide a therapeutically equivalent drug or device in a timely manner consistent with reasonable expectations for filling the prescription, except for the following or substantially similar circumstances:

(a) Prescriptions containing an obvious or known error, inadequacies in the instructions, known contraindications, or incompatible prescriptions, or prescriptions requiring action in accordance with WAC 246-875-040.
(b) National or state emergencies or guidelines affecting availability, usage or supplies of drugs or devices;
(c) Lack of specialized equipment or expertise needed to safely produce, store, or dispense drugs or devices, such as certain drug compounding or storage for nuclear medicine;
(d) Potentially fraudulent prescriptions; or
(e) Unavailability of drug or device despite good faith compliance with WAC 246-869-150.

(2) Nothing in this section requires pharmacies to deliver a drug or device without payment of their usual and customary or contracted charge.

(3) If despite good faith compliance with WAC 246-869-150, the lawfully prescribed drug or device is not in stock, or the prescription cannot be filled pursuant to subsection (1)(a) of this section, the pharmacy shall provide the patient or agent a timely alternative for appropriate therapy which, consistent with customary pharmacy practice, may include obtaining the drug or device. These alternatives include but are not limited to:

(a) Contact the prescriber to address concerns such as those identified in subsection (1)(a) of
this section or to obtain authorization to provide a therapeutically equivalent product;

(b) If requested by the patient or their agent, return unfilled lawful prescriptions to the patient or agent; or

(c) If requested by the patient or their agent, communicate or transmit, as permitted by law, the original prescription information to a pharmacy of the patient's choice that will fill the prescription in a timely manner.

(4) Engaging in or permitting any of the following shall constitute grounds for discipline or other enforcement actions:

(a) Destroy unfilled lawful prescription.

(b) Refuse to return unfilled lawful prescriptions.

(c) Violate a patient's privacy.

(d) Discriminate against patients or their agent in a manner prohibited by state or federal laws.

(e) Intimidate or harass a patient.
Proposed Conscientious Objection Legislation


H.R. 1652 [109th]: Access to Legal Pharmaceuticals Act

A BILL

To establish certain duties for pharmacies when pharmacists employed by the pharmacies refuse to fill valid prescriptions for drugs or devices on the basis of personal beliefs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the “Access to Legal Pharmaceuticals Act”.

SEC. 2. FINDINGS.

The Congress finds as follows:

(1) An individual’s right to religious belief and worship is a protected, fundamental right in the United States.

(2) An individual’s right to access legal contraception is a protected, fundamental right in the United States.

(3) An individual’s right to religious belief and worship cannot impede an individual’s access to legal prescriptions, including contraception.

SEC. 3. DUTIES OF PHARMACIES WITH RESPECT TO REFUSAL OF PHARMACISTS TO FILL VALID PRESCRIPTIONS.

(a) IN GENERAL.—Part B of title II of the Public Health Service Act (42 U.S.C. 238 et seq.) is amended by adding at the end the following section:

“SEC. 249. DUTIES OF PHARMACIES WITH RESPECT TO REFUSAL OF PHARMACISTS TO FILL VALID PRESCRIPTIONS.

“(a) IN GENERAL.—A pharmacy that receives prescription drugs or prescription devices in interstate commerce shall maintain compliance with the following conditions:

“(1) If a product is in stock and a pharmacist employed by the pharmacy refuses on the basis of a personal belief to fill a valid prescription for the product, the pharmacy ensures, subject to the consent of the individual presenting the prescription in any case in which the individual has reason to know of the refusal, that the prescription is, without delay, filled by another pharmacist employed by the pharmacy.

“(2) Subject to subsection (b), if a product is not in stock and a pharmacist employed by the pharmacy refuses on the basis of a personal belief or on the basis of pharmacy policy to order or to offer to order the product when presented a valid prescription for the product—

“(A) the pharmacy ensures that the individual presenting the prescription is immediately informed that the product is not in stock but can be ordered by the pharmacy; and
“(B) the pharmacy ensures, subject to the consent of the individual, that the product is, without delay, ordered by another pharmacist employed by the pharmacy.

“(3) The pharmacy does not employ any pharmacist who engages in any conduct with the intent to prevent or deter an individual from filling a valid prescription for a product or from ordering the product (other than the specific conduct described in paragraph (1) or (2)), including—

“(A) the refusal to return a prescription form to the individual after refusing to fill the prescription or order the product, if the individual requests the return of such form;

“(B) the refusal to transfer prescription information to another pharmacy for refill dispensing when such a transfer is lawful, if the individual requests such transfer;

“(C) subjecting the individual to humiliation or otherwise harassing the individual; or

“(D) breaching medical confidentiality with respect to the prescription or threatening to breach such confidentiality.

