

The Application of the Canadian Charter in the Health Care Context

Martha Jackman

Introduction

With its entry into force in April, 1982, the *Canadian Charter of Rights and Freedoms*¹ has had a significant impact on many aspects of Canadian life. The *Charter* is generally seen as drawing upon a nineteenth century liberal rights tradition, in the sense of being designed primarily to protect citizens from state action which impinges upon individual liberty and autonomy. The claim that the right to “life, liberty and security of the person” under section 7 guarantees the right to refuse unwanted health care treatment is consistent with this conception of the *Charter*.² Since its enactment, questions have also been raised as to whether the *Charter* not only prevents the state from interfering with individual freedoms, but requires governments to take positive measures to ensure that Canadians can indeed enjoy the full benefit of basic human rights. From this perspective, the issue whether the *Charter* guarantees access to health care services as an element of the right to life, liberty and security of the person under section 7, or of the right to equal protection and equal benefit of the law under section 15(1) of the *Charter*, is a matter of even greater interest.³ The first question which must be resolved in considering the potential impact of the *Charter* in the health care context, however, is to what extent the *Charter* applies to the decisions and actions of those involved in the health care system. The object of the following note is to attempt to answer this question, with particular focus on the Supreme Court of Canada’s decision in *Eldridge v. British Columbia (Attorney General)*.⁴

The Situation Prior to Eldridge

The application of the *Charter* is governed by the language of section 32(1), which states that the *Charter* applies to Parliament and the government of Canada in respect of all matters within federal authority, and to the provincial legislatures and governments in respect of all matters within provincial jurisdiction. In its first decision on the meaning of section 32(1), in *R. W. D. S. U., Local 580 v. Dolphin Delivery*

Ltd.,⁵ the Supreme Court of Canada held that the *Charter* applied only to “government.” Thus, while the decisions and actions of the legislative and executive branch, whether in the form of laws, regulations, policies or practices, would be subject to *Charter* scrutiny, the actions of “private” entities would not.⁶ The Court also concluded, in *Dolphin Delivery*, that the *Charter* did not apply to common law rules or principles unless these were being relied upon by government.⁷

The question to what extent the *Charter* applied in the health care setting was addressed by the Supreme Court for the first time in its 1990 decision in *Stoffman v. Vancouver General Hospital*.⁸ At issue in the *Stoffman* case was whether the *Charter* applied to the Vancouver General Hospital’s mandatory retirement policy for physicians, which the appellant claimed violated the prohibition against age discrimination under section 15(1) of the *Charter*. In his decision for a majority of the Court, Justice LaForest found that, while the government of British Columbia retained ultimate control over the Vancouver General Hospital, provincial hospital legislation did not subject routine aspects of the hospital’s management to government control.⁹ As a consequence, Justice LaForest held that the hospital did not form part of “government” within the meaning of section 32(1) of the *Charter*. The hospital’s failure to renew the appellant’s admitting privileges when he reached the age of 65 was not therefore subject to *Charter* review.¹⁰

The Eldridge Decision

The issue of the application of the *Charter* in the health care context was raised again in *Eldridge v. British Columbia (Attorney General)*.¹¹ The appellants in the *Eldridge* case, Robin Eldridge and John and Linda Warren were deaf residents of British Columbia. All had experienced problems within the provincial health care system because of their inability to communicate with health care providers in the absence of sign language interpretation services. Mrs. Warren, for example, underwent an emergency delivery of

her twin daughters without being able to communicate with the attending physician or nurses during the delivery, because sign language interpretation was not available in the hospital. Until 1990, free medical interpretation services had been provided in British Columbia by the Western Institute for the Deaf, a private non-profit agency. In 1990, the Institute discontinued the service due to lack of funds after the provincial health ministry refused the Institute's request for financial assistance. In an application commenced in the British Columbia Supreme Court, the appellants claimed that the failure to provide sign language interpretation services under the province's *Medical and Health Care Services Act*¹² and *Hospital Insurance Act*¹³ violated their *Charter* right to equality without discrimination based on physical disability.

