

Reconstructing Paradise: Canada's Health Care System, Alternative Medicine and the *Charter of Rights*

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I. Introduction

As one humble member of a [medical] profession, which for more than two thousand years has devoted itself to the pursuit of the best earthly interests of mankind, always assailed and insulted from without by such as are ignorant of its infinite perplexities and labors, always striving in unequal contest with [disease and death] not merely for itself and the present moment, but for the race and the future, I have lifted my voice against this lifeless delusion, rolling its shapeless bulk into the path of a noble science it is too weak to strike, or to injure.

Oliver Wendell Holmes, Homeopathy and its Kindred Delusions

It's supposed to be a professional secret, but I'll tell you anyway. We doctors do nothing. We only help and encourage the doctor within.

Albert Schweitzer

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A growing global awareness of alternative¹ medicine is affecting health care systems in countries as diverse as Canada, the U.K., the U.S., South Africa, France, Norway, Japan, Russia and Australia, amongst others.² It has caused a number of health care agencies to attempt to reforge the traditional relationship between orthodox medicine and other services.³ It has infiltrated the historically conservative health care insurance industry, to the extent that in some jurisdictions, particularly in the United States, insurers are now required by law to pay for alternative ways of treating illnesses.⁴

Studies in Canada, Britain and the U.S. show exponential growth in the number of users of alternative medical services in the past few years. A Canada Health Monitor survey showed that in 1996, more than 20% of Canadians sought an alternative health practitioner for a health problem—up from a 1994 Statistics Canada figure of 15%—for a total of about 3.3 million annual visits.⁵ In the U.K., a University of Sheffield study showed that in 1993 between 10 and 12 million separate visits to complementary therapists were conducted. The British Holistic Medical Association estimates that the number of complementary practitioners is increasing at a rate of 11% per year.⁶ A comprehensive U.S. study estimates that

¹The terms “alternative,” “complementary,” and “unorthodox” will be used interchangeably throughout this paper. Note, however, that the terminology itself is subject to dispute. Some argue the only acceptable term is “complementary,” as these therapies are an adjunct to medical care, acting cooperatively together – see U. Sharma, *Complementary Medicine Today: Practitioners and Patients* (London: Routledge, 1992). In contrast, the term “alternative” focuses on the nature of these therapies as marginalized and outside the established health care system – see M. Saks, “The Paradox of Incorporation: Acupuncture and the Medical Profession in Modern Britain” in M. Saks, ed., *Alternative Medicine in Britain* (Oxford: Clarendon Press, 1992) 183-200. But others disagree: “[h]omeopathy is a radical alternative to orthodox medicine, it is not complementary” – cited in S. Cant & U. Sharma, “Demarcation and Transformation within Homeopathic Knowledge: A Strategy of Professionalization” (1996) 42:4 Soc. Sci. Med. 579 at 585. See also J.H. Young, “The Development of the Office of Alternative Medicine in the National Institutes of Health, 1991-1996” (1998) 72 Bulletin Hist. of Med. 279 at 294 (the OAM broadened its name to include the more diplomatic “complementary”) and W. Sampson, “Antiscience Trends in the Rise of the “Alternative Medicine” Movement” in P.R. Gross, N. Levitt & M.W. Lewis, eds., *The Flight from Science and Reason* (New York: New York Academy of Sciences, 1996) 188.

²A good survey of the global increase in complementary medical practices is found in S. Goldbeck-Wood *et al.*, “Complementary Medicine is Booming Worldwide” (1996) 313:7050 Brit. Med. J. 131.

³R. Schober, “Complementary and Conventional Medicine Working Together” (1997) 5:1 Can. Health Psychologist 14; see also Ontario, *Report of the Ad Hoc Committee on Complementary Medicine to the Council of the College of Physicians and Surgeons of Ontario* (Toronto: Sept. 1997, Dr. David Walker, Chair) [hereinafter Walker Report].

⁴See M.H. Cohen, “Holistic Health Care: Including Alternative and Complementary Medicine in Insurance and Regulatory Schemes” (1996) 38 Ariz. L. Rev. 83 at n. 509-15 and accompanying text.

⁵*Statistics Canada National Population Health Survey Overview, 1994-95* (Ottawa: Queen’s Printer, 1995). The alternative health categories measured included massage therapist, acupuncturist, homeopath, naturopath, chiropractor, Feldenkrais or Alexander Method teacher, relaxation therapist, biofeedback specialist, rolfer, herbalist, reflexologist, spiritual healer, or participation in self-help groups such as Alcoholics Anonymous.

⁶Figures quoted in Cant & Sharma, *supra* note 1. The figures in France are even more compelling: more than a third of people use some form of complementary medicine “*medicine differente or medicine douce*,” 10,000 or more doctors use homeopathy, have studied it during their medical training where it is funded by the state – cited in R.W. Davey, “A Perspective on Complementary Medicine” (1997)

33% of Americans use alternative medicine annually and that visits to its practitioners were more common than those to primary care physicians (425 million visits versus 338 million to registered physicians).⁷ Another U.S. report estimates that 70-90% of worldwide health care is based on alternative practices, while only 10-30% is related to biomedicine.⁸

Despite these increases, most Western legal regimes still treat the two systems differently, usually by not covering alternative procedures to the same extent as biomedical procedures in funding or insurance schemes. In France, for example, unorthodox treatments are only partly reimbursed under the national health scheme, compared to full reimbursement for bioscientific interventions. In Australia, complementary treatments are, for the most part, not covered by Medicare.⁹ But the tides are shifting. Patients, now more powerful and aware, are requesting that complementary medical treatments be included within health care systems. Even once sceptical physicians are joining in, as a recent U.K. survey of general practitioners found that 75% thought that public funds should pay for some forms of complementary medicine.¹⁰

The creation of complementary medicine research centres underscores developments to legitimize and popularize this area. In the U.S., the National Institute of Health has created an Office of Alternative Medicine.¹¹ In Canada, a number of specialized clinics have formed, the pre-eminent one being the Tzu-Chi Institute for Complementary and Alternative Medicine, opened in Vancouver in 1996.¹² Nova Scotia and Ontario have both set up environmental health clinics to treat patients suffering from “environmental illnesses” or “multiple chemical

65:2 *Medico-Legal J.* 65 at 71.

⁷See D.M. Eisenberg, *et al.*, “Unconventional Medicine in the United States: Prevalence, Costs, and Patterns of Use” (1993) 328:4 *New Eng. J. Med.* 246. The types of therapies and percentage of visits were: relaxation techniques (13%), chiropractic (10%), massage (7%), imagery, biofeedback and hypnosis (6%), spiritual and energy healing (5%), homeopathy (1%) and acupuncture (less than 1%). The study estimated that \$13.7 billion U.S. is spent annually on these treatments. Some concerns over the outcomes in this survey have been made – see S. Barrett, “‘Alternative’ Therapy, Buzzword for the ‘90s” (1993) 10 *Nutrition Forum* 1.

⁸See United States, *Alternative Medicine: Expanding Medical Horizons*, A Report to the National Institutes of Health on Alternative Medical Systems and Practices in the United States (1992) ix [hereinafter Chantilly Report].

⁹See Goldbeck-Wood, *supra* note 2. There are exceptions for certain general practitioners offering treatments such as acupuncture.

¹⁰See G. Cameron-Blackie & Y. Mounser, “Complementary Therapies in the NHS” (1993) *NAHAT* 22.

¹¹See Young, *supra* note 1. A scathing attack on the OAM is provided by Sampson, *supra* note 1. Congress funded it without evidence of alternative medicine’s validity; a vast majority of the advisory board was made up of its proponents; research awards are given out to many without research records; and there is no peer review.

¹²See “Alternative Medicine, It’s Official” (1997) 342:8009 *Economist* (Cdn. ed.) 54.

hypersensitivity,” and to study the etiology of environmental hypersensitivity and evaluate treatment therapies through research.¹³

Rising expectations, however, do not necessarily result in fundamental change, especially in such a traditionally conservative institution as the health care system. For it would be difficult to argue that orthodox medical practices are in immediate danger of losing their monopolies over health care in Canada. Legislative policies, funding arrangements and historically entrenched roles continue to favour a health care system dominated by biomedicine. To some proponents of complementary medicine, these structural constraints mean that real change will likely be too slow in coming.

The paper ultimately explores the question whether the *Charter of Rights and Freedoms*¹⁴ is a possible site for grounding challenges to extant provincial medical systems – primarily by focussing on the anti-discriminatory provisions found in section 15 and to a lesser extent the fundamental justice provisions of section 7. In doing so, it makes the initial assumption, hardly controversial, that scientific medical care has a dominant place in the health care field in Canada, at least as far as coverage under Medicare plans is concerned. The paper then examines in detail the interaction between orthodox medicine, alternative medicine, and law.

The paper begins by providing a basic overview of complementary medicine and its practices in Part 2. Part 3 outlines the current state of Canada’s Medicare system. Although all ten provinces have their own particularities, for brevity, only British Columbia, Alberta and Ontario will be examined. The discussion starts with the basic structure of the Canadian health care system, and then proceeds to analyse those inroads that alternative medical practices have made into the orthodox system. Following that, Part 4 explores theoretically some aspects of alternative medicine and its place within both the legal and Medicare systems. Part 5 then turns to look at jurisprudence under the *Charter*, specifically as it relates to provision of government services such as health care, and then undertakes a *Charter* analysis of the Medicare system and its relation to alternative medicine. The conclusion in Part 6 offers some general recommendations and ideas about future developments in this area.

¹³The Nova Scotia Environmental Health Medicine Clinic started in 1991 as a response to a devastating case of sick building syndrome at the city’s Camp Hill Hospital; the Environmental Health Clinic in Toronto was formed in 1996. The mandate of the Toronto Clinic and the associated Environmental Hypersensitivity Research Unit (EHRU) is to study the etiology of environmental hypersensitivity and evaluation of therapies to treat the condition, if it exists — see G. McKeown-Eyssen, *et al.*, “Research Initiatives at the University of Toronto Environmental Hypersensitivity Research Unit” (1996) 24 Reg. Tox. and Pharm. 126.

¹⁴*Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter the *Charter*].

2. Alternative Medicines: an Overview

...this is Gwa-sah...a form of gentle massage [using an appliance along my back]. When I turn around to see what this new appliance is, she shows me an ordinary Chinese porcelain soup spoon. Not the sort of thing that requires a hospital fund-raising drive to purchase.

Financial Post Magazine (Canada), February, 1997, at 38-45

A. Introduction

The holistic health movement has returned, at least temporarily, despite the best efforts of the medical establishment. Although dissident groups challenged the medical profession for much of its history, this changed with the advent of technology and professionalism. Many alternative therapies had long traditions of their own, but the twentieth century dominance, in the West, of professional, scientific medicine, resulted in the near extinction of many formerly popular therapies.¹⁵ It was only with the advent of the counterculture movements of the 1960s and 70s that biomedicine's monopoly was again seriously questioned. The hippie counterculture sought health care that rejected technology and emphasized wholeness of body and mind, natural forces and mysticism.

One possible reason for the huge growth in alternative medicine recently is not the efficacy of alternative therapies per se, but rather the failure of modern medical practices to provide complete answers to common health problems. Bioscientific medicine is often characterized as impersonal, mainly because of the role played by doctors: they are too scientific, they overutilize technology and chemicals, they are at best overworked, at worst, unfeeling. Compare this to the glamourized portrayal of the alternative practitioner who gently touches patients and spends more time with them.¹⁶ Patients also complain of a feeling of loss of individual control in the

¹⁵Naturopathy, homeopathy and midwifery were all especially popular forms of practice in previous centuries. See e.g. G.L. Albrecht & J.A. Levy, "The Professionalization of Osteopathy: Adaptation in the Medical Marketplace" (1982) 2 *Research in Soc. of Health Care* 161; P. Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982) chap. 1-3; and R.G. DeVries, "Midwifery and the Problem of Licensure" (1982) 2 *Res. in Soc. of Health Care* 77. The distinction between regular and irregular medical practices was very much blurred before the early 19th century – for an excellent overview of the general history of medicine, including some of the developments of alternative medicines see L.I. Conrad, et al., *The Western Medical Tradition, 800 BC to AD 1800* (Cambridge: Cambridge University Press, 1995). Institutions such as the *British Medical Journal* helped to lead the assault on quackery – see P. Bartrip, "Secret Remedies, Medical Ethics, and the Finances of the *British Medical Journal*" in R. Baker ed., *The Codification of Medical Morality* (Amsterdam: Kluwer Academic Publishers, 1995) 191.

¹⁶According to "Alternative Medicine" (1992) *CQ Researcher* 73, practitioners of alternative medicine spend on average 8 times as long with their patients as orthodox physicians. See also "The Power to Heal: Modern Science Can't Explain Medical Miracles" (1996) *B.C. Rept.* 32; but compare R. Coward, *The Whole Truth: The Myth of Alternative Health* (London: Faber and Faber, 1989) who presents a devastating critique of this "romanticism" and J. Marks, "Commentary: Holism" (1995) 16 *Clin. Pharm. and Therapy* 305.

medical system, and a switch to an alternative therapy evinces a desire to take personal responsibility in health care and thus open up patient choice.¹⁷

But the long-term future of many alternative therapies, as independent practices, is still in doubt.¹⁸ Classical models of social theory state that challengers to established orthodoxies usually face a number of shaming and labelling techniques intended to cause their demise. To survive, some unorthodox groups may abandon their distinctive philosophies in favour of the dominant view, becoming co-opted into traditional orthodoxies.¹⁹ Or others succeed despite rejecting the accepted wisdom, if certain conditions of internal respectability are in place.²⁰ Still others end up outside the mainstream, marginalized in a form of parallel market. Various alternative health care practices have adopted one or other of these survival strategies. But by far the most common is the former – there is a growing acceptance of certain alternative practices within the established medical system, and an increasing number of practicing holistic MDs. There is a documented tendency for biomedicine to co-opt or absorb alternative medical systems that it cannot eliminate.²¹

There is evidence that this is already occurring in Canada. A growing number of physicians believe in complementary therapies. Whereas not more than 25 years ago, a doctor who referred a patient to a non-medical practitioner would have been brought before a disciplinary tribunal, doctors today are much more likely to consider and inform patients of the availability of complementary therapists.²² Even respected clinical journals are debating the merits of alternative medicines at a level that would have been incomprehensible a few years ago.²³ Also, the eagerness with

¹⁷See E. Mitchell, "Natural Selection: Growing Unease with Modern Medicine Has Led to a Surge of Interest in Alternative Therapies" (1996) 62:8 Quill and Quire 31. Others disagree, arguing that choice is lessened when orthodox medical services are replaced with alternative options – see D. Crittenden, "Frontier Medicine" *The [Toronto] Globe and Mail* (9 April 1994) A4 (taking obstetrics from the exclusive domain of the medical profession by allowing midwives to perform deliveries, results also in a loss of anaesthetic services).

¹⁸Excluding the well established distinct professions such as chiropractic and osteopathy.

¹⁹In the health care field, osteopathy falls into this camp – see H.A. Baer, "The Organizational Rejuvenation of Osteopathy: A Reflection of the Decline of Professional Dominance in Medicine" (1981) 15A Soc. Sci. Med. 701.

²⁰Chiropractic is an example. For an explanation of its continued success see W.I. Wardwell, "Chiropractors: Challengers of Medical Domination" (1981) 2 Res. Soc. Health Care 207.

²¹H.A. Baer, "The Potential Rejuvenation of American Naturopathy as a Consequence of the Holistic Health Movement" (1992) 13 Med. Anthropol. 369 at 380. See also Starr, *supra* note 15 at Book One.

²²See "In Praise of Alternative Medicine: Doctors Discuss Why They Don't Stick Strictly to Conventional Methods" (1994) 30:18 Medical Post 40. Of course, this is still far from universally accepted within the medical profession – one of the most damning indictments of alternative practices is the 15 year old article by C. Glymour & D. Stalker, "Sounding Board: Engineers, Cranks, Physicians, Magicians" (1983) 308:16 New Eng. J. Med. 960. For a recent articulation of the debate in Canada, see N. Robb, "Some MDs Displeased as MSNS Board Gives Nod to Complementary Medicine Section" (1994) 150:9 Can. Med. Assoc. J. 1462.