“(b) PRODUCTS NOT ORDINARILY STOCKED.—Sub-section (a)(2) applies only with respect to a pharmacy ordering a particular product for an individual presenting a valid prescription for the product, and does not require the pharmacy to keep such product in stock, except that such subsection has no applicability with respect to a product for a health condition if the pharmacy does not keep in stock any product for such condition.

“(c) ENFORCEMENT.—

“(1) CIVIL PENALTY.—A pharmacy that violates a requirement of subsection (a) is liable to the United States for a civil penalty in an amount not exceeding $5,000 per day of violation, not to exceed $500,000 for all violations adjudicated in a single proceeding.

“(2) PRIVATE CAUSE OF ACTION.—Any person aggrieved as a result of a violation of a requirement of subsection (a) may, in any court of competent jurisdiction, commence a civil action against the pharmacy involved to obtain appropriate relief, including actual and punitive damages, injunctive relief, and a reasonable attorney’s fee and cost.

“(3) LIMITATIONS.—A civil action under paragraph (1) or (2) may not be commenced against a pharmacy after the expiration of the five-year period beginning on the date on which the pharmacy allegedly engaged in the violation involved.

“(d) DEFINITIONS.—For purposes of this section:

“(1) The term ‘employ’, with respect to the services of a pharmacist, includes entering into a contract for the provision of such services.

“(2) The term ‘pharmacist’ means a person authorized by a State to practice pharmacy, including the dispensing and selling of prescription drugs.
“(3) The term ‘pharmacy’ means a person who—

‘‘(A) is authorized by a State to engage in the business of selling prescription drugs at retail; and

‘‘(B) employs one or more pharmacists.

“(4) The term ‘prescription device’ means a device whose sale at retail is restricted under section 520(e)(1) of the Federal Food, Drug, and Cosmetic Act.

“(5) The term ‘prescription drug’ means a drug that is subject to section 503(b)(1) of the Federal Food, Drug, and Cosmetic Act.

“(6) The term ‘product’ means a prescription drug or a prescription device.

“(7) The term ‘valid’, with respect to a prescription, means—

‘‘(A) in the case of a drug, a prescription within the meaning of section 503(b)(1) of the Federal Food, Drug, and Cosmetic Act that is in compliance with applicable law, including, in the case of a prescription for a drug that is a controlled substance, compliance with part 1306 of title 21, Code of Federal Regulations, or successor regulations; and

‘‘(B) in the case of a device, an authorization of a practitioner within the meaning of section 520(e)(1) of such Act that is in compliance with applicable law.

“(8) The term ‘without delay’, with respect to a pharmacy filling a prescription for a product or ordering the product, means within the usual and customary timeframe at the pharmacy for filling prescriptions for products for the health condition involved or for ordering such products, respectively.’’.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect upon the expiration of 30 days after the date of the enactment of this Act, without regard to whether the Secretary of Health and Human Services has issued any guidance or final rule regarding such amendment.

General Provision

A pharmacist has the right not to dispense or participate in dispensing, and no pharmacist shall be required to dispense or participate in dispensing, any prescription drug that violates his or her religious, moral, or ethical beliefs. However, this provision does not permit a pharmacist to refuse to dispense a prescription drug on the basis of a patient’s race, ethnicity, national origin, sex, religion, or sexual orientation.

Obligations of the Pharmacist-Employee

A pharmacist that intends to refuse to dispense a prescription drug under this statute must report his or her intention to

1. the state pharmacy board and
2. his or her employer.

When a pharmacist refuses to dispense a prescription drug in accordance with this statute, and no other non-refusing pharmacist is available to dispense the medication, the pharmacist must either:

1. transfer the prescription to a pharmacy or other healthcare facility that can dispense the prescription drug, or
2. refer the customer to a pharmacy or other healthcare facility that can dispense the prescription drug.

Obligations of Pharmacy-Employer

A pharmacy that chooses not to carry certain prescription drugs in accordance with this statute must provide its customers with advance notice of its policy. Such notice may be posted in a location visible to customers or may be provided to customers by some other equally adequate means that ensures customers are made aware, in advance, of the drugs the pharmacy refuses to carry on conscience grounds.

Obligations of State Pharmacy Boards, Physicians, and Other Healthcare Providers

Each state pharmacy board is required to provide physicians and other healthcare providers in the state with a list of pharmacies available to dispense emergency contraception and other prescription drugs objected to on conscience grounds. Physicians and other healthcare providers should provide patients with such information when prescribing the particular medication.
Appendix B: Professional Codes of Ethics

Canada


ii) Moral or Religious Beliefs

If physicians have moral or religious beliefs which affect or may affect the provision of medical services, the College advises physicians to proceed cautiously with an understanding of the implications related to human rights.