The equality rights claim in *Eldridge*, which had been rejected at trial and by the British Columbia Court of Appeal, was granted in a unanimous decision by Justice LaForest.¹⁴ In order to deal with the section 15(1) argument, however, Justice LaForest had first to revisit the issue of the applicability of the *Charter* in the health care setting, and the specific question whether the failure to provide interpretation services for the Deaf within the publicly funded health care system was subject to *Charter* scrutiny. Upon reviewing the terms of the B.C. *Medical and Health Care Services Act* and the *Hospital Insurance Act*, Justice LaForest found that the two statutes were drafted permissively and, except in the case of certain specialized services, did not specify what specific health services were to be provided under the provincial medical and hospital insurance regime. Consistent with Chief Justice Lamer's reasoning in *Slaight Communications Inc. v. Davidson*,¹⁵ Justice LaForest determined that since the B.C. health and hospital insurance legislation neither required nor prohibited the provision of interpretation services, it could not be said to infringe section 15(1) of the *Charter*.¹⁶ Because the power to decide what services would be funded was delegated by the *Medical and Health Care Services Act* to the province's Medical Services Commission, and by the *Hospital Insurance Act* to individual hospitals, Justice LaForest held that it was the actions of these entities rather than the legislation itself which gave rise to the appellants' equality rights claim.¹⁷

With regard to the application of the *Charter* to the hospitals' failure to provide interpretation services, Justice

LaForest reiterated his earlier conclusion in *Soffman* that hospitals were private rather than governmental entities within the meaning of section 32(1). However, he held that, in implementing the government's program of providing publicly funded health care services to provincial residents, the hospitals' actions were subject to *Charter* scrutiny. In coming to this decision, Justice LaForest distinguished between matters of internal hospital management, such as the mandatory retirement policy at issue in *Stoffman*, and the delivery of patient care. Justice LaForest argued that, in providing medically necessary services, hospitals were simply the vehicles chosen by the legislature "for the delivery of a comprehensive social program" established under provincial health and hospital insurance legislation.¹⁸ In the case of the Medical Services Commission, Justice LaForest found that, in exercising the authority granted to it

by the government to determine which health care services were eligible for provincial funding and which were not, the Commission was acting in a "governmental capacity". As a consequence, the Commission's actions and decisions were also subject to *Charter* review, whether or not the Commission was considered to be part of government for other

purposes.¹⁹

The Implications of the Eldridge Decision

The Supreme Court's decision on the application of the *Charter* in *Eldridge* is an extremely significant one. As part of government within the meaning of section 32(1), the laws, policies and actions of federal, provincial/territorial, and municipal departments of health and other government bodies are clearly subject to *Charter* review. With the Court's initial decision in the *Stoffman* case, it appeared that hospitals and other non-governmental health care providers would be immune from *Charter* scrutiny as "private" rather than public entities.²⁰ However, the Court's decision in *Eldridge* expands the enquiry under section 32(1) to focus on the activity or decision giving rise to the *Charter* claim, and its relationship to the government's objective of providing universal access to publicly funded health care. While the *Eldridge* case involved the actions of the provincially appointed Medical Services Commission and public hospitals in the province, the Court's reasoning suggests that other quasi- or non-governmental bodies, and

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the administrators and staff they employ,²¹ will also be required to act in conformity with the *Charter* when engaged in the planning and delivery of government funded health care services. Such bodies might include, for example, regional and local health authorities, community health clinics, nursing homes, long-term and chronic care facilities and other diagnostic and treatment facilities in receipt of public funding.²²

The difficult question left unresolved by the *Eldridge* case is the application of the *Charter* to the actions of non-employee health care providers working in hospitals, as well as independent health care providers delivering health care services in other settings, most notably physicians. Justice LaForest's analysis in *Eldridge* would appear to be equally applicable to individual as to institutional care givers. For example, while most physicians in Canada are paid on a fee-for-service basis, the insurance model for delivery of medical care in Canada is largely a historical anomaly.²³ Physician services are funded almost entirely through provincial health and hospital insurance regimes, and medicare remains one of the most important social policies and programs provided by government. As Justice LaForest explained in *Eldridge*:

In recent decades...health care, including that generally provided by hospitals, has become a keystone tenet of governmental policy. The interlocking federal-provincial medicare system...entitles all Canadians to essential medical services without charge. Although this system has retained some of the trappings of the private insurance model from which it derived, it has come to resemble more closely a government service than an insurance scheme.²⁴