²³For example, see successive exchanges in the journal *Pediatrics* beginning in May, 1994 with a homeopathy report; see also Eisenberg, *supra* note 7 and editorial in the same issue of the *New England Journal of Medicine*.

which some alternative practices are being taken up by the medical mainstream is illuminating. An estimated 30,000 North American nurses now employ therapeutic touch, the updated nonphysical version of the laying on of hands described in the Bible.²⁴ Toronto's East General Hospital was the first Canadian hospital to adopt a policy making therapeutic touch available to all patients.²⁵ Now Toronto's Doctors Hospital offers massage, acupuncture and relaxation techniques to patients suffering from mental illness.²⁶ In its Traditional Healing Services Program for women, the hospital encourages women substance abusers to deal with their problems holistically, by addressing the needs of the body and the mind. It employs alternative healing practices in combination with other, more conventional, treatments.²⁷

The demand for these services has followed a typical diffusion of innovation pattern.²⁸ A Price Waterhouse monitor of the health habits of Canadians found that public demand for various forms of alternative health care was considerable – in 1996, at least half of all people reporting colds, coughs or allergies used some form of alternative therapy. This led to some alternative therapies gaining coverage under employee health care plans.²⁹ It is now commonly believed, across the entire health care community spectrum, that all health care providers should be trained or knowledgeable in complementary therapies, especially those, such as acupuncture and manual healing, that are widely recognized and accepted.³⁰

B. What is Alternative Medicine?

There is no simple description of alternative medicine. It encompasses a diverse set of therapies, tending to emphasize the integration of body, mind and spirit. Most unorthodox therapies regard disease as having dimensions beyond the purely biological. These forms of medicine are generally perceived to run counter to the positivism and empiricism of Western science, and involve a radically

²⁴See "The New Spirituality: Mainstream North America is on a Massive Search for Meaning in Life" *Maclean's* 107:41 (1994) 44. Further evidence of its success is the opening of the Touch Research Institute, University of Miami School of Medicine.

²⁵See "The Healing Touch" *Flare* 16:10 (1994) 70.

²⁶See K. Cottrell, "The Age of Alternatives" *Chatelaine* 68:7 (1995) 29 at 31.

²⁷See "Body is the Conduit for Alternative Treatments (Holistic Approach to Addiction Treatment for Women, Doctors Hospital, Toronto)" (1996) 23:6 *J. Addiction Res. Foundation* 2.

²⁸See E.M. Rogers, *Diffusion of Innovation* (New York: Free Press of Glencoe, 1962). The theory is that all new ideas spread amongst a population in a similar way. In common parlance, innovation patterns begin with innovators, and go through stages where "early adapters," then "early majority," "late majority" and finally "laggards" adopt an idea, product or service.

²⁹See O. Edur, "Beyond Mainstream: More Employee Health Plans are Providing Some Limited Coverage for Alternative Treatments" *Financial Post* 10:70 (1997) 28. As an example, Husky Injection Molding Systems Ltd., a company in Bolton, Ontario, brings a naturopath onto its premises two days per week. The private plan utilizes both orthodox and complementary medicine in a holistic approach to health care for its employees. This is the main reason cited for Husky's significantly lower than industry average drug costs.

³⁰See M. Habib, "Health Care Workers Face Demands for Alternative Therapies" *Canadian Press Newswire* (6 June 1997).

different epistemology, especially in cases of indigenous medicine.³¹ Many are influenced strongly by Eastern philosophies,³² and offer a revitalized spirituality and meaning in life.³³

A 1993 survey found that 20% of Canadians use some form of alternative therapy; this compares with an estimated 33% of Americans.³⁴ In 1995, Canadians spent almost \$150 million on herbal remedies alone. That these new therapies have reached a new level of legitimacy cannot be questioned.³⁵ However, despite increases in visits to alternative therapists, people are not abandoning their regular doctors. Most patients continue to consult a family physician; on average, 90% of those seeking alternative medical treatment continued to visit their family physicians.³⁶

Alternative therapies range across a wide spectrum.³⁷ There are the accepted or traditional forms, such as:

- faith healing and prayer;³⁸
- acupuncture (the Chinese practice of inserting needles at specified points to release energy along the body's meridians, and to stimulate brain chemicals, including pain-relieving endorphins);
- Shiatsu (massage along the same principle as acupuncture);
- chiropractic (treatment of muscular and skeletal disorders through manipulation);

³¹See E. Alderete, "The Formulation of a Health Research Agenda by and for Indigenous Peoples: Contesting the Western Scientific Paradigm" (1996) 2:3 J. Alt. and Comp. Med. 377.

³²See Baer, *supra* note 19.

³³See "The New Spirituality" *supra* note 24.

³⁴See *supra* notes 5, 7 and accompanying text.

³⁵So much so that alternative therapies have entered the popular literature to such an extent that renders the term "alternative" suspect. For example, *Maclean's* and *Time* magazines frequently run articles on alternative medicine; there is a directory available of the widespread use of alternative medicine – see C. Harden & B. Harden, *Alternative Health Care: The Canadian Directory* (Toronto: Noble Ages, 1996); even pharmacies are turning to alternative medicine sections — see "Drug Chain Sells Wellness" *Canadian Press Newswire* (24 October 1996) reporting on the Health Sense stores developed by Pharma Plus.

³⁶See M. Kelner & B. Wellman, "Who Seeks Alternative Health Care? A Profile of the Users of Five Modes of Treatment" (1997) 3:2 J. Alt. and Comp. Med. 127.

³⁷Most books on alternative medicine, and there are hundreds, provide information on most of the therapies listed in this section. As examples, see C. Harden & B. Harden, *ibid.*; C. DeMarco, *Take Charge of Your Body: A Women's Health Advisor* 5th ed. (Winlaw, B.C. Well Women Press, 1994), G.T. Levith, ed. *Alternative Therapies: A Guide* 1985; D. Chopra, *Creating Health: Beyond Prevention, Toward Perfection* (Boston: Houghton Mifflin, 1987); Cant & Sharma, *supra* note 1. The Chantilly Report, *supra* note 8, lists many alternative medicine titles.

³⁸One of the earliest instances is laying on of hands on the sick and prayer attributed to Jesus, in Mark 16.

- indigenous or folk remedies (herbs and animal products such as shark cartilage used to cure diseases);³⁹
- mind-body medicine (a combination of relaxation techniques and other uses of the mind's capacity to affect the body);
- massage therapy (stroking and kneading soft tissue to promote circulation, relieve pain and tension and help heal injuries);
- homeopathy (a German-developed treatment based on the principle that "like cures like," where super-diluted solutions of otherwise toxic substances are taken to promote cures of various ailments, including headaches, infections, etc.); and
- naturopathy (an umbrella term referring to a system of health care that uses natural methods and substances to support and stimulate the body's inherent self-healing processes. Some of the other forms of alternative medicine are often contained within the rubric of naturopathy, including homeopathy, lifestyle counselling, and herbal medicine, amongst others)

Then there are the lesser known forms including:

- Traditional Chinese Medicine (TCM) (a heterogeneous array of ideologies and practices developed over the past 5000 years mainly within, but also outside China);⁴⁰
- chelation (intravenous treatments of ethylene diamine tetracetic acid (EDTA) for dissolving deposits in arteries as an alternative to heart surgery);
- special diets (macrobiotic);
- bioelectromagnetics (magnet use);
- reflexology (massaging certain points of hands and feet to stimulate or "detoxify" organs and correct illnesses);
- aromatherapy (hands-on therapy combining the physical and emotional effects of gentle massage with the medicinal and psychotherapeutic properties of plant essences);
- Ayurvedic therapy (6,000 year-old Indian health care tradition, using mind-body connections);

³⁹Indigenous or native medicine is sometimes included within the purview of alternative or complementary medicine, but in some ways is fundamentally distinct as it reflects an historically and culturally accepted form of practice – see E. Zubek, "Traditional Native Healing: Alternative or Adjunct to Modern Medicine?" (1994) 40 Cdn. Fam. Phys. 1923. Indigenous medicine is becoming more popular as aboriginal patients at some hospitals are now allowed native healers to work on them during their stay – see "The Power to Heal," *supra* note 16 at 35-36. In another instance, a first right of refusal was granted to aboriginal leaders to take over an Edmonton hospital that was slated for closure – see "Sweetgrass and Laser Surgery: the Province Considers Giving Indians Control of Edmonton's Cam sell Hospital" *Western Report* 9:34 (1994) 35.

⁴⁰For a good overview, see P. Unschuld, "Traditional Chinese Medicine: Some Historical and Epistemological Reflections" (1987) 24:12 Soc. Sci. Med. 1023. TCM has, despite its diversity, proven more adaptable to American culture than other nationalistic health practices such as Ayurvedic medicine and South Amerindian shamanism – see A. Oubré, "Social Context of Complementary Medicine in Western Society, Part II: Traditional Chinese Medicine and HIV Illness" (1995) 1:2 J. Alt. and Comp. Med. 161.

- Reiki or manual healing (gentle laying on of hands on body parts to relieve pain, tension, hasten healing and promote well-being by becoming attuned to universal energy); and
- iridology (studying the iris to determine body dysfunctions, in the belief that the iris is connected to every organ through the brain and nervous system).

As might be expected, there is no lack of criticism of the benefits of alternative medicine. These complaints come from a number of disciplines, and most commonly relate to the lack of scientific foundation for the proof of alternative treatments.⁴¹ Proponents of alternative therapies argue that traditional scientific methods, including double blind, randomized controlled trials, do not adequately deal with more holistic treatments.⁴² The debate is not likely to resolve itself in the near future. But even scientists and physicians accept that there are many things outside their control, and many inexplicable events result in better outcomes for patients. Most will admit that non-invasive procedures, such as exercise and prayer, and maintaining healthy attitudes towards disease and cure, can have benefits.⁴³

Moreover, there is evidence showing that false conclusions and contradictions exist in orthodox medical science. The U.S. Congress Office of Technology Assessment study on the efficacy and safety of medical technologies found that only 10-20% of conventional procedures have proof of clinical efficacy.⁴⁴ After billions of dollars spent on research, conventional scientific investigation has had limited effects on the rise in chronic disease rates. Other claims have been made that many surgical practices are unnecessary, and many drug treatments are harmful

⁴¹A sample: "US Agency Bends Rules of Science, Say Some" (1996) 32 Medical Post 33; the Discovery channel in its flagship science show, @discover.ca, ran a week-long series on alternative medicine in September, 1996; "A No-Touch Therapy: Critics Attack a Mystical Hand Motion Treatment Spreading Through Nursing Schools and Hospitals" *Time* 144:21 (1994) 70. See also Coward, *supra* note 16. The Australian Skeptics have a web site devoted to exposing alternative medical quackeries, "Qakatak" <<http://www.skeptics.com.au/features/qakatak/qakatak.htm>>. The pre-eminent medical journals also periodically publish editorials, letters and articles exposing weaknesses in alternative medical practices: see, for example, *Lancet*, 1998 – Aug. 1, 352:9125–408; 1997 – Sept. 20, 350:9081–834-43, May 31, 349:9065–1629; 1994 – Nov. 5, 344:8932–1279-81; *New Engl. J. Med.* 1998 – Sept. 17, 339:12–839-41; *Brit. Med. J.*, 1998 – Oct 31, issue devoted to randomized controlled trials; 1997 – Jan. 11, 314:7074–94; 1995 – Sept. 2, 311:7005, 633. Interestingly, these same journals do publish occasional pieces that might be considered supportive of alternative medicine (see, for example Goldbeck-Wood, *supra* note 2, Eisenberg, *supra* note 7) whereas this author was unable to find the reverse, i.e. criticism of alternative medical practices in those journals dedicated to it.

⁴²Although scientifically valid studies are possible through other methods such as single case reports (n=1), and unblinded studies that are properly stratified and randomized. Perhaps one way out of this dilemma might be to employ randomized trials in individual patients – the 'N of 1' method. See e.g. G. Guyatt, *et al.*, "Determining Optimal Therapy — Randomized Trials in Individual Patients" (1986) 314:14 *New Eng. J. Med.* 889. In any event, reproducibility is probably the true test of scientific and medical validity.

⁴³See J.J. Aulas, "Alternative Cancer Treatments: Miraculous Cures are a Myth, But Some Regimens May Well Improve the Quality of Life for Patients" (1996) 275:3 *Sci. Amer.* 162.

⁴⁴United States, *Assessing the Efficacy and Safety of Medical Technologies* (OTA: Washington, D.C., 1978) at 7.

to both individuals and the larger population.⁴⁵ If even a small portion of this is true, it begs the question why some treatment modalities are given primacy over others, and why patients receive free medical care primarily for only one form of practice.

The argument becomes even stronger with the adoption of evidence-based medicine by the medical mainstream. Evidence-based medicine, in simple terms, means that procedures must be established by proof to be accepted. Eventually, it may result in drastic changes to Medicare plans, by requiring proof of the efficacy of every procedure or service before reimbursement is provided. While this form of proof may be anathema to some alternative health supporters, it is also possible to envisage a modification to Medicare schemes whereby all forms of treatment that meet evidence-based protocols are included. Simply put, those orthodox and alternative practices that meet proper testing criteria should both be given equal place in a rational health insurance scheme. This issue will be taken up later on; it is first necessary to outline some of the basic features of the Canadian health care system, and to examine the role of alternative medicines in this system.

3. Medicare in Canada

To restrict the art of healing to one class of men and deny equal privileges to others will constitute the Bastille of medical practice.

Benjamin Rush, Surgeon General of the Continental Army

Although a comprehensive Canadian historiography of the rise of bioscientific medicine and medical systems at the expense of alternative medicine remains unwritten,⁴⁶ it is likely that Canada's history would be similar to other countries. There are a number of reasons why scientific medicine, despite competition from alternative forms, came to dominate the health care field: scientific rationalism and social and cultural organizational hegemony amongst physicians are the two most important.⁴⁷ In the early twentieth century, the public became ardent supporters of medical authority, and the medical establishment was able to use this to instill its

⁴⁵See Position Paper of American College for Advancement in Medicine (1995) [unpublished]. Available from ACAM, 23121 Vedugg Drive, Suite 204, Laguna Hills, CA, 92653.

⁴⁶Most of the historical work in Canada centres on the provision of Medicare, and less so on the growth of professionalism explored in studies done elsewhere. For an exhaustive study of the effects of autonomy, prestige and structural conditions in the creation of the medical oligopoly, see *e.g.* Starr, *supra* note 15. The seminal work on the sociology of American medicine is E. Friedson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York: Dodd, Mead, 1970) which develops further themes first addressed in T. Parsons, "The Professions and Social Structure" (1939) 17 *Social Forces* 457; see also G. Grob, "The Social History of Medicine and Disease in America" in Patricia Branca, ed., *The Medicine Show* (New York: Science History Publications, 1977). For an excellent study on the development of the Canadian health and Medicare system, see M.G. Taylor, *Health Insurance and Canadian Public Policy*, 2nd ed. (Kingston, Ont.: McGill-Queen's University Press, 1987); see also D. Colburn *et al.*, *Health and Canadian Society: Sociological Perspectives* (Don Mills, Ont.: Fitzhenry & Whiteside, 1981) and G. Sharpe, *The Law & Medicine in Canada*, 2nd ed. (Toronto: Butterworths, 1987) especially at chapter 1.

⁴⁷See Starr, *supra* note 15.

definitions of health and pathology.⁴⁸ This led to legal recognition and endorsement, for without licensing and standard-setting, the potential for public harm, through exposure to charlatans and quacks, was seen to be real enough to require monopoly licensing. In Canada, the medical establishment was given even greater legitimation through the relatively early adoption of public and universal health care schemes.

A. The Canadian Medicare System

Medicare in Canada arose out of federal proposals tabled at the Dominion-Provincial Conference on Reconstruction in 1945. Although the proposals were never adopted—they were linked to a tax reform package the provinces found unacceptable—they brought attention to the idea of a public form of health insurance, which would provide health care regardless of a person's ability to pay.

The primary objective of the Canadian health care policy is “to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.”⁴⁹ The *Canada Health Act* (CHA) stipulates that the federal government will contribute to the funding of provincial health insurance programs provided that they conform to certain specified criteria.⁵⁰ Sections 5 and 7 establish the basic conditions:

Subject to this Act, as part of the contribution provided by Canada to each province, a full cash contribution is payable under the Act of 1977 for each fiscal year in respect of the cost of insured health services provided under a health care insurance plan of the province.

In order that a province may qualify for a full cash contribution...for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

- (a) public administration;
- (b) comprehensiveness,;
- (c) universality;
- (d) portability; and
- (e) accessibility.⁵¹

⁴⁸See M.H. Cohen, “A Fixed Star in Health Care Reform: The Emerging Paradigm of Holistic Healing” (1995) 27 *Ariz. St. L.J.* 79 at 129-130. All this was a natural outcome of rationalism in general, following from the ages of Newton and Descartes – see J.H. Randall, Jr., *The Making of the Modern Mind* (New York: Columbia University Press, 1976) at 499ff.

⁴⁹*Canada Health Act*, s. 3.

⁵⁰The constitutionality of this kind of conditional grant was approved by the Supreme Court of Canada in *Reference Re Canada Assistance Plan (B.C.)*, [1991] 2 S.C.R. 525 at 567.