Personal beliefs and values and cultural and religious practices are central to the lives of physicians and their patients.

Physicians should, however, be aware that the Ontario Human Rights Commission or Tribunal may consider decisions to restrict medical services offered, to accept individuals as patients or to end physician-patient relationships that are based on physicians’ moral or religious beliefs to be contrary to the *Code*.

College Expectations

The College has its own expectations for physicians who limit their practice, refuse to accept individuals as patients, or end a physician-patient relationship on the basis of moral or religious belief.

In these situations, the College expects physicians to do the following:

- Communicate clearly and promptly about any treatments or procedures the physician chooses not to provide because of his or her moral or religious beliefs.

- Provide information about all clinical options that may be available or appropriate based on the patient’s clinical needs or concerns. 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.

- Treat patients or individuals who wish to become patients with respect when they are seeking or requiring the treatment or procedure. This means that physicians should not express personal judgments about the beliefs, lifestyle, identity or characteristics of a patient or an individual who wishes to become a patient. This also means that physicians should not promote their own religious beliefs when interacting with patients, nor should they seek to convert existing patients or individuals who wish to become patients to their own religion.

- Advise patients or individuals who wish to become patients that they can see another physician with whom they can discuss their situation and in some circumstances, help the patient or individual make arrangements to do so.

The College will consider the extent to which a physician has complied with this guidance, when evaluating whether the physician’s behaviour constitutes professional misconduct.

**Preamble**

All members of the College have moral obligations in return for the trust given them by society. They are obliged to act in the best interest of and advocate for the patient, observe the law, uphold the dignity and honour of the profession, and practice in accordance with ethical principles and their respective standards of practice.

**Principle One**

The patient's well-being is at the centre of the member’s professional and/or business practices. Each member develops a professional relationship with each patient at a level that is consistent with his or her scope of practice. Patients have the right to self-determination and are encouraged to participate in decisions about their health.

**Principle Four**

Each member respects the autonomy, individuality and dignity of each patient and provides care with respect for human rights and without discrimination. No patient shall be deprived of access to pharmaceutical services because of the personal convictions or religious beliefs of a member. Where such circumstances occur, the member refers the patient to a pharmacist who can meet the patient’s needs.

**Principle Five**

Each member acts with honesty and integrity.

**Principle Seven**

Each member collaborates with other health care professionals to achieve the best possible outcomes for the patient, understanding the individual roles and contributions of other health care providers and consulting with or referring to them as appropriate.

**Principle Eight**

Each member practices under conditions which neither compromise professional standards nor impose such conditions on others

*Members are defined as pharmacists, registered pharmacy students, interns and registered pharmacy technicians (pending).*
United States


Code of Ethics for Pharmacists

PREAMBLE

Pharmacists are health professionals who assist individuals in making the best use of medications. This Code, prepared and supported by pharmacists, is intended to state publicly the principles that form the fundamental basis of the roles and responsibilities of pharmacists. These principles, based on moral obligations and virtues, are established to guide pharmacists in relationships with patients, health professionals, and society.

I. A pharmacist respects the covenantal relationship between the patient and pharmacist.

Considering the patient-pharmacist relationship as a covenant means that a pharmacist has moral obligations in response to the gift of trust received from society. In return for this gift, a pharmacist promises to help individuals achieve optimum benefit from their medications, to be committed to their welfare, and to maintain their trust.

II. A pharmacist promotes the good of every patient in a caring, compassionate, and confidential manner.

A pharmacist places concern for the well-being of the patient at the center of professional practice. In doing so, a pharmacist considers needs stated by the patient as well as those defined by health science. A pharmacist is dedicated to protecting the dignity of the patient. With a caring attitude and a compassionate spirit, a pharmacist focuses on serving the patient in a private and confidential manner.

III. A pharmacist respects the autonomy and dignity of each patient.

A pharmacist promotes the right of self-determination and recognizes individual self-worth by encouraging patients to participate in decisions about their health. A pharmacist communicates with patients in terms that are understandable. In all cases, a pharmacist respects personal and cultural differences among patients.

IV. A pharmacist acts with honesty and integrity in professional relationships.

A pharmacist has a duty to tell the truth and to act with conviction of conscience. A pharmacist avoids discriminatory practices, behavior or work conditions that impair professional judgment, and actions that compromise dedication to the best interests of patients.

VI. A pharmacist respects the values and abilities of colleagues and other health professionals.
When appropriate, a pharmacist asks for the consultation of colleagues or other health professionals or refers the patient. A pharmacist acknowledges that colleagues and other health professionals may differ in the beliefs and values they apply to the care of the patient.


**Principles of Medical Ethics**

**Preamble**

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self: The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

**Principles of Medical Ethics**

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. 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.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

Adopted June 1957; revised June 1980; revised June 2001.