⁵¹These principles are at the core of an ethical vision of the Canadian health care system. Equality in the health care system is a principle that some state is as strong as equality before the law – see F. Baylis *et al.*, *Health Care Ethics in Canada* (Toronto: Harcourt Brace, 1995); D.J. Roy *et al.*, *Bioethics in*

The actual mechanism for transfer of payments from the federal government to the provinces occurs under the Canada Health and Social Transfer implemented in the *Federal-Provincial Fiscal Arrangements Act*⁵² and outlined in the *Budget Implementation Act, 1995*⁵³ and the *Budget Implementation Act, 1996*.⁵⁴

The purpose of the CHA is made explicit in section 4:

...to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

The phrase “insured health services” means both “hospital services” and “physician services” as they are provided to insured persons. “Hospital services” is further defined as consisting of specific services such as accommodation, nursing services and access to diagnostic and treatment facilities, so long as such services are “medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability.”⁵⁵ “Physician services” are defined very broadly, as consisting of “any medically required services rendered by medical practitioners.”⁵⁶ The CHA does not go beyond this by defining the phrase “medically required.”⁵⁷ It is up to each province to determine which services fall within the term, and by doing so, decide what is the physician component of “insured health services.” So far, none of the provinces has defined “medically required” or specified any defining criteria of their own, but instead simply list applicable services in schedules to regulations. This effectively means that the Provincial Health Ministers each control what is medically necessary and unnecessary, making it relatively easy for provinces to control the provision of subsidized medical services.⁵⁸

In order for a province to qualify for a full cash contribution from the Federal Government for health care services, the province must comply with the five principles of the CHA. Aside from this, provinces are free to implement health care policy in their own way.

Canada (Scarborough, Ontario: Prentice-Hall Canada, 1994) at 95.

⁵²R.S.C. 1985, c. F-8.

⁵³S.C. 1995, c. 17.

⁵⁴S.C. 1996, c. 18.

⁵⁵*Supra* note 49.

⁵⁶*Ibid.* at s. 2.

⁵⁷Since the French version of the *Canada Health Act* only uses the term “médicalement nécessaires,” there is little chance that “medically necessary” and “medically required” are not identical. I am grateful to S. Choudhry, “The Enforcement of the *Canada Health Act*” (1996) 41 McGill L.J. 461 for this point.

⁵⁸See Canadian Bar Association Task Force on Health Care, *What’s Law Got to Do with It? Health Care Reform in Canada* (Ottawa: Canadian Bar Association, 1994).

British Columbia provides a useful example of how these benefits are organized. It is left to the discretion of the Medical Services Commission, a 9-member panel composed of representatives from the government, the British Columbia Medical Association and health care consumers, to determine what constitutes a benefit. Under s. 4(1) of the *Medical Practitioners Act*⁵⁹, the Commission is authorized to determine those services that are a benefit and the services that are not.⁶⁰ The only limit on the Commission's discretion is set out in s. 4(2), which cautions that it must not exercise its powers against the criteria described in section 7 of the CHA. The Commission also administers the Medical Services Plan (MSP), which controls those practices that are covered under the British Columbia Medicare scheme.

As another example, the Ontario *Health Insurance Act*⁶¹ sets out the provisions governing Ontario's obligations under the CHA. Those services that qualify for benefits under the provincial medicare scheme, the Ontario Hospital Insurance Program (OHIP), are described in section 11.2. Aside from those services which hospitals ordinarily engage (emergency and nursing care, for example), services are divided into "medically necessary services" rendered by a physician and "health care services" rendered by prescribed practitioners.⁶² Both medically necessary services and health care services are undefined. Certain specified health care services that were once considered "alternative" are included as insured services under OHIP. These are: midwifery, optometry, chiropractic, osteopathic, chiropody, physiotherapy (only under the order of a physician), and laboratory service tests authorized by physicians or midwives (specifically excluding services ordered by dentists, osteopaths, chiropractors or chiropodists).⁶³ Many of those services are capped, however, usually by regulating the number of patient visits,⁶⁴ or by controlling the allowable types of procedure.⁶⁵

There is a clear philosophical division between professions in the Ontario *Health Insurance Act*, with "physicians" kept distinct from all other health professions, who are collectively referred to as "practitioners."⁶⁶ For example, section 5 provides for the establishment of a Medical Review Committee, which must be comprised of at least three times more physician representatives than non-physician representatives. Practitioner Review Committees, established for chiropody, chiropractic, dentistry, optometry and osteopathy, are not governed by similar limitations.⁶⁷ Physicians' fees may be reduced where a service was "not

⁵⁹R.S.B.C. 1996, c. 285, s. 82.

⁶⁰See *Medical Practitioners Act*, s. 4(1)c, j.

⁶¹R.S.O. 1990, c. H.6 [hereinafter HIA (ON)].

⁶²*Ibid.* s. 11.2(1).

⁶³See Health Insurance Act Regulations, R.R.O. Reg. 552, s. 24(2)(3), as amended [hereinafter O. Reg. 552].

⁶⁴See e.g. *ibid.* s. 17(5) for optometrists.

⁶⁵See e.g. *ibid.* s. 18(3) for chiropractors.

⁶⁶*Ibid.* at s.1.

⁶⁷*Ibid.* at s. 6.

medically necessary”; practitioners fees, on the other hand, may be reduced where a service was “not therapeutically necessary.”⁶⁸ Sections 18(3) and 19.1 allow the government to refuse payment to ineligible physicians; there are no corresponding provisions for practitioners.

Hospital admitting privileges and other services provided under OHIP reflect scientific medicine’s dominant position. All out-patient services must be under the control of a physician, except for certain drugs and other preparations that midwives may provide.⁶⁹ Physicians retain control over other out-patient services such as diet counselling and speech therapy when these are prescribed.⁷⁰ Non-physician practitioners may authorize insured services in a hospital but only in limited circumstances. “Legally qualified medical practitioners” are entitled to admit patients to a hospital as in-patients and to receive patients in a hospital and treat them as out-patients.⁷¹ Generally, only physicians may refer patients to hospitals as out-patients, except osteopaths and chiropractors who may refer a person to a hospital as an out-patient in order to obtain X-rays.⁷² Only physicians may receive or refer patients to certain rehabilitation and crippled children’s physiotherapy centres described in Schedule 6 to the Regulation.⁷³

The *Regulated Health Professions Act, 1991* (RHPA)⁷⁴ is the main health licensing legislation in Ontario, dictating the organization of the various professions. Despite a number of provisions under the Ontario *Health Insurance Act* that distinguish between physicians and therapeutic practitioners, the RHPA represents a significant step towards recognizing a partnership between biomedicine and certain alternative medical practices.

The RHPA sets out the basic framework for establishing self-governing health professions in Ontario. Twenty-one profession-specific acts and governing bodies (“colleges”) were initially set up under the RHPA to regulate twenty-three authorized health professions, which remain the only licensed professions: Auditory and Speech Pathology, Chiropody, Chiropractic, Dental Technology, Dental Hygiene, Dentistry, Denturism, Dietetics, Massage Therapy, Medical Laboratory Technology, Medical Radiation Technology, Medicine, Midwifery, Nursing, Occupational Therapy, Opticianry, Optometry, Pharmacy, Physiotherapy,

⁶⁸The same language is found in the HIA (ON)’s record-keeping section 37.1(3) vs. (4) and the General Review section 39.1(6)2(i) vs. (ii). As mentioned, “medically necessary” is not defined, and the introduction of a new term, also undefined (“therapeutically necessary”), is confusing to say the least.

⁶⁹See O. Reg. 552, *supra* note 63 at s. 8(5).

⁷⁰*Ibid.* diet counselling is s. 8(4) and speech therapy is s. 8(3).

⁷¹*Ibid.* s. 11(1)(b).

⁷²*Ibid.* s. 11(1)(c).

⁷³*Ibid.* s.11(2).

⁷⁴R.S.O. 1991, c. 18. [hereinafter RHPA]

Psychology, and Respiratory Therapy.⁷⁵ In order to ensure consistency, Schedule 2 to the RHPA provides ethical guidelines (Health Professions Procedural Code, or HPPC)⁷⁶ that are deemed to be a part of each individual health profession's act. Each individual act (or regulations thereunder) then sets out activities considered to be professional misconduct for the purposes of complying with clause 51(1)(c) of the HPPC.⁷⁷ The HPPC standards are set forth in general terms: for example, "contravening a standard of practice of the profession" is an act of professional misconduct.⁷⁸ Most of the designated professions also set out in varying detail, in the constituent act, the scope of practice⁷⁹ and, in order to further elaborate on this, the authorized activities of the particular profession.⁸⁰

The RHPA delineates a set of "controlled acts" that can only be performed by members of an authorized health profession. These acts are described in section 27 and include a range of activities from general diagnosis to very specific procedures, including casting fractures and putting an instrument beyond the external ear canal, amongst others. Certain activities, set out in regulations enacted under the RHPA, are exempt from the strictures of the RHPA. These range from activities such as ear or body piercing, electrolysis and tattooing, to male circumcision and naturopathic services under the *Drugless Practitioners Act*. As well, chiropodists and dentists performing electrocoagulation, defibrillation and fulguration (forms of energy treatment), midwives ordering diagnostic ultrasound, physicians employing acupuncture and persons applying MRI or ultrasound upon the direction of a physician or midwife, are also exempt from this section.⁸¹ Finally, section 35 of the RHPA exempts certain aboriginal midwives and healers from its provisions where they provide services to aboriginal persons or members of an aboriginal community.

The RHPA permits only practitioners of five professions to "diagnose": Medicine, Dentistry, Chiropractic, Optometry and Psychology.⁸² All other

⁷⁵See, respectively, *Auditory and Speech-Language Pathology Act, 1991*, S.O. 1991, c. 19; *Chiropody Act, 1991*, S.O. 1991, c. 20; *Chiropractic Act, 1991*, S.O. 1991, c. 21 [hereinafter *Chiropractic Act*]; *Dental Technology Act, 1991*, S.O. 1991, c. 22; *Dental Hygiene Act, 1991*, S.O. 1991, c. 23; *Dentistry Act, 1991*, S.O. 1991, c. 24; *Denturism Act, 1991*, S.O. 1991, c. 25; *Dietetics Act, 1991*, S.O. 1991, c. 26; *Massage Therapy Act, 1991*, S.O. 1991, c. 27; *Medical Laboratory Technology Act, 1991*, S.O. 1991, c. 28; *Medical Radiation Technology Act, 1991*, S.O. 1991, c. 29; *Medicine Act, 1991*, S.O. 1991, c. 30 [hereinafter *Medicine Act*]; *Midwifery Act, 1991*, S.O. 1991, c. 31; *Nursing Act, 1991*, S.O. 1991, c. 32; *Occupational Therapy Act, 1991*, S.O. 1991, c. 33; *Opticianry Act, 1991*, S.O. 1991, c. 34; *Optometry Act, 1991*, S.O. 1991, c. 35; *Pharmacy Act, 1991*, S.O. 1991, c. 36; *Physiotherapy Act, 1991*, S.O. 1991, c. 37; *Psychology Act, 1991*, S.O. 1991, c. 38; and *Respiratory Therapy Act, 1991*, S.O. 1991, c. 39.

⁷⁶The Health Professions Procedural Code – see RHPA, *supra* note 74 at sch. 2 [hereinafter HPPC].

⁷⁷See *e.g.* Professional Misconduct Regulations under the *Midwifery Act*, O. Reg. 858/93.

⁷⁸HPPC, *supra* note 76 at cl. 2.

⁷⁹See generally under s. 3 of the specific act, *supra* note 75.

⁸⁰See generally under s.4 of the specific act, *ibid.*

⁸¹See Regulations under the RHPA, Exemptions—O. Reg. 887/93, ss. 1-4; Forms of Energy—O. Reg. 886/93, s. 1.

⁸²See RHPA and constituent Acts at s. 3, *supra* notes 74-75.

professions, both regulated and unregulated, are only permitted to “assess.” Even amongst the above five professions, the standard of diagnosis differs, again pointing to double standards between orthodox medicine and others. Medical doctors are given the widest latitude to diagnose. The Act states that diagnosis of any disease, disorder or dysfunction is allowed.⁸³ In contrast, chiropractic diagnosis relates to “dysfunctions or disorders arising from the structures or functions of the spine [or joints] and the effects of those on the nervous system.”⁸⁴ This specificity in defining activities associated with unorthodox practices, compared to the generality given to scientific medicine, gives wide latitude to biomedical scope of practice provisions, at the same time shackling alternative forms into tightly—and easily—regulated and controlled practices.

Unregulated health practitioners are not subject to the legislative provisions of the RHPA and are therefore only subject to common law duties and responsibilities. Section 27 of the RHPA protects patients from regulated professionals who do something harmful that is outside of their scope of practice. While many formerly unregulated complementary therapies are included under the new RHPA, certain more esoteric practices are excluded. The Government’s position on these seems to be that they do not pose any significant risk to patients, thus allowing anyone to provide such services as long as they stay within the bounds of common law negligence, and outside the scope of practice bounds of other regulated professions.

Regulations made under the *Medicine Act, 1991* in Ontario indicate a general trend towards greater acceptance of alternative practices. But by giving orthodox medicine the power to oversee such therapies, there is a strong possibility that alternative practices will eventually be swallowed up by the existing establishment. For example, any member of the College of Physicians and Surgeons of Ontario may now lawfully use or recommend unorthodox treatment,⁸⁵ whereas in the past this would have been grounds for disciplinary measures. If the U.S. experience in nursing provides any guidance, one can expect further attenuation of the independent status of alternative practices as the established health care professions attempt to modify their own scope of practice laws to allow alternatives.⁸⁶

In September of 1997, an ad hoc committee of the Ontario College of Physicians and Surgeons presented its report on alternative medicine to the Council of the College.⁸⁷ The committee was formed to determine the core values that the College might adopt in respect to complementary medicine and to advise members

⁸³See *Medicine Act*, *supra* note 75 at s. 3.

⁸⁴See *Chiropractic Act*, *supra* note 75 at s. 3.

⁸⁵See O. Reg. 52/95.

⁸⁶See B.J. Safriet, “Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing” (1992) 9 Yale J. Reg. 417 (the role of advanced practice nurses has been severely limited by restrictions on scope of practice).

⁸⁷See Walker Report, *supra* note 3.

on when and how they may be able to offer alternative therapies. The final recommendations exhibit a more open acceptance of complementary medicine, while still maintaining a strong focus on biomedicine, by relying on arguments related to public safety and the value of scientific assessment methods. The initial recommendation states that conventional diagnosis and treatment options must be canvassed with patients prior to engaging in any discussion of alternatives. Thereafter, it should not be misconduct to refer a patient to unconventional or complementary practitioners, where there "is no reason to believe such a referral would expose the patient to harm."⁸⁸ Also, when providing treatments that are controversial and of uncertain efficacy, patients should be told the degree to which treatments have been evaluated, and their degree of certainty and predictability. To this end, members of the College should be prepared to collaborate in the collection of information relating to such treatments. Finally, as regards complaints or concerns related to complementary practices, the Report found that the College should adopt standards, expect members to assist in evaluating colleagues and rely on advisory panels composed of respected members of complementary professions.⁸⁹

B. Alternative Medicine and Medicare in Canada

Whether various treatment modalities are included in so-called universal health care plans depends on a number of factors, which have as much to do with a country's sociopolitical composition as they do with medicine. In Britain, for example, homeopathy is part-mainstream and part-alternative. Some homeopaths hold MD degrees and practice under the National Health System where their services are covered by medicare. Others, comprising the non-medically-qualified homeopaths, operate within a shadow health care system overseen by the Society of Homeopaths.⁹⁰ The British National Health System, unlike Canada's, also allows physicians to refer patients to a number of different complementary practitioners, where they receive full reimbursement. In India, to give another example, four publicly funded health care systems—bioscientific, homeopathic, unani and ayurvedic—compete amongst each other. Practitioners in all four traditions are educated and trained in their respective medical schools and patients pick and choose the type of doctor they want.⁹¹ That Canada has a different view of complementary practices, and their relationship to Medicare, is to some extent, therefore, a cultural construct. Many would like to see this situation changed; a blending of scientific and complementary medicine in a truly comprehensive government health care scheme might lead to better health for the population and a more efficient use of resources.⁹²

⁸⁸*Ibid.* at Recommendation 3 under "Treating."

⁸⁹*Ibid.* at Recommendations 1-3 under "Assessing Complaints or Concerns."

⁹⁰See Cant & Sharma, *supra* note 1 at 583.

⁹¹See Goldbeck-Wood, *supra* note 2.

⁹²D.I. Rice, "There's More to Medicine than Science: Holistic Med. May Add the Art: Dr. Rice" (1987) 33 Can. Fam. Physician 1129.

But as discussed, scope of practice laws continue to protect the medical profession wherever regulatory gaps exist. Recent legislative changes in a few provinces have gone some way towards rectifying this problem, but those therapies not protected by legislation are still vulnerable to attack – from both the medical profession and the Crown. In *R. v. Sandhar*⁹³, for example, a homeopathic practitioner was convicted on the basis that he contravened sections 76 and 77 of the *Medical Profession Act* (Alberta) as he was not a licensed physician. The Court found that since homeopathy was not protected by any other legislation, it came under the regulatory umbrella of the *Medical Profession Act*. This, in part, explains why more complementary professions are seeking formal recognition: naturopaths, acupuncturists and TCM practitioners are making bids for professional regulation across Canada;⁹⁴ homeopaths in Ontario, Manitoba and British Columbia have established associations to bring formal standards into the profession. Official status is seen as desirable because (i) it reflects a concern for public safety and provides quality assurance; (ii) it can overcome the concern over “colonization” by orthodox medical hierarchies;⁹⁵ and (iii) it proves the medical profession’s tolerance for practices that have been established as safe.⁹⁶

British Columbia and Alberta, as examples, both show a growing acceptance of alternative medicine, but take different approaches. British Columbia, of all provinces with the possible exception of Ontario, has gone the furthest in providing access to alternative treatments within the provincial health plan. The Medical Services Plan recognizes some complementary professions, including chiropractic, massage therapy, physical therapy, naturopathy, optometry and podiatry. The *Medical Practitioners Act* also expressly recognizes, *inter alia*, the alternative practices of chiropractic, naturopathy and podiatry, by exempting those practices from the strictures of the defined term, “practising medicine.” Its Ministry of Health started paying for physician-referred appointments with massage therapists, naturopaths and physiotherapists in 1992. Due to the current fee structures, however, many alternative practitioners have opted-out of the provincial medicare plan, arguing that the scheduled fees for most alternative medical consultations are insufficient to cover even basic costs.⁹⁷

The *Medicare Protection Act* in British Columbia authorizes payments under their Medical Services Plan for massage therapy, physiotherapy and naturopathy.⁹⁸

⁹³(1988), 86 A.R. 241 (Q.B.).

⁹⁴In some provinces, this has already occurred – see below notes 99ff and accompanying text.

⁹⁵See below notes 137-144 and accompanying text.

⁹⁶See J. Stone, “Regulating Complementary Medicine: Should Aim for Standards Not Status” (1996) 312:7045 *Brit. Med. J.* 1492. Stone is critical of the regulatory model, however, because it can fundamentally alter the nature of many alternative therapies.

⁹⁷Private communication with Mr. Bill Edwards, head of MSP for supplementary medical groups in B.C., dated 17 Oct. 1997, on file with author; also, private communication with Glen Cassie, Executive Director, British Columbia Naturopathy Association, dated 13 Sept. 1997, on file with author.

⁹⁸R.S.B.C. 1996, c. 286, as amended.

Plans to broaden this list to include acupuncturists and midwives have been announced by the provincial government.⁹⁹

British Columbia also leads the way in attempting to legitimize certain alternative medical practices through research endeavours. The Tzu Chi Institute for Complementary and Alternative Medicine was established in October 1996 in conjunction with the Vancouver General Hospital. Its mission is "to promote health through scientific evaluation of complementary and alternative approaches, and integration of safe and effective therapies into mainstream health care practice."¹⁰⁰ The College of Physicians and Surgeons of British Columbia has also developed a policy regarding what it refers to as "unproven and unconventional treatment." The policy is less charitable towards alternative practices than the government initiatives discussed above. Under it, doctors are cautioned that it is unethical to engage in treatment that has no acceptable scientific basis, that may be dangerous, may deceive a patient by giving false hope, or that may cause a patient to delay in seeking *proper* care beyond a point where a condition becomes irreversible.¹⁰¹ The policy exemplifies an overly broad scope of practice that favours orthodox medicine.

Alberta legislation developed slightly differently. A recent amendment to Alberta's *Medical Profession Act*¹⁰² allows medical practitioners to provide complementary therapies¹⁰³ without fear of liability. The only restriction is that such practice cannot be shown to "ha[ve] a safety risk for that patient unreasonably greater than the prevailing treatment."¹⁰⁴

The College of Physicians and Surgeons of Alberta, dismayed at a possible loss of control over its members because of the amendment, responded by passing a bylaw requiring physicians to apply for approval from the College prior to providing alternative treatments.¹⁰⁵ The bylaw identifies complementary practices by grouping them into broad categories: diet, nutrition or lifestyle changes; mind or body control; traditional [meaning indigenous] and ethnomedicine; structural and energetic therapies; pharmacological and biological treatments; and

⁹⁹See "Healthy Alternative: Many Benefit Plans Have Some Coverage for Alternative Therapies, But Can They be Part of a Preventative Health Care Plan That Aids a Company's Bottom Line?" (1997) 21:2 Benefits-Canada 47.

¹⁰⁰See Mission Statement of Tzu Chi Institute, 715 West 12th Avenue Health Centre, Vancouver, B.C. See also "Beyond Mainstream," *supra* note 29. One year into its operation, the Institute had not produced any clinical reports or studies – confirmed by private communication with Ian Woodcock, Director of Operations, dated 6 Oct. 1997, on file with author. Attempts to obtain updated information from Mr. Woodcock prior to publication were unsuccessful.

¹⁰¹See K. Capen, "Courts, Licensing Bodies Turning Their Attention to Alternative Therapies" (1997) 156:9 Cdn. Med. Assoc. J. 1307.

¹⁰²R.S.A. 1990, c. M-12, amended by S.A. 1996, c. 27, s. 2.

¹⁰³Stated as "non-traditional or depart[ing] from the prevailing medical practices."

¹⁰⁴See s. 34(3) of the *Medical Profession Act*.

¹⁰⁵Complementary Health Care Therapy Provided by Medical Practitioners, approved June 21, 1996 [hereinafter Alberta College bylaw].

bioelectromagnetic applications. Medical practitioners engaged in alternative therapies are required to submit standards of practice for these therapies (or in the alternative, evidence of a theoretical or scientific rationale for such practice), regulatory recognition of the practice, and other safety requirements.¹⁰⁶ Under section 3 of the bylaw, the Registrar may subject the practice to peer review.

Practice Guidelines issued with the bylaw indicate procedures that physicians licensed with the College must follow when practicing complementary medicine. Again, the Guidelines reflect what some may perceive as a bias towards orthodox medical practices, reinforcing existing double standards. For example, the Guidelines state that:

- prior to offering advice on complementary practices, conventional evaluations must have been completed;¹⁰⁷
- conventional treatment options must be reviewed with the patient, but complementary practice options need not be;¹⁰⁸
- how the complementary therapy *interferes* with conventional treatment must be documented [emphasis added];¹⁰⁹
- a symptom diary must be kept, which shall include discussions regarding, amongst others, the patients preferences, expectations and experiences,¹¹⁰ evidence for the efficacy of the therapy,¹¹¹ and the limitations of existing information including information that *complementary therapy is largely unproven, and noting the difference between anecdotal and scientific evidence*;¹¹² and
- a 72 hour reflection period prior to the initiation of any complementary therapy must be given, unless waived by the patient.¹¹³

When the bylaw and Practice Guidelines were first enacted, those physicians whose practice included alternative medical therapies reacted strongly, saying the bylaws were too stringent and impossible to follow.¹¹⁴ A public action group, Citizens for Choice in Health Care, threatened to take the College to court for over-

¹⁰⁶*Ibid.* at s. 2.3 and 2.4.

¹⁰⁷See Practice Guidelines to Alberta College bylaw, paragraph 2.1.

¹⁰⁸*Ibid.* at para. 2.3.

¹⁰⁹*Ibid.* at para. 2.3.

¹¹⁰*Ibid.* at para. 3.3.1.

¹¹¹*Ibid.* at para. 3.3.3.

¹¹²*Ibid.* at para. 3.3.5 [emphasis added].

¹¹³*Ibid.* at para. 4.

¹¹⁴See “Feud Pits Mainstream Doctors Against Alternative Therapists in Alberta” *Canadian Press Newswire* (8 September 1996); “Some Doctors Balk at Controls: Alternative Medicine” *Calgary Herald* (23 July 1996) B1.

reaching its jurisdiction.¹¹⁵ Since then, many practitioners have simply refused to comply with the bylaw.¹¹⁶

C. Alternative Medicare?

The Medicare system that has served the country adequately in the past few decades is not only under attack from within, as government funding cuts force health care administrators to do more with less, it is also under attack from without. Growing numbers of Canadians seeking health care remedies via alternative medical practices question Medicare's very legitimacy.

Part of the explanation for this loss of confidence in the Medicare system is structural. Under Canadian Medicare schemes, most doctors are remunerated on a fee-for-service basis, which means that seeing more patients for shorter appointments translates into greater rewards. Similarly, Canadian physicians are less likely to give detailed counselling on other issues that may have a large effect on health – for example, ideas about nutrition and exercise. This means that patients are beginning to feel short-changed, and are seeking out other professionals to look after their health problems.

But legislative changes to many Medicare regimes are beginning to meet these new demands. Complementary professions are gaining legitimacy as they become regulated, and health insurance plans are broadening coverage to include unorthodox therapies. The strict regulatory landscape that has governed the scope of medical practice throughout most of the twentieth century has been widened to include alternative medicine in some areas. In addition, canons long-established in orthodox medicine have begun to crack: a good example can be found under regulations to the *Medicine Act, 1991* in Ontario, where it is now not necessarily culpable for a member of the College of Physicians and Surgeons of Ontario to use or recommend an alternative treatment. However, legislative changes such as these are being approached with caution by the medical establishment.¹¹⁷ Thus, despite the new openness of the regulatory language, the medical fraternity is not likely to easily relinquish its monopoly.

This caution is also evidenced by the piecemeal nature of the legislative changes. Not all of the complementary professions are being treated equally. For

¹¹⁵See "Herbologists and Homeopaths Fight for Rights: Alberta Alternative Medicine Group Gets U.S. Backing" *Medical Post* 32:33 (1996) 16. As of the date of writing, the threatened challenge has not materialized – private correspondence from Tanya Northfield, Executive Secretary to Assistant Registrar, on file with author.

¹¹⁶As at February, 1997, only five physicians had complied – Northfield correspondence *ibid*.

¹¹⁷See disciplinary case of Dr. Felix Ravikovich, College of Physicians and Surgeons of Ontario, Member's Dialogue, January/February 1996. In that case, the College Committee stated that misrepresenting the uses of histamine injections was insufficient to find misconduct given the new regulation, but nevertheless found him guilty of professional misconduct by failing to maintain adequate (i.e. orthodox) standards of practice.

example, naturopathy is regulated in some provinces, but not all. Chiropractic therapy is regulated throughout Canada, but only about half the provinces have health plans that cover a portion of the fees. Massage is regulated only in Ontario and BC. Homeopathy, iridology, Shiatsu massage, reflexology and aromatherapy are unregulated. Anyone may simply set up a clinic and commence practice in these areas. And even in those jurisdictions where complementary therapies are given legal legitimacy, double standards still linger.

In publicly funded health care systems it is a given that government will influence medical policy. It will have a say in what is an appropriate use of limited resources, in imposing financial constraints upon “medically necessary” procedures and in determining the scope of procedures themselves. In Canada, practitioners can only be reimbursed for those treatments and procedures that are listed. This is probably the single largest influence government has over the methods employed by health care practitioners.¹¹⁸ In recent years, provincial governments have simply delisted certain services as not being medically necessary. Arguably, this is more a rationalization of government expenditures than a rational response to national or provincial health care needs. But it shows how easy it is for governments to have a large effect on policy by simply invoking a line-by-line costing analysis.

The health principles espoused in the *Canada Health Act* have a great deal of public support in Canada. But limits in overall resources mean that certain choices are required – a decision made more difficult in an area such as health care where costs can be prohibitive and consequences traumatic:

The fact of limitation may not pose much of a problem when health services are relatively cheap and the demand for them is slight. However, as the services become more expensive, as the number of people who demand them increases, and as the number of requests for the services themselves go up, so does the relative drain on the health care resource pool. Sooner or later, no matter how they are drawn, the limits of that resource pool are reached, and society has to make a decision. Who shall have when not all can have? What shall be available when not everything can be made available? What is the extent of the right to health-care particularly when resources are scarce? And who should decide?¹¹⁹

The CHA also determines the basic structure of every provincial Medicare scheme. Provinces receive transfer payments to fund health-care plans if they abide by the conditions set out in the CHA. The legislation does not prevent health-care providers from operating outside the system, however, and each provincial health Act allows providers to opt out of provincial health insurance plans. So the

¹¹⁸See Sharpe, *supra* note 46 at 5-12.

¹¹⁹E. Kluge, ed., *Readings in Biomedical Ethics – A Canadian Focus* (Scarborough, Ontario: Prentice Hall Canada, 1993).

legislative intention is not to prohibit all forms of private health services in Canada. Most dentists, for example, operate privately.¹²⁰ Practitioners of complementary medicine have, in the past, also functioned in this private sphere since most alternative therapies were excluded from Medicare. Only recently have changes to provincial medicare schemes occurred to allow complementary practitioners more choice.

These changes to the health care legislation in some provinces also point out the political nature of licensing laws. In the past, licensing statutes gave primacy to the orthodox medical profession, assuming that only physicians were competent to perform medical services. This applied even to those activities that were, on the face of it, peripherally related to medical care, such as prescribing, counselling and preventing injuries and ailments.¹²¹ It was regulation based on education, rather than function. The recent legislative changes in some jurisdictions see alternative health care as part of a larger, community interest in health. However, scientific medicine's dominance over complementary therapies continues even in those provinces where alternative therapies are most widely accepted, such as British Columbia and Ontario. Even where scope of practice legislation has been relaxed to allow alternatives, there are controlling elements that keep traditional hierarchies intact, such as procedures requiring medical practitioners to maintain a supervisory role or political entities such as health and professional boards statutorily required to have a majority of medically qualified practitioners. So while this acceptance of alternative modalities reflects a large departure from the "regulatory capture" that existed in the past, monopoly control is still maintained, but in more subtle ways.¹²²

Alternative medicine's new legitimacy, exemplified legally by wider licensing provisions and a more open regulatory environment, is arguably long overdue. But all the new reforms may simply repeat previous missteps.¹²³ For it is quite possible that the medical profession will usurp many of the currently fashionable alternative practices. There are two reasons for this. First, the profession will strive to retain institutional dominance in the twenty-first century by relying on the same methods used to gain prominence in the 1800s; the combination of monopoly control, social readiness, and scientific rationalism. Of course, it does not control those practising outside of it, but by vigorously prosecuting anyone who infringes on its jurisdiction, and exercising strict control of its own members, the profession acts as a forceful presence. Law and orthodox medicine in this way are mutually legitimating

¹²⁰See M. Jackman, *The Regulation of Private Health Care under the Canada Health Act* (Canadian Bar Association Health Care Task Force, April 1994).

¹²¹See E.H. Hadley, "Nurses and Prescriptive Authority: A Legal and Economic Analysis" (1989) 15 *Am. J. L. & Med.* 245; also D.J. Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decisionmaking* (New York: Basic Books, 1991).

¹²²A good overview of this phenomenon in the U.S. can be found in Cohen, *supra* note 48, at Part II; see also L.B. Andrews, "The Shadow Health Care System: Regulation of Alternative Health Care Providers" (1996) 32 *Hous. L. Rev.* 1273.

¹²³Homeopathy underwent a similar period of acceptance followed by rejection – see Starr, *supra* note 15 at "Book One." See also, Baer, *supra* note 19 regarding osteopathy.

discourses and practices.¹²⁴ Secondly, the alternative profession, in attempting to claw back some legitimacy of its own, will likely adopt the procedures and language of the dominant bioscientific model as occurred previously.¹²⁵

Evidence of this can already be found. There is the ever-present vigilance of medical associations in prosecuting recalcitrant members. The Ravikovitch¹²⁶ and Krop¹²⁷ cases and the Alberta College's investigation of chelation therapy¹²⁸ indicate the medical establishment's cautionary approach. In addition, new guidelines have been created to deal with the influx of complementary therapies. As the Alberta College's bylaws show, however, they pay lip service to alternative practices, while at the same time reaffirming much of the dominant traditional ideology. Finally, as the example of the Tzu Chi Institute in British Columbia shows, alternative practices need establishment ties in order to function effectively. While notionally independent, the Tzu Chi Institute is legally associated with the Vancouver Hospital and other orthodox medical institutions.¹²⁹ To the extent that any of the Institute's findings will be scientifically valid and useful, these will assuredly find their way into mainstream medical practice. Those that do not stand up to traditional scrutiny, if the Institute is to retain any credibility, must be discarded.¹³⁰

So to argue for the inclusion of alternative therapies within Medicare plans is a catch-22 – it means patients will gain free access to a new world of treatment options, but it also means these practices may end up conforming to bioscientific medical models. Promoting their continued exclusion, on the other hand, will gain them independence, but at the cost of reduced legitimacy and continued exposure to the vagaries of the market. Moreover, as some alternative therapies become accepted into the medical mainstream, and even partially funded under Medicare schemes, those that are not so funded face an even greater likelihood of marginalization.

Having seen how alternative therapies have made some inroads into mainstream health care, the ongoing concern will be to see whether they can be more fully integrated within a government-funded medical care model. The next section of this paper looks at some of the social implications involved in addressing alternative medicine as a parallel profession; following that, the paper examines

¹²⁴See N. Ehrenreich, "The Colonization of the Womb" (1993) 43 Duke L. J. 492 at 565.

¹²⁵See Cant & Sharma, *supra* note 1 for an example of this in the field of homeopathy in Britain.

¹²⁶See *supra* note 117.

¹²⁷See "Hearing Called Medical "Turf War": Environmental Medicine Practitioner Faces Disciplinary Hearing" *The [Toronto] Globe and Mail* (27 October 1994) A12.

¹²⁸See "Alberta College Investigating Six MDs for Practising Chelation Therapy" *Medical Post* 30:37 (1994) 12.

¹²⁹It is also linked to the following: B.C. Women's Hospital and Health Centre, B.C. Children's Hospital Canadian Cancer Society; Saint Paul's Hospital, and Holy Family Hospital.

¹³⁰Perhaps this is one reason that research papers have not been forthcoming.

whether excluding these practices can be justified within a pluralistic, non-discriminatory legal framework such as exists under Canada's *Charter of Rights*.

4. Alternative Medicine, Professionalism and Medicare

The notion of life forces and vital energies and how they heal is highly selective. Only certain substances instantly convey the essential energies. No one [in the alternative medicine camp] suggests eating a freshly killed young rabbit on the ground that its life forces could greatly benefit the consumer.

Rosalind Coward, *The Whole Truth*

While there is little doubt that the scientific medical system largely owes its dominant position in Canada to its effectiveness in treating disease, it is simplistic to think that this is the only reason. Western therapeutic ideology typically favours inpatient care, hospital-based outpatient care, pharmaceuticals, high technology surgical interventions and overuse of the medical delivery system. This ideology does have some grounding in health outcomes, such as exceptionally low mortality and morbidity rates, but it is also, arguably, in part traceable to the training, socialization and self-interest of physicians, hospitals, drug companies, medical equipment manufacturers and others.¹³¹

Ultimately, it is society's values that determine the rights, privileges and obligations of a health care establishment and health care scheme. There is still too much about human health that remains unknowable to allow "health" (whatever that is) to determine a particular form of institutional health care. Despite the advances of bioscience and a belief in science, some maintain that only about 15% of clinical interventions are supported by objective scientific evidence that they do more good than harm, and up to 60% of all therapeutic benefits can be attributed to a combination of placebo and so-called Hawthorn effects.¹³² While these figures are highly debatable, it is much less controversial to suggest that some procedures covered under certain provincial medicare schemes may be of no greater efficacy than others that are not because they are considered "alternative." It makes sense to be sceptical about some causal links between practice and measured outcomes

¹³¹See Starr, *supra* note 15. Also, A.K. Dolan, "Antitrust Law and Physician Dominance of Other Health Practitioners" (1980) 4:4 J. Health Polit. Pol. and Law 675; and the excellent symposium on medical anthropology found in vol. 24:12 of *Social Science Medicine*, especially articles by Farquhar, Kay, Greenfield, Bastien and Maretzki.

¹³²See Foreword to L. Payer, *Medicine and Culture* (New York: Henry Holt and Company, 1988). The placebo effect is a physical or emotional change occurring after a substance is taken or administered that is not the result of any special property of the substance. The Hawthorn effect is also a generally unintended but beneficial effect related not to a substance, but to the effect of an encounter, as with an investigation or health care provider, or of a change in a program or facility, as by painting an office or changing the lighting system.

when it is clear that there is a huge variety, both between and within Western nations themselves, in what is considered acceptable medical practice.¹³³

If, therefore, some medical practices are less the result of a scientific epistemology than they are of certain cultural practices, then it takes little to acknowledge that other, alternative health care practices, deserve similar recognition and legitimation. True recognition will only occur when complementary practices, at least those that offer similar safety and benefit rates as biomedical practice, are included as part of a comprehensive medical insurance scheme. As Lynn Payer notes, in discussing differing *biomedical* treatments between nations:

...the range of “acceptable” treatments for most diseases is much wider than that admitted in any one country, and a wider view of such acceptable treatments would better serve both doctors and patients. [O]ur medical biases cause us to accept certain treatments and reject others, or to accept some too quickly and others not quickly enough. A better understanding of these biases should help to illuminate our past mistakes – and perhaps avoid future ones.¹³⁴

Since therapeutic practices amongst countries can vary to such an extent that a treatment in one may be considered malpractice in another, should not a health care system that is bound by the ideals of universality, comprehensiveness and accessibility be as open as possible to cultural differences in medicine? Within a country’s own borders even, one type of specialist may diagnose and treat differently from another. Because these social and cultural forces affect public care and well being, should they not be more adequately addressed in provincial health care laws?

One of the problems of a large institutionalized service provider, like a universal health care system, is bureaucratic inertia. Reform is difficult. In Canada, where the method of reimbursement is fee-for-service, this problem is exacerbated. Changes to components of a Medicare plan, such as fee schedules, methods of payment, scope of practice and forms of treatment, is exceedingly complex because of the competing interests of physicians, patients, governments and private insurers.¹³⁵

A fee-for-service profession relies upon guaranteed reimbursement for providing particular services. Excluding most Canadian alternative practitioners from Medicare plans reduces each one’s likelihood of surviving, when measured against a carefully planned and regulated scheme of guaranteed remuneration for other practitioners. In effect, it devolves into a managed approach to orthodox health care, and a free market approach to alternative health care, a view which

¹³³*Ibid.*

¹³⁴*Ibid.* at 22.

¹³⁵See Wardwell, *supra* note 20 at 227-28.

seems illogical at best. In any event, there is little sense to the current system, where a number of Medicare's scheduled items seem incorporated into the health care scheme simply by reference to the educational qualification of the provider. This will be taken up in the three policy areas discussed below.

A. Professional Classifications and Scope of Practice Legislation

(i) Classifying Professional Licences

Walter Wardwell uses a functional classification system of health-related professions as an analytical starting point for assessing regulatory schema.¹³⁶ In it, the health care profession is divided into six main groups:

- Medical professionals (MDs);
- Ancillary professionals (those functioning under the supervision of a licensed physician, including nurses, physical therapists, etc.);
- limited medical professionals (those whose practice is independent of medical supervision, but is limited in scope. Examples include dentistry, optometry, psychology, etc.);
- marginal professionals (health professions that challenge the validity of orthodox conceptions of illness and therapy. These include chiropractors, naturopaths, and for a time, osteopaths);
- parallel professions (a marginal profession that achieves equal acceptance with medicine as an alternative health profession, without compromising its philosophies and beliefs – examples would be homeopathy in Britain, some indigenous medicines and TCM); and
- quasi-professions (faith healers, shamans, etc. whose benefits are due mainly to psychological influences).

The history of medical regulation, until recently, seemed to follow Wardwell's classification scheme. Ancillary professions were regulated under physicians, and obtained their legal status as a direct result of a physician's status. Limited medical professions were licensed separately from physicians, but scope of practice legislation, and the watchful eye of medical licensing boards, ensured that practice within these professions was strictly circumscribed.¹³⁷ Marginal professions consistently metastasized – establishing legitimacy firstly by moving from quasi-professional status into marginal status, and as they gained further prominence, being subsumed into the medical mainstream. Quasi-professionals were generally unregulated.

¹³⁶*Ibid.* Obviously, some take issue with these categories, but the analytical framework is useful.

¹³⁷See Cohen, *supra* note 4 at Part I.c, p. 90-98; E.L. Hodgson, "Restrictions on Unorthodox Health Treatment in California: A Legal and Economic Analysis" (1979) 24 U.C.L.A. Law Rev. 647 (earlier scope of practice acts were drafted much more restrictively leaving room for alternative practices to fill in the gaps). See also Part 3 above.

But this organizational model is not so accurate now. The licensing and regulation of an ever-growing number of quasi-professional bodies is testament to greater acceptance of quasi-professionals and movement towards Wardwell's marginal state.¹³⁸ Moreover, legal and professional restrictions on licenses (a part of the socialization and conforming process) often have an opposite effect from what was originally intended. Licensing, by curtailing some practices and promoting others, creates an initial division between acceptability and quackery; however, if the non-licensed, stigmatized practice produces results over time, these same restrictions produce false barriers.¹³⁹

Professional licensure gives legal, political and social leverage. Not only does it allow one specific segment to profess that it has the public interest at heart, it formalizes and legitimates one method through official recognition. Moreover, licensure proscribes an area of practice, so that one group gains influence and benefits at the expense of the less influential groups. For medical practitioners, licensing has a direct economic effect by helping to attract patients.

The concern that some legal commentators have with present medical systems is that the law helps define it in terms that entrench orthodoxy and criminalize alternative practice. In the past, it was argued that this would prevent fraud and protect public health, but this position is no longer tenable because the boundaries imposed are artificial, arbitrary and over-determined. Even in those jurisdictions that have granted some legal status to alternative professions, the current regulatory structure still encourages a monopoly that bears little correlation with fraud prevention. Instead of protecting public health, the licensing schemes often limit choices and diminish patient welfare.¹⁴⁰ The system, by giving paramouncy to orthodox medicine, fails to address the interdependency of many forms of therapeutic practice.¹⁴¹ Why, for example, should a physician receive Medicare compensation for seeing a patient with common cold symptoms, possibly prescribing antibiotics, but a naturopath seeing the same patient and prescribing echinacea or zinc pills, does not? As the scientific evidence shows that there is no cure for the common cold, the orthodox physician is receiving a subsidy for a procedure that is no more beneficial than the non-subsidized alternative practitioner's remedy. In cases such as these, the additional fraud and health issues that would arise by allowing alternative practitioners access to the medicare system would be negligible. Of course, public safety is important, and alternative practitioners are clearly not equipped to handle many medical illnesses, especially

¹³⁸See *e.g.* Ontario and British Columbia, above Part 3, especially the new RHPA. Today, it is harder to agree with Wardwell's statement: "Other groups including shamans, faith healers and quacks could be called *quasi professions*. ...Quasi professionals pose only limited threats to orthodox medicine. Conceptually they are so far removed that while they treat sick people, they are more complementary than competitive with medicine, and, indeed, are sometimes simultaneously or even cooperatively employed." – *supra* note 20 at 210.

¹³⁹See Hodgson, *supra* note 137 at 657ff.

¹⁴⁰Cohen, *supra* note 48 at 145ff.

¹⁴¹*Ibid.*

life-saving emergency treatment and surgery. The point is that safety and fraud issues have boundaries that operate independently of discipline.

In Canada, the mere existence of universal Medicare for scientific medical practices creates another level of legitimacy and grants even greater authority to the orthodox system. Where only a circumscribed set of professional services are covered by Medicare, it matters less whether other professionals practising outside this sphere are regulated or not, because they still do not have access to similar funding arrangements. Thus, while licensing is granted to more and more forms of alternative therapy, the same therapies still exist largely on the outside of the Canadian health care system because they remain uncovered by Medicare – a fact that undoubtedly contributes to biomedicine's dominance.

Provincial governments have added to this admixture a new factor: the devolution of medical regulatory powers from provincial level to regional and local boards. Increased citizen representation and participation in the health care system has been instituted in all but one province.¹⁴² Unfortunately, there is no clear view on what results will ensue from this increased citizen participation.¹⁴³

(ii) Restricting Legislation: Scope of Practice Provisions

Scope of practice legislation is the legal method by which professional practice is restricted. In the health care field, this is accomplished by granting only orthodox medicine the authority to perform functions such as general diagnosis and treatment. As shown in Part 3.A above, the *Medicine Act* (Ontario) gives wide latitude to physicians to diagnose, treat and prevent virtually any health problem.¹⁴⁴ Moreover, physicians are authorized to render services in aid of such practice, including communicating advice and performing procedures. On the other hand, scope of practice legislation for licensed alternative medical practices is much more restricted. The *Chiropractic Act* (Ontario) has already been mentioned in this regard – an even stricter example, drafted in the imperative, is the *Chiropractors Act* (B.C.) which states in section 21(1) that a person registered must not “engage in the practice of diagnosis or treatment of the human body for disease, or the causes of disease, otherwise than as a chiropractor,” and section 29 forbids prescribing or administering drugs, anaesthetics or practicing medicine, surgery or midwifery.¹⁴⁵

¹⁴²Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland, Nova Scotia, Prince Edward Island, Quebec, Saskatchewan - only Ontario has moved to centralized authority; see the four-part article by J. Lomas, *et al.*, “Devolving Authority for Health Care in Canada's Provinces” (1997) 3 *Can. Med. Assoc. J.* 371; 4 *Can. Med. Assoc. J.* 513; 5 *Can. Med. Assoc. J.* 669 & 6 *Can. Med. Assoc. J.* 817.

¹⁴³For a detailed discussion of this phenomena, see Lomas, *ibid.*

¹⁴⁴See *Medicine Act, 1991*, S.O. 1991, c. 30, ss. 3-4.

¹⁴⁵*Chiropractors Act*, R.S.B.C. 1996, c. 48.

Courts have consistently interpreted scope of practice statutes in favour of the orthodox medical profession and orthodox therapies.¹⁴⁶ For example, in *R v. Kish*,¹⁴⁷ the accused practiced phytotherapy, a form of therapy combining spiritualism and “unusual” nutritional requirements. One of his patients, diagnosed with terminal lung cancer, was prescribed a program of vitamins and minerals and hydrogen peroxide. The Court found that this was “treating” and that these treatments came within the purview of the Alberta College. The Court found a breach of sections 76 and 77 of the *Medical Profession Act*. In the Ontario case of Dr. Felix Ravikovich,¹⁴⁸ the College Committee made some general pronouncements on the subject of licensed physicians using alternative therapies, declaring that members using a drug in a novel fashion, or outside traditional indications, must (i) prove that the drug is safe; (ii) record changes in the clinical state of the patient produced by the medication; and (iii) be aware of all pertinent publications that bear on the clinical problem as well as the proposed treatment.¹⁴⁹

There are exceptions, of course. In *R. v. Gaulin*¹⁵⁰ an acupuncturist was found not to be engaged in the practice of medicine as defined in the *Health Disciplines Act*. The Court decided on two grounds, stating that statutes creating monopolies must be construed strictly, and use of the term “doctor” by an acupuncturist was not likely to mislead the public. Courts are also more likely to allow alternative therapies where the issue is not determining the limits of scope of practice legislation, but compensation. In *Medley v. Wadsworth and Vancouver Taxi Ltd.*¹⁵¹ the British Columbia Court of Appeal accepted that an injured victim may use complementary treatments to aid in recuperation. The Court held that such actions were not unreasonable, despite the fact that the treatments did not improve the plaintiff’s condition. Implicit in the judgment is an acknowledgment that in many personal injury cases, orthodox medical techniques do not ensure full recovery, and can, in fact, be quite unsatisfactory, so alternative therapies should be made available to the patient.

¹⁴⁶See Cohen, *supra* note 4 and Hodgson, *supra* note 137. Although these writers are commenting on the U.S. experience, Canadian experience is similar – see *R. v. Sandhar*, *supra* note 93. See also, *College of Physicians and Surgeons v. Lesage* (1943), 80 C.C.C. 139 (Que. Ct. of Sessions of Peace) (adjustments and manipulation of spine performed by chiropractor constitute treatment of disease for purposes of s. 44 of the *Quebec Medical Act*); *R v. Ringrose* (1989), 94 A.R. 350 (Q.B.) (defines “treatment”); *Percheson v. College of Physicians and Surgeons (Ont.)* (1985), 10 O.A.C. 76 (doctor prescribing terminal cancer patient with vitamins, minerals and alternative medicine was liable for professional misconduct as her practice fell below the standards of the profession). For a full exploration of the use of litigation in maintaining the medical hegemony, see Cohen, *supra* note 48 at Part II.

¹⁴⁷(1993), 12 Alta. L.R. (3d) 185 (Prov. Ct.).

¹⁴⁸See *supra* note 117.

¹⁴⁹Note the similarity to the positions adopted by both the Alberta and Ontario Colleges on alternative medicine within orthodox medical practice – see above Part 3.

¹⁵⁰(18 August 1980), (Ont. Prov. Ct.) [unreported], *aff’d* (1981), 35 O.R. (2d) 195 (Co. Ct.).

¹⁵¹(1991), 56 B.C.L.R. (2d) 210 (C.A.).

(iii) The Future of Regulation

As noted, the strict scope of practice regulatory landscape in health care that has been common throughout most of the twentieth century has been lessened somewhat by legislation expanding the areas of permitted alternative practice. Professional liability standards are also changing, as the Supreme Court of Canada has established in *Lapointe v. Hôpital Le Gardeur*.¹⁵² That Court recognized the existence, within biomedicine, of various treatment options. It found that the standard of care for physicians depends on factors such as the availability of a number of treatment methods and the difficulty in distinguishing between error and fault. The Court held that a doctor will not be found liable if a patient's diagnosis and treatment correspond to those recognized by medical science at the time, even in the face of competing theories.¹⁵³ This standard has recently been applied to physicians employing alternative therapies in their practice.¹⁵⁴

Commentators have also been proposing new alliances between competing health professions. Cohen proposes a scheme based on collaboration, where, for example, a patient under a physician's care for cancer may receive nutritional advice, massage therapy and acupuncture to support a return to "wholeness." He sees law's role as a consumer watchdog, by creating a regulatory regime based on consumer protection, rather than monopolization and criminalization.¹⁵⁵ Hodgson proposes three alternatives to strict licensing regimes: (i) eliminating them, and relying on tort liability alone; (ii) certifying, which would identify skilled practitioners, but not forbid others from setting up a practice; (iii) amending medical practice acts, by restricting definitions and allowing non-harmless treatment modalities; and (iv) allowing intermediate licensing categories.¹⁵⁶ In Canada, many provinces have adopted Hodgson's third option. For instance, the new regulatory professions legislation in Ontario recognizes complementary professions and represents an honest attempt at defining the extent of these various practices in concert with orthodox medical care.¹⁵⁷ Given both these relaxed licensing standards, and a movement to modify scope of practice and liability standards, now may be a suitable time for provincial governments to reform Medicare provisions and schedules to allow a greater number of alternative practices to be covered.

¹⁵²(1992), 90 D.L.R. (4th) 7 (S.C.C.).

¹⁵³*Ibid.* at 15.

¹⁵⁴*Hacking v. Ouellette* (9 September 1996) (Ont. Gen. Div.) [unreported].

¹⁵⁵See Cohen, *supra* note 4 at Part IV.

¹⁵⁶Hodgson, *supra* note 137.

¹⁵⁷See Part 3 above.

B. Medicine and Culture

(i) Illness as Artifact

Culture can be described as the ways in which groups of people arrange their lives; enculturation of the results of practices passed on through generations. Culture can include material aspects of a society, such as forms of eating, housing and institutions and systems of delivery such as goods and services and health care. It also includes nonmaterial aspects such as attitudes, assumptions, beliefs, myths, concepts, models and laws. Within a society most of us employ cultural norms daily, in order to create a sense of belonging: we know what should be done, what can be ignored, what rules may acceptably be broken, and more. But this state is dynamic. Cultures respond to material and nonmaterial ideas that continually infiltrate from both within and without.¹⁵⁸

Because it exists within culture, illness itself is partly a cultural construct. At least since Pasteur and Ehrlich established the germ theory of disease in the 19th century, Western nations have tried to take control over illness, to master it. Other cultures, in contrast, may treat it differently – viewing illness as a state created by social factors, supernatural causes or other indeterminate influences. The Chinese, for instance, may regard medical treatment more passively, with less emphasis on treatment and life-prolonging measures, and more on letting nature heal on its own.¹⁵⁹ In India, pain and suffering are accepted as a normal part of life, and death is observed as a natural event.¹⁶⁰ Latin American views on medicine are informed by Roman Catholic theology and folk medicine.¹⁶¹ Many Africans accept that health is related to magic and religion.¹⁶² Even in the West, vast differences in health care approaches exist between such seemingly simple ideas as drug prescription levels, procedures for medical check-ups and the definition of health.¹⁶³

¹⁵⁸See P. Rieff, *Fellow Teachers* (New York: Harper & Row, 1973). To some, even the concept of “culture” is inherently cultural, which makes the argument that illness is cultural even stronger. It is unfortunate that the Supreme Court of Canada, in the context of indigenous rights, may have misconstrued this dynamic aspect of culture – see R.L. Barsh & J.Y. Henderson, “The Supreme Court’s *Van der Peet* Trilogy: Naive Imperialism and Ropes of Sand” (1997) 42 McGill L. J. 993, especially at 1001-02.

¹⁵⁹See R.-Z. Qui, “Medical Ethics and Chinese Culture” in E. Pellegrino, ed., *Transcultural Dimensions in Medical Ethics* (Frederick, Md.: University Publishing Group, 1992) at 170.

¹⁶⁰See M.F. Kodiath & A. Kodiath, “A Comparative Study of Patients Who Experience Chronic Malignant Pain in India and the United States” (1995) 18 *Cancer Nursing* 189.

¹⁶¹See A.M. Villarruel & B. Ortiz de Montellano, “Culture and Pain: A Mesoamerican Perspective” (1992) 15 *Advanced Nursing Sci.* 21 at 29.

¹⁶²See B.O. Osuntokun, “Biomedical Ethics in the Developing World: Conflicts and Resolutions” in Pellegrino, ed., *supra* note 159 at 132-33.

¹⁶³See Payer, *supra* note 132; also A. Oubré, “Social Context of Complementary Medicine in Western Society, Part I” (1995) 1:1 *J. of Alt. and Comp. Med.* 41.

(ii) Canadian Perspectives on Medical Culture

Canada is no different. Canada's Medicare system is part of Canadian culture – some argue one of the truly distinguishing features of being Canadian.¹⁶⁴ But it also reflects a culture. Each province's Medicare plan is a coherent body of knowledge and behaviour characterized by specific delivery styles, practitioner training, theoretical models, professional groupings, technology, production and distribution systems, and social and legal mandates for practice. In effect, they prescribe a set of conditions and assumptions that are ethnocentric. In order to reap its benefits, patients need to be educated, or enculturated, into accepting a rationalist, bioscientific model of medicine as a basic premise.

There is, of course, no consensus on the efficacy of some medical therapies, both scientific and alternative. Nevertheless, anthropological and folkloric studies note that spiritual therapies can be as effective as scientific remedies for certain classes of ailments in certain circumstances. Indigenous healers can achieve such results because they can maximize psychosocial and cultural treatment in those cases where there is a great psychological involvement in the illness, or where the disorder is primarily of a psychosomatic or hysterical nature.¹⁶⁵ These practitioners attach symbols to ailments and ritually manipulate those symbols so that complaints are resolved through cultural transformation.¹⁶⁶

Those who seek complementary health care do so often because of their cultural beliefs.¹⁶⁷ As meanings given to illness are some of the deepest meanings formulated in a culture, the importance of accepting different approaches to health and healing is fundamental to our nature as humans. Modern medicine very often ignores traditional cultural beliefs. In Canada, where multiculturalism remains official policy, and rights discourse continues to gather momentum, particularly for immigrants and indigenous Canadians, the need for the health care system to address cultural issues more pluralistically beckons.

Is it possible to find a connection between alternative medicine and certain cultural or racial preferences? Can this lead to a constitutional challenge on the ground that some could argue that they would benefit from inclusion of alternative

¹⁶⁴See the Royal Commission on New Reproductive Technologies, quoted in M. Jackman, "The Constitutional Basis for Federal Regulation of Health" (1996) 5 Health L. Rev. 3 at 4.

¹⁶⁵See E. Gourguignon, "The Effectiveness of Religious Healing Movements: A Review of the Literature" (1976) 13 Transcultural Psychiatric Res. Rev. 5 at 18; see also A. Kleinman, *Patients and Healers in the Context of Culture: An Exploration of the Borderline Between Anthropology, Medicine and Psychiatry* (Berkeley, Calif.: Univ. of Calif. Press, 1980).

¹⁶⁶See J. Comaroff, "Medicine and Culture: Some Anthropological Perspectives" (1978) 12B Soc. Sci. Med. 247; J. Dow, "Universal Aspects of Symbolic Healing: A Theoretical Synthesis" (1986) 88 Am. Anthropol. 56; A. Kleinman & L.H. Sung, "Why Do Indigenous Practitioners Successfully Heal?" (1979) 13B Soc. Sci. Med. 7.

¹⁶⁷See J.O. Ogunranti, "Cultural and Biological Diversity in Medical Practice" (1995) 16 World Health Forum 66 at 66-67. However, see below notes 196-199 and accompanying text for a contrary view.

medicine in Medicare schemes? Or does it require the finding that all would benefit? In other words, if some cultural groups benefit from spiritual healing while others may not, is it an infringement of a *Charter* right not to provide medical insurance coverage to those groups? Is a deaf patient wanting an interpreter's services to be included within Medicare analogous to a Chinese national permanently residing in Canada wanting his TCM treatment covered by provincial health care? Is the need for alternative medical care to be included with Medicare, to employ the words of La Forest J. in *Eldridge*, "essential to proper medical care"?¹⁶⁸ These issues are discussed in more detail in Part 5.

5. Medicare and the *Charter of Rights*

[T]he medical establishment has become a major threat to health. The disabling effect of professional control over medicine has reached the proportion of an epidemic.

Ivan Illich, *Limits to Medicine*

In the previous section, I queried whether it would be possible to find a sufficient nexus between alternative medicine and certain cultural or racial preferences or between alternative medicine and fundamental individual rights so as to engage the protection of the *Charter*. The argument depends upon showing that alternative care users are somehow a stigmatized group worthy of enhanced *Charter* protection, and further, that the solution to such stigmatization is to revise current Medicare schedules. It is an argument that largely relies upon a showing of discrimination under s. 15 or, less likely, establishing that free access to alternative health care is fundamental to liberty or security of the person under s. 7. This section offers a preliminary look at whether there are these necessary linkages in order to come within the protective shield of the *Charter*.

As a prefatory note, prior to analyzing substantive *Charter* sections, it first must be established that the *Charter* applies. The Supreme Court has determined in a number of cases interpreting "legislature and government" in section 32 of the *Charter*,¹⁶⁹ that the *Charter* applies to activities that constitute part of the executive or administrative branches of government. This is so where the government has the power of routine or regular control over an entity. In these cases, the *Charter* applies to all of that entity's activities, including any that might be construed as

¹⁶⁸See *Eldridge v. British Columbia (Attorney General)*, (1995) 7 B.C.L.R. (3d) 156 (C.A.) rev'd [1997] 3 S.C.R. 624, 151 D.L.R. (4th) 577 at para 69 [hereinafter *Eldridge*, cited to paragraph number for S.C.C.].

¹⁶⁹Section 32(1) of the *Charter* states: "This Charter applies (a) to the Parliament and government of Canada in respect of all matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest Territories; and (b) to the legislature and government of each province in respect of all matters within the authority of the legislature in each province."

private.¹⁷⁰ As regards the Medicare system, services that are deemed to be “medical” under provincial health care Acts, and are thus insured procedures, are direct government policy initiatives. In *Eldridge*, the Court held that hospitals, by providing medical services under legislation, are effectively implementing governmental policy, and for this purpose, are subject to *Charter* scrutiny. La Forest, J. stated:

Although the benefits of [providing services to the public] are delivered and administered through private institutions—hospitals—it is the government, and not hospitals, that is responsible for defining both the content of the service to be delivered and the persons entitled to receive it.¹⁷¹

Thus, when assessing the *Charter*'s application to the implementation of specific health bylaws and subordinate regulation, rather than the activities of hospitals, the case is much stronger. Legislatures that define an objective such as guaranteeing access to a range of medical services, must do so without breaching the *Charter*. Again, as La Forest J. states in *Eldridge*, in so far as it relates to the British Columbia Medical Services Commission and discretionary decisionmaking powers:

It was not contested that the *Charter* applies to the Commission in exercising its power to determine whether a service is a benefit pursuant to s. 4(1) of the *Medical and Health Care Services Act*. It is plain that in so doing, the Commission implements a government policy, namely, to ensure that all residents receive medically required services without charge. In lieu of setting out a comprehensive list of insured services in legislation, the government has delegated to the Commission the power to determine what constitutes a “medically required” service. There is no doubt, therefore, that in exercising this discretion the Commission acts in government capacity and is thus subject to the *Charter*.¹⁷²

Having established this, it is time to turn to the specific sections of the *Charter*.

¹⁷⁰See *RWDSU v. Dolphin Delivery Ltd.*, [1986] 2 S.C.R. 573; *Harrison v. University of British Columbia*, [1990] 3 S.C.R. 451; *Stoffman v. Vancouver General Hospital*, [1990] 3 S.C.R. 483; *Douglas/Kwantlen Faculty Association v. Douglas College*, [1990] 3 S.C.R. 570; and *Lavigne v. Ontario Public Service Employees Union*, [1991] 2 S.C.R. 211.

¹⁷¹*Eldridge*, *supra* note 168 at para. 49.

¹⁷²*Ibid.* at para. 52.

A. Discrimination Under Section 15

(i) Background Jurisprudence

Equality rights are constitutionalized under s. 15(1) of the *Charter*:

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.

In its latest jurisprudence, the Supreme Court of Canada has established a three-pronged inquiry that follows from the language of s. 15(1) itself: (i) it must be established that, because of a distinction drawn between the claimant and others, the claimant has been denied “equal protection” or “equal benefit” of the law or that the claimant’s already disadvantaged position is unaccounted for; (ii) this differential treatment must constitute discrimination on the basis of any one of the grounds listed in s. 15(1) or an analogous ground; and (iii) the differential treatment must discriminate in a substantive sense, considering the purpose of s. 15 is generally to remedy ills affecting human dignity, such as prejudice, stereotyping and historical disadvantage.¹⁷³

In deciding whether there has been “equal benefit of the law without discrimination” within the meaning of s. 15(1) of the *Charter*, the Court has laid down an open and liberal interpretative framework. The distinction can either be explicit (direct discrimination) or be facially neutral but have adverse effects (adverse effect discrimination). In *Andrews v. Law Society of British Columbia*,¹⁷⁴ McIntyre J. found that facially neutral laws may be discriminatory by recognizing that identical treatment under the law may frequently produce serious inequality. The main consideration is on the impact of the law on the individual or the group concerned.¹⁷⁵ This means that the intention of the legislature is irrelevant; a law is discriminatory where the effect simply denies someone the equal protection or benefit of the law applied to others.¹⁷⁶ Constructing the analysis along these lines acknowledges the multifarious nature of discrimination, showing a complexity beyond a straightforward “similarly-situated” approach.¹⁷⁷ For example, in *Eldridge*, the claimants were successful in claiming that although all persons are

¹⁷³See *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497 [hereinafter *Law*]; followed in *M. v. H.* [1999] 2 S.C.R. 3.

¹⁷⁴[1989] S.C.R. 143 [hereinafter *Andrews*].

¹⁷⁵*Ibid* at 164-65; see also *R. v. Big M Drug Mart Ltd.* [1985] 1 S.C.R. 295.

¹⁷⁶*Andrews*, *supra* note 174 at 173-74; see also *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 [hereinafter *Rodriguez*] at 544-49, (Lamer C.J.C.); *Ontario Human Rights Commission v. Simpsons-Sears*, [1985] 2 S.C.R. 536 at 547.

¹⁷⁷See *M. v. H.*, *supra* note 173, and compare the different viewpoints of the majority (Lamer C.J.C., Cory, L’Heureux-Dube, McLachlin, Iacobucci and Binnie JJ.) with that of Bastarache J. (concurring in result) and Gonthier J. (in dissent).

entitled to receive specific medical services free of charge, the lack of funding for sign language interpreters meant that persons with hearing disabilities were unable to benefit to the same extent as persons who could hear.

The Supreme Court has formulated different approaches to the analysis under this subsection, although amongst these competing decisions there is broad agreement on the general framework, especially since the unanimous holding in *Law*. The divergence of opinion appears in the methodology for locating an appropriate comparator group for the purposes of establishing a distinction. The analysis first looks at whether the impugned law either draws a formal distinction between a claimant and others on the basis of one or more personal characteristics, or fails to take into account a claimant's already disadvantaged position resulting in differential treatment between the claimant and others on the basis of one or more personal characteristics. Second, does the differential treatment arise on the basis of one or more of the enumerated and analogous grounds? Finally, does the differential treatment discriminate in a way that reflects the high-mindedness of the *Charter*?¹⁷⁸ In *M. v. H.*, Gonthier J. reiterated the point that not all distinctions drawn by a legislation will infringe the *Charter*. In the past, this meant the inquiry would examine whether a distinction was based on an irrelevant personal characteristic, where "irrelevance" is related to the functional values underlying the law (provided that those values are not themselves discriminatory). It is not clear if this analysis is still relevant.¹⁷⁹ Where the distinction is clearly an irrelevant personal characteristic, however, the matter is less controversial, as stated by La Forest J. in *Eldridge*:

In my view, in the present case the same result is reached regardless of which of these approaches is applied... There is no question that the distinction here [deaf patients not having free access to interpreters] is based on a personal characteristic that is irrelevant to the functional values underlying the health care system. Those values consist of the promotion of health and the prevention and treatment of illness and disease, and the realization of those values through the vehicle of a publicly funded health care system. There could be no personal characteristic less relevant to these values than an individual's physical disability.¹⁸⁰

Once a distinction is shown, the next stage of the analysis depends upon the form of legislation or government activity that is under scrutiny. In the case of

¹⁷⁸*Law*, *supra* note 173 at para 39.

¹⁷⁹For more on this discussion, see M.D. Lepofsky, "A Report Card on the *Charter's* Guarantee of Equality to Persons with Disabilities after 10 Years: What Progress? What Prospects?" (1997) 7 N.J.C.L. 263 at 288ff. Compare *Miron v. Trudel*, [1995] 2 S.C.R. 418 (Gonthier and La Forest JJ.); *Egan v. Canada*, [1995] 2 S.C.R. 513 [hereinafter *Egan*], *Thibadeau v. Canada*, [1995] 2 S.C.R. 627 (Cory and Iacobucci JJ.); *Eldridge*, *supra* note 168; and *Eaton v. Brant County Board of Education*, [1997] 1 S.C.R. 241 at para 62 [hereinafter *Eaton*].

¹⁸⁰*Eldridge*, *ibid.* at para. 59.

legislation that applies to all persons equally, it is the impact of the legislation on particular individuals or groups that is important. As Lamer C.J.C. held in *Rodriguez*, universally applicable legislation may infringe the right to equality enshrined in s. 15(1) because governments must take into account differences that exist between individuals and so far as possible ensure that any legislation adopted will not have a greater impact, due to irrelevant personal characteristics, on certain classes of people than on the public as a whole. The Chief Justice noted that one of the purposes behind section 15 was to promote a more equal society. Those already disadvantaged, for whatever reason, must be taken into account.¹⁸¹ In *Eaton*, Sopinka J. again referred to this notion, noting that:

in general, distinctions based on presumed rather than actual characteristics are the hallmarks of discrimination...the purpose of s. 15(1) of the *Charter* is not only to prevent discrimination by the attribution of stereotypical characteristics to individuals, but also to ameliorate the position of groups within Canadian society who have suffered disadvantage by exclusion from mainstream society...

The other equally important objective seeks to take into account the true characteristics of this group which act as headwinds to the enjoyment of society's benefits and to accommodate them. Exclusion from the mainstream of society results from the construction of a society based solely on "mainstream" attributes to which disabled persons will never be able to gain access... It may be seen rather as a case of reverse stereotyping which, by not allowing for the condition of a disabled individual, ignores his or her disability and forces the individual to sink or swim within the mainstream environment. It is recognition of the actual characteristics, and reasonable accommodation of these characteristics which is the central purpose of s. 15(1) in relation to disability.¹⁸²

In *Eldridge*, the adverse effects on those persons with a hearing disability stemmed from a failure to ensure that they benefited equally from Medicare.

The final stages in the analysis depend upon whether the distinction is based on the enumerated grounds set out in s. 15 or on an analogous ground and whether the differential treatment discriminates in the widest sense of the word. Where the ground for discrimination is not listed, a claimant must show a relationship between

¹⁸¹*Rodriguez*, *supra* note 176 at 549; see also the lengthy discussion on dignity and human values by Iacobucci J. in *Law*, *supra* note 173 at para. 42-50. Note that there is a slight difference from the case where legislation on its face clearly creates differential treatment or where the concern is with pre-existing disadvantaged groups – there is likely to be a different focus, for example, where subsidized medicare is in issue than where benefits to certain relationships are denied others – see discussion below at notes 204-206 and accompanying text.

¹⁸²*Eaton*, *supra* note 179 at para. 66-67.

the adverse effect created by the legislation and the disadvantage suffered from. This additional step may not be required where the alleged discrimination occurs under one of the enumerated grounds, as it is presumed that such disadvantage occurs, although the Court has indicated that it would be prudent for a potential litigant to establish such a relationship.¹⁸³

This analysis is appropriate in cases involving universal legislative provisions, where, for example, complete legislative uniformity may fail to recognize that a blind person cannot see, or that a person in a wheelchair needs a ramp simply to enter a building.¹⁸⁴ But there is some concern that where there is government inaction—by failing to legislate or regulate an area of activity within government control, for example—the analysis is different. In some cases, the judiciary has been reluctant to find that a lack of positive state action is contrary to s. 15(1) of the *Charter*. In *Adler v. Ontario*,¹⁸⁵ the Supreme Court considered the constitutionality of a provision of the *Education Act* (Ontario) that provided different funding arrangements between non-denominational schools and religion-based schools, except for the special case of Catholic schools. The appellants, who sent their children to private schools because of their religious beliefs, argued that as compared to Catholic families, they suffered an economic disadvantage. Although a majority of the Court declined to apply s. 15 of the *Charter*, four justices did examine the application of the *Charter*. Sopinka and Major JJ. found that not being able to benefit from publicly funded schooling is not an effect of the statute but relates to a particular individual's choice. Because this choice does not arise from the legislation, there is no government action or distinction to which s. 15 of the *Charter* can attach. The two judges then went on to hold that even if there was a distinction between public and private schools, it was not discriminatory because no preferential treatment was given to any one religion over another. A mere distinction between public and private does not bring on *Charter* scrutiny.¹⁸⁶ McLachlin and L'Heureux-Dubé JJ. both dissented, basing their analysis on adverse effect discrimination. In short, they argued that because certain religious adherents were affected differently, and because religion is deeply embedded within a culture and an individual, it is not acceptable to speak of choices available to a person in such an instance.¹⁸⁷

Despite the more recent determination in *Vriend v. Alberta*,¹⁸⁸ where the Court firmly decided that the *Charter* is not restricted to situations where government actively encroaches on rights—legislative underinclusiveness and other omissions may be equally unsound—the Court is still struggling with this potential divide and

¹⁸³See *Symes v. Canada*, [1993] 4 S.C.R. 695; also, *Eldridge*, *supra* note 168 at para.75-76 where La Forest J. makes this point.

¹⁸⁴These examples come from Lepofsky, *supra* note 179.

¹⁸⁵[1996] 3 S.C.R. 609 [hereinafter *Adler*].

¹⁸⁶*Ibid.* at 704ff.

¹⁸⁷*Ibid.* at 660ff.

¹⁸⁸[1998] 1 S.C.R. 493 [hereinafter *Vriend*].

will likely need to consider it in more detail in future cases. It is my view, however, that too much may be made of this analytical differentiation between governmental action and inaction. In *Eldridge*, for example, is it the government action in creating a universally applicable medicare system, or should we instead look at their inaction in failing to provide similar access to medical care for those persons with particular disabilities? Whether the importance of this distinction is exaggerated will be examined in greater detail below.

(ii) A Purposive Approach to Medicare Discrimination

Subsection 15(1) of the *Charter* is meant to serve two separate purposes.¹⁸⁹ As outlined in *Andrews*, the first, or “dignity” branch, is to ensure that the law recognizes the inherent dignity and equal worth of all human beings. The second purpose, which I shall refer to as the “disadvantaged” branch, is to focus on particular groups that have traditionally suffered from discrimination and to ensure that existing discrimination against these groups is rectified, and future discrimination is prevented.¹⁹⁰ As noted by Iacobucci J. in *Law*, the overall reason for having provisions such as s. 15(1) is to

prevent the violation of essential human dignity and freedom through the imposition of disadvantage, stereotyping, or political or social prejudice, and to promote a society in which all persons enjoy equal recognition at law as human beings or as members of Canadian society, equally capable and equally deserving of concern, respect and consideration.¹⁹¹

In *Eldridge*, La Forest J. noted the great historical disadvantage faced by disabled persons generally, resulting in their not generally being afforded the “equal concern, respect and consideration” demanded by s.15(1) of the *Charter*. He cited statistics showing the persistence of social and economic disadvantage faced by the disabled generally, including figures showing lower levels of formal education, poorer employment rates compared with the general population and proportionately greater numbers represented at the low end of pay scales.¹⁹² To drive the point home, he might also have noted statistics showing those with disabilities having, amongst many others, greater levels of health problems, higher suicide rates and shorter life spans than the general population.¹⁹³

Using section 15 to analyze the lack of alternative health care funding in Medicare schemes will require showing that this funding vacuum adversely affects certain groups, and depending upon the categorization, that these groups are

¹⁸⁹*Eldridge*, *supra* note 168 at para. 54.

¹⁹⁰*Andrews*, *supra* note 174 at 150ff; see also *R. v. Turpin*, [1989] 1 S.C.R. 1296 at 1333, Wilson J.

¹⁹¹*Law*, *supra* note 173 at para 51.

¹⁹²*Eldridge supra* note 168 at para 56.

¹⁹³See *Report on Health Indicators, 1997*, Statistics Canada, (Ottawa: Queen’s Printer).

historically disadvantaged. The constitutional context in this regard is crucial.¹⁹⁴ The most compelling argument, therefore, relates to First Nations peoples, where the abysmal state of health is well-documented. Statistics show that on all the usual health indicators such as morbidity and mortality rates, birth weight, life expectancy, alcoholism, drug abuse and suicide rates, aboriginal persons do not attain anywhere near the levels of health of the general population, despite the existence of universal medical care.¹⁹⁵

The argument against general discrimination would be bolstered by showing that alternative or indigenous medical practices are an aspect of First Nation culture, forming the basis of aboriginal rights under s. 25, preservation of multiculturalism under s. 27, or an "existing right" for purposes of s. 35(1) of the *Charter*.¹⁹⁶ Obviously, if a right to alternative medical care could be established under these grounds, claimants who were indigenous Canadians would not need to show discrimination for purposes of s. 15. But in order to make the more general argument that medicare schedules are per se discriminatory against all proponents of alternative health care, evidence gathered from the indigenous experience could be invaluable in showing the necessary link to adverse treatment.

Unfortunately, under the Supreme Court's latest determination of aboriginal rights, made explicit in the *Van der Peet* trilogy of cases,¹⁹⁷ it may be almost impossible to obtain legally relevant evidence of historic practice. As Russel Barsh and James Henderson, commenting on the trilogy, summarize:

[to invoke the protection of s. 35(1)] the Aboriginal practice at issue must be shown to be preexisting and central; it must be shown never to have been extinguished by the Crown prior to 1982; it must have been infringed by government action after 1982; the government action must be shown to have lacked adequate justification; and it must be shown to go beyond the reasonable discretion enjoyed by the Crown as a "fiduciary" to determine whether the Aboriginal community concerned

¹⁹⁴See *Eldridge*, *supra* note 168; *Law*, *supra* note 173. In *Law*, the fact that the claimant belonged to a group of people simply classified as "over 45 years old" was a crucial point in the Court's finding of no breach of s. 15, as this was not a group historically disadvantaged. It is almost as if the Court was hoping she could draw herself into a different category.

¹⁹⁵See Report on Health Indicators, *supra* note 193; also K. Scott, "Indigenous Canadians" (Kishk Anaquot Health Research and Program Development: Canadian Profile, 1997).

¹⁹⁶Section 25 of the *Charter* states: "The guarantees in this Charter of certain rights and freedoms shall not be construed so as to abrogate or derogate from any aboriginal, treaty or other rights or freedoms that pertain to the aboriginal peoples of Canada, including (1) any right or freedoms that have been recognized by the Royal Proclamation of October 7, 1763, and (b) any rights or freedoms that now exist by way of land claims agreements or may be so acquired."

Section 27 states: "This Charter shall be interpreted in a manner consistent with the preservation and enhancement of the multicultural heritage of Canadians." Section 35(1) states: "The existing aboriginal and treaty rights of the aboriginal peoples of Canada are hereby recognized and affirmed."

¹⁹⁷*R. v. Van der Peet*, [1996] 2 S.C.R. 507; *R. v. N.T.C. Smokehouse Ltd.*, [1996] 2 S.C.R. 672; *R. v. Gladstone*, [1996] 2 S.C.R. 723.

has been given an adequate “priority” in the enjoyment of the resources it has traditionally utilized.¹⁹⁸

A similar claim of discrimination may arise as regards other distinct national or cultural groups, where it can be established that funding limitations in the *Canada Health Act* or provincial affiliate acts preclude distinct forms of medical practice from reaching full expression, thereby causing adverse effects. To establish this line of reasoning will require, at a minimum, an ethnicity survey of all forms of medical practice in Canada. Current piecemeal evidence is conflicting. U.S. data supports the view that the use of alternative forms of health care is to some degree dependent on factors such as sex, race, social or cultural beliefs, immigration status, and economic standing.¹⁹⁹ A Canadian report also showed lower socio-economic classes are more apt to rely on alternative medicines.²⁰⁰ But other studies indicate that users of alternative medicine should not be regarded as homogeneous, and are as diverse as the multicultural society itself.²⁰¹ Or, even more dispiriting for constructing arguments along these lines, Eisenberg’s U.S. survey of alternative practices found that the use of unconventional therapies is consistent amongst most groups, with blacks being the only group with a significantly lower rate of usage than other racial groups surveyed (White, Hispanic, Asian or Other).²⁰²

Establishing historical disadvantage, vulnerability or marginalization will also be required since the recent reformulation of s. 15 by the Supreme Court in *Law*.²⁰³ If it can be shown that certain well-defined segments of the population—a prime example might be persons linked by national or ethnic origin—whose cultural values incorporate and rely on alternative medical practices (TCM, for example) have been less well served by the Medicare system (by having to expend extra finances on alternative practitioners) than other groups then it increases the argument’s strength. It would then remain to be shown that this distinction, like that in *Eldridge*, is irrelevant to those functional health care values such as promotion of health, treatment of illness, and realization of these goals through a publicly funded system.

That still leaves the potential problem of finding government inaction to be discriminatory. In *Eldridge*, the provincial government provided a service—free medical coverage—to all citizens. The Supreme Court found that this was

¹⁹⁸Barsh & Henderson, *supra* note 158 at 1004.

¹⁹⁹See S. Loue, “An Epidemiological Framework for the Formulation of Health Insurance Policy” (1993) 14 J. Legal Med. 523.

²⁰⁰See “Poor More Likely to Use Complementary Therapies” *Medical Post* 33:15 (1997) 41. Other possible arguments would hold that forms of practice are linked to specific nationalities, such as Chinese and Ayurvedic medicine – see e.g. “The Chinese Energizer: Getting Needled is a Healthy Experience” *Vancouver Sun* (18 July 1994) C4. Similar arguments might hold for Ayurvedic medicine based on ancient Indian beliefs and homeopathy as a German or Continental European practice.

²⁰¹See Kelner & Wellman, *supra* note 36.

²⁰²See Eisenberg, *supra* note 7.

²⁰³See *Law*, *supra* note 173 at para. 53ff.

discriminatory because a distinction existed between two classes – while most citizens were able to partake equally of the available service, certain particular classes could not. In *Adler*, on the other hand, the Court seemed to view any differentiation that occurred as less of an overt legislative distinction. In *Vriend*, the majority noted the distinction between failure to act at all and underinclusive or omitted legislation, finding the latter clearly subject to *Charter* challenges, while the former it left undecided.²⁰⁴

This leads to two possible interpretations in the case of alternative medical practices in Canada. On the one hand, no person entitled to Medicare coverage, no matter what age, sex, ability or disability etc., is entitled to a subsidy over non-included alternative medicine – conceptually, a complete failure to act. This is not the same as a case where those with a hearing disability cannot obtain equivalent medical coverage for the same expenditure. However, on another reading, the reason that Eldridge's physical disability prevented her from obtaining Medicare benefits was because she would have to pay a greater amount—the cost of an interpreter—to receive the same service as those not physically disabled. In that case, interpreting, or more generally, communication between doctor and patient, therefore, was found to be an essential component of a health care system and the government had simply been underinclusive. Since it was only those with hearing disabilities who had to pay this extra cost, the Court found that this distinction was based on an enumerated ground, and thus found it to be discriminatory. On this reading, then, the basic approach in the case of the lack of subsidized alternative health care is to determine whether an *economic* distinction can be made between various segments of society entitled to a public service, thus pointing out an omission rather than a complete absence of legislative activity. As the dissenting judges pointed out in *Adler*, if this is found to be the case, and if the service is then deemed to be fundamental to one's nature or well-being, any distinction may well be discriminatory.

With respect to the judges in *Adler* who held otherwise on this point, the dissenting justices seem to have it right, if only as a way of reconciling some of the reasoning in *Eldridge* with that in *Adler*. If, as the majority in *Adler* argues, a parent can *choose* to avoid the publicly funded school system, why cannot persons with hearing disabilities *accept* a certain level of Medicare without an interpreter? There is little to distinguish the two conceptions. Of course, as regards the physically disabled, the notion is anathema to an enlightened view of equality. But as McLachlin and L'Heureux-Dubé JJ. in *Adler* point out, it is also nonsense to speak of choice where strongly held, fundamental beliefs effectively reduce the number of options to one. Thus, those who forfeit their own beliefs because of economic incentives to conform (via subsidized Medicare), should be able to apply the *Charter's* equity provisions to compel governments to include alternative forms of health care. As McLachlin and L'Heureux-Dubé JJ. state, ideas that inform and

²⁰⁴See *Vriend*, *supra* note 188 at para. 60-64.

define a culture and a community are not always capable of being subject to strict rational analysis.²⁰⁵ Even if alternative medicine is not scientifically proven, it does, for some persons in some situations, represent the only acceptable medical treatment.

(iii) An Accommodation Right?

This is an alternative way to analyse situations involving differentiation between certain segments of the population.²⁰⁶ Once government chooses to provide specific services to the public, it must, in order to meet the requirements of s.15 of the *Charter*, accommodate the needs of persons listed within the enumerated grounds, subject to reasonable limits as set out in s.1. In other words, in extending certain benefits to the populace, government has a duty to do so to everyone despite their race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability.²⁰⁷ This duty applies whether discrimination is direct or indirect. As an example, in the *Eldridge* case it was held that as Medicare is available to all citizens who meet the basic qualifying conditions, those with hearing disabilities must be accommodated via an interpreter in order to receive equivalent medical care. Their need for extra funding arises out of a physical disability (an enumerated ground) and, therefore, must be accommodated.

This argument works well with some of the enumerated categories, such as disability, but not so well with other categories. Take age, for example: most governments make driving licences available to persons aged 16 and over. This is a distinction based on age, but there is no logical way to speak of accommodation in this case. An age limit is a blanket prohibition – reasonable accommodation would have to mean that government should allow driver's licences to those under 16 who could demonstrate the skills, competence and responsibility of a 16-year old driver. Or, if mature enough at 15, to vote. The accommodation right may have value in particular situations, but it is unlikely that anyone would extend it to cover all aspects of section 15 analysis.

That leaves open the question of whether reasonable accommodation lies in respect of those enumerated categories pertaining to alternative medicine followers as previously discussed. Does the duty to accommodate include funding other forms of medical care for those whose national or ethnic origin, or cultural beliefs derived therefrom, alter their ability to fully participate in typical Medicare schemes? Again, the argument depends upon where the category in question is drawn. If government participation in the health of its subjects, via the provision of Medicare, is functionally related to scientifically proven methods, then it is not contrary to s.

²⁰⁵ *Adler*, *supra* note 185 at 66 1ff.

²⁰⁶ This position was well argued in Lepofsky, *supra* note 179 at 343-58, 385-86, as it applies to those with disabilities.

²⁰⁷ See *Andrews*, *supra* note 174 at 173-74; *Eaton v. Brant (County) Board of Education* (1995), 22 O.R. (3d) 1 (C.A.).

15 to fail to accommodate new practices such as alternative therapies, unless they are rationally proven.²⁰⁸ On the other hand, if the provision of Medicare is simply one aspect of the more broadly defined goal of facilitating and aiding in the general health of the population, then, as in *Eldridge*, the government should take into account and accommodate those persons who, because of their national or ethnic origin, maintain a fundamental belief in the value of alternative medical practices. Given that the objective of Canadian health policy under the CHA is to promote and restore the well-being of residents of Canada, there is strength in this latter argument.

(iv) Summary

In summary, the complex and sometimes flimsy distinctions made by the Supreme Court in s. 15(1) cases is problematic. In any claim made on behalf of users of alternative therapies, it will need to be asked whether or not free access to complementary medical care is of fundamental importance for those whose ways of thinking about and practicing medicine have historically been different. Is their very dignity affected by a lack of subsidized alternative medical care? And whether failing to provide these other forms of subsidized medical care, while still providing “mainstream” medical care, therefore amounts to a breach of s. 15, incapable of surviving the reasonable limits test under s. 1.²⁰⁹ In all cases, it would be necessary to establish the legitimacy of alternative therapeutic practices for the subject group. Given the Supreme Court’s recent holding in *Law*, it may require a claimant who comes from a particular historically disadvantaged group, whose very culture expects forms of medical practices that are different from those less disadvantaged.

B. Fundamental Justice Under Section 7

Section 7 of the *Charter* provides a general guarantee of basic rights:

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.

The Supreme Court’s rulings on the relationship between s. 7 of the *Charter* and health care issues are now well-known. In *Morgentaler v. R. (No. 2)*²¹⁰, the Court was asked to determine the constitutionality of provisions in the Criminal Code restricting access to therapeutic abortions. In a number of separate judgments, the Court generally found that the provisions breached s. 7 of the *Charter*. Chief Justice Dickson found that there was an infringement of the purely physical aspect of an individual’s right to security of the person by virtue of the delays occasioned

²⁰⁸For arguments along similar lines, see for example, *Brown v. British Columbia (Min of Health)* (1990), 66 D.L.R. (4th) 444 (B.C.S.C.).

²⁰⁹See the brief discussion on s. 1 at 5.C below.

²¹⁰[1988] 1 S.C.R. 30.

by abortion committee and hospital admission approval.²¹¹ Beetz J. concentrated more on the criminal law aspect of the provisions and found that for security of the person to have any meaning, it must include protection from state interference when a person's life or health is in danger. To him, the important aspect in any s. 7 analysis was that there needed to be state intervention in order to cause a breach of security of the person.²¹² Wilson J. held that state enforced medical treatment was a clear example of a security of the person violation. In her mind, taking away fundamental decisions from a person, such as a woman's decision whether or not to have an abortion, was a serious violation of s. 7.²¹³ The Court expanded further on this theme in *Rodriguez*, where McLachlin J. (in dissent but not contradicted on this point), maintained that security of the person forms part of the persona and dignity of all humans, and that each of us should have the autonomy to decide what is best for our own bodies.²¹⁴

The question of whether s. 7 entitles a person to specific forms of health care, or whether it could be used to compel government to add certain benefits to a schedule of insured health services, however, is thornier. If the idea of health care is posited as a social right – that it is part of human welfare at its most basic social level, similar to, for example, public education – there is a possible case to be made.²¹⁵ In Canada, this is supported by the fact that Medicare, in the 50 years since it was first introduced, has solidified its place in the social fabric, so that subsidized health care has arguably become a basic right of Canadian citizenship. In other words, the provision of a government service can, over time, become a fundamental right, as a part of the cultural history of a nation. This view also fits within a growing acknowledgment of social and economic rights developed in international commitments.²¹⁶ But the position is weakened by noting that some individual rights more fundamental than those of health, such as the rights to food and water, are not included in the *Charter*, and to somehow imply any of these rights into the Constitution is unlikely. Moreover, the same reasoning can be used today to draw an opposite conclusion: recent history shows that government is as much a force for reducing social programs as it is for introducing and promoting them, which by implication sends a message that any form of guaranteed government program is a relic of our past.²¹⁷

²¹¹*Ibid.* at 73.

²¹²*Ibid.* at 90.

²¹³*Ibid.* at 173 & 183-4.

²¹⁴*Rodriguez*, *supra* note 176 at 617-18.

²¹⁵See M. Jackman, "The Right to Participate in Health Care and Health Resource Allocation Decisions under Section 7 of the *Canadian Charter*" (1995) 4 Health L. Rev. 213.

²¹⁶See *Universal Declaration of Human Rights*, UNGA Res. 217A (111), UN Doc. A/810 (948) at art. 25(1); *International Covenant on Economic, Social and Cultural Rights* (1966) 993 U.N.T.S. 3, Can. T.S. 1976 No. 46, art 12(1), 12(2)(d).

²¹⁷An example of governments tampering with accepted rights like this in the context of the health care system is with the changes wrought in Alberta under the *Regional Health Authorities Act* and in Ontario under Bill 26, *Savings and Restructuring Act* – see G.D. Marriott, "The Regional Health Authorities Act and the Privatization of Health Care in Alberta" (1995) 3 Health L. Rev. 35 and J.F. Kotalik, "Ontario's Bill 26 and Foundational Values of Canadian Health Care" (1996) 5 Health L. Rev. 11, respectively.

A number of lower level court cases seem to bear out the argument that s. 7 does not provide much in the way of ensuring a basic right to health care – at most it could ensure limited access to some form of subsidized care.²¹⁸ Both *Whitbread v. Walley*²¹⁹ and *Ontario Nursing Homes Association v. Ontario*²²⁰ found that legislation that has no direct effect on the life, liberty or security of a person, but instead deals with financial interests, is not subject to the same kind of *Charter* scrutiny as legislation that actively bars certain procedures, or criminalizes them, as was the case in *Morgentaler*. Using this rationale, any provision of health care above a basic level will be seen as an enhancement rather than a minimally guaranteed right, which leaves little room for an expanded health care system incorporating alternative therapies. The Supreme Court's decision in *Eldridge* implicitly agrees with this analysis, as the Court ignored the s. 7 arguments, favouring the use of s. 15 where the issues revolved around relatively minor differences in the provision of health services, not direct health and safety risks or criminalized practices.

One final approach under s. 7 may be to rely on the legislative provisions of the CHA itself. Under the CHA, services to be included under Medicare are those “medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability.”²²¹ Section 7 of the *Charter* could be employed to combat instances where existing medical treatments are removed from provincial listings, on the presumption that if they were included previously, they must have been medically necessary. Rather than simply delisting items by regulatory fiat, fundamental justice, as entrenched under the *Charter*, could require open, public discussion of the treatment modality and other health policy decisions that reverberate through a number of professions and therapies. As Professor Martha Jackman states:

An individual whose health-related interests are at risk would also have the right to discuss fully the health service or treatment decision with the physician or other health care provider actually responsible for making it. To meet the requirements of fundamental justice, such a discussion should enable the person affected to thoroughly understand and assess the entire spectrum of treatment choices available, including those of a non-medical nature, and fully convey his or her own particular priorities and concerns....

Another example is the various “Workfare” programs recently proposed which fundamentally alter traditional conceptions of social insurance and welfare.

²¹⁸See B.F. Windwick, “Health Care and Section 7 of the Canadian Charter of Rights and Freedoms” (1994) 3 Health L. Rev. 20.

²¹⁹(1988), 51 D.L.R. (4th) 509 (B.C.C.A.).

²²⁰(1990), 72 D.L.R. (4th) 166 (Ont. H.C.).

²²¹CHA, *supra* note 49, ss. 2, 22.

Due process requirements [in the broader sense of policy and regulatory decisions] can be met by ensuring that generalized decisions relating to health policy and the allocation of health care resources and services are publicly discussed and debated...mechanisms include public hearings and consultation on such matters as...the listing and delisting of services under government health insurance plans.²²²

In the last few years, however, delisting of health services has been almost entirely at the expense of the bioscientific medical profession and its therapies, while the alternative profession has witnessed a growth in listed procedures. Ultimately, therefore, it is difficult to see how s. 7 of the *Charter* can be effective in requiring governments to extend Medicare Plans to include alternative practices.

C. Reasonable Limits under Section 1

Even if it can be shown that refusing certain forms of alternative treatment under Medicare offends a provision of the *Charter*, there is still the matter of passing the reasonable limit test set out in s. 1.²²³ A full description of the s. 1 analysis is outside the scope of this paper; however, given the place of Medicare in Canadian society, it is likely to be difficult to overcome the reasonableness provisions. To succeed under this head, government would need to show that the two stages set out in *R. v. Oakes*²²⁴ are met. These are: that the legislation meets a pressing objective (and the objective and policy behind omitting or underinclusiveness is included here²²⁵) and reasonable means are chosen to achieve this, by being “rationally connected” and “minimally impairing” the *Charter* right.

Given the broad values of the *Canada Health Act* of universality and comprehensiveness, and the different approaches to these values taken in each province, there may be strong arguments showing how omitting alternative health care from medicare schedules does not meet any pressing objective. Under the second stage, the impugned provision (in this case the Medicare schedules) must infringe as little as possible the guaranteed constitutional right. One way of doing this would be to adopt evidence-based medical theories to show that some procedures covered by Medicare schedules are not provably beneficial. Since the schedules permit (to a certain degree) only physicians to recover fees for these procedures, and not alternative practitioners, this indicates that the limits might be unreasonable. Based on a limited knowledge of medical practice, it seems arguable that some existing procedures could be dealt with equally effectively by alternative

²²²Jackman, *supra* note 120 at 6-7.

²²³Section 1 of the *Charter* states: “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.”

²²⁴[1986] 1 S.C.R. 103. This test has been further refined in *Eldridge*, *supra* note 168 at para. 84; Egan, *supra* note 179 at para. 182; and *M. v. H.*, *supra* note 173 at para. 75ff.

²²⁵See *Vriend*, *supra* note 188 at para. 110-11.

practitioners (visits relating to common colds, counselling, and support for certain chronic ailments come to mind), meaning that current scheduled procedures under Medicare are overbroad. In other words, in order to minimally impair *Charter* values, Medicare schedules should be organized functionally, according to the procedure, rather than according to the professional designation of the practitioner. Further argument in this area would require additional research into the scope and extent of current medical practices claimable under Medicare that could reasonably be classified as non- or extra-medical. Of course the question of remedy, where infringement is found, is outside the scope of this paper.

6. Conclusion

Both government and the mainstream medical monopolies are taking a new interest in complementary medicines. The scientific medical establishment, through its provincial medical colleges, is now much more willing to allow its membership to utilize complementary therapies in everyday practice. Professional licensure and regulation of many formerly eschewed or even “quack” practices have grown in the last few years. It is difficult to predict how far these boundaries will extend: in the last few years, for example, a new federal designation of herbal drugs has brought “natural remedies” within traditional drug categories; the University of Toronto has offered fourth-year pharmacy students an elective course in alternative medicine; and even veterinarians have begun using acupuncture to improve the performance of racehorses.²²⁶ All this is probably a reflection of a greater acceptance of these new medicinal therapies within the wider community rather than through any overt agreement of their philosophies by a nascent medical establishment.

This paper has examined some of the legal and philosophical aspects of alternative medicine’s place in Canada’s modern health care system. It has briefly explored some constitutional arguments that can be employed against current Medicare Plans as a way of seeking inclusion of a wider variety of procedures within scheduled medical services. In some limited cases, *Charter* litigation along these lines may prove to be a useful agent for change. However, it is important to understand the limitations of such methods, and of the availability of extra-legal means of achieving social change.

In many cases consumer advocacy can be just as successful, less expensive and less controversial or politically uncertain than complex constitutional argument before the courts. In the U.K. for example, many complementary therapies have

²²⁶The outer limits of these boundaries must be the establishment of alternative medicine clinics for animals (and the concomitant growth of scholarly activity on this topic in veterinarian journals). An example is the Freis, Alternativs Institut für Tierheilkunde (FAT) in Gelsenkirchen, Germany. The Canadian owner, horseman J. Baxter, advertises the benefits of acupuncture, naturopathy, homeopathy and other forms of alternative therapy for horses and other animals. (From a private communication with a former employee who requested confidentiality).

been available under the NHS since 1992.²²⁷ This shift in policy resulted from a confluence of four factors: the inability of the Government to wait for complementary medical practices to self-regulate; the soaring costs of health care; increased public dissatisfaction with orthodox health care; and a proliferation of disorders left unexplained by medical science. All led to increased consumer demand for complementary medicine and a rejection of the medical professional monopoly.²²⁸

Time will tell whether similar changes take hold in Canada. While demand for alternative services has increased, and provincial governments have shown a willingness to provide a few “carrots” for patients interested in alternative remedies, wholesale reform driven by dissatisfied consumers remains elusive. It may be that constitutional challenges to Medicare Plans will be a necessary component of such reform. Until then, many believers in alternative medicine will remain convinced that Canada’s health care system falls short of paradise.

²²⁷See D.J. Benor, “Healers and a Changing Medical Paradigm” *Centre for Frontier Science*, 3.2 (1993) 38 (more than 8,000 registered healers are permitted by law to give healings in hospitals at a patient’s request – some are covered under the NHS).

²²⁸See B. Inglis, “Health: Will Alternative Ever Become Mainstream?” *Daily Telegraph* (5 January 1993) 13. In recognition of these fundamental changes in the U.K., Inglis humorously notes: “Who 20 years ago would have thought that so many patients would be swearing by, rather than swearing at, aromatherapists, or cranial osteopaths who mysteriously manipulate the skull, or reflexologists who, even more mysteriously, work on the soles of the feet?”