Justice LaForest's discussion of the role of hospitals within the Canadian health care system is equally applicable to physicians and other individual health care providers whose services are subsidized through health and hospital insurance legislation. Like hospitals, physicians and other publicly funded health care providers can readily be characterized as acting "as agents for government in providing the specific medical services set out"²⁵ in provincial health insurance legislation, under the general framework of the *Canada Health Act*.²⁶

The specific issue of the application of the *Charter* to physicians was addressed by the Supreme Court in the pre-*Eldridge* case of *R. v. Dersch*.²⁷ The appellant was charged with criminal negligence causing death following a motor vehicle accident in which he was involved. Upon his arrival in hospital, the appellant refused to give a blood sample,

which was eventually taken by the attending physicians for medical reasons while the appellant was unconscious. At trial, admission of the blood sample and blood alcohol test results led to the appellant's conviction. At issue before the Supreme Court of Canada was whether the appellant's section 8 right to be secure against unreasonable search and seizure had been violated, and whether the actions of the emergency room physicians who took the blood sample without the appellant's consent were subject to *Charter* review.

A majority of the Court found that, in light of the *Stoffman* decision, the hospital where the appellant was treated was not part of government, so that the physicians' participation in the appellant's emergency care did not in itself render them agents of the government for *Charter* purposes. In contrast to a situation where a blood sample was taken pursuant to a provision of the *Criminal Code*²⁸ or at the request of the police, the Court concluded that the physicians in *Dersch* were not acting as agents of government in taking the blood sample solely for medical purposes.²⁹ It can be argued that since the physicians providing emergency care in *Dersch* were not carrying out a governmental function of obtaining evidence in a criminal prosecution, their actions should not have been subject to scrutiny under section 8 of the *Charter*. Independently of the issue whether the appellant's legal rights were violated during the police investigation, however, reviewed in light of *Eldridge*, the emergency care itself would arguably be susceptible to *Charter* review, including for potential violation by the attending physicians of the appellant's section 7 right to consent to medical treatment.³⁰

For the same reasons that the public or "private" character of a health care provider does not resolve the applicability of the *Charter*, the reasoning in *Eldridge* suggests that the application of the *Charter* should not be determined by the particular location in which a patient receives a given service. For example, it would be anomalous for a hospital to be subject to *Charter* scrutiny for providing discriminatory health care within the hospital, while a physician providing the same care in his or her medical office was not. In *Eldridge*, the Attorney General of B.C. argued that the issue of access to interpretation services for the Deaf should have been dealt with under provincial human rights legislation, which applied equally to the private sector, rather than under the *Charter*, which applied only to government.³¹ The Supreme Court rejected this argument, finding instead that the *Charter* required the provision of interpretation services for the Deaf in all cases where this was necessary to ensure "effective communication" between care giver and patient.³² In other words, as suggested above, the Court resolved the issue of



the application of the *Charter* by considering the nature of the service being provided and its relationship to governmental objectives, rather than the particular location where the health care services was being delivered, or the public or private character of the care giver involved.

Conclusion

With the Supreme Court's decision in *Eldridge*, the potential for invoking the *Charter* in the health care context has expanded significantly. In its earlier decisions in *Dolphin Delivery* and in *Stoffman*, the Court appeared to limit the application of the *Charter* to entities which were subject to a degree of governmental control such that they could be characterized as being "part of government" for the purposes of section 32(1). In the health care context, however, such a sharp distinction between "public" and "private" does not exist.³³ Because of its origins in the private medical insurance plans which emerged in many parts of Canada before the World War II,³⁴ the current Canadian health care system retains many of the trappings of a private insurance regime, most notably in the method of government funding for health and hospital services under the *Canada Health Act*.³⁵ The fact that health care services are delivered in a mixed system, however, does not alter the fact that publicly funded health care has become a core government program in Canada, and a defining feature of Canadian society.³⁶ As Justice Wilson argued in her dissenting opinion in the *Stoffman* case: "government has recognized for some time that access to basic health care is something no sophisticated society can legitimately deny to any of its members."³⁷ The Supreme Court's decision in the *Eldridge* case recognizes that this important area of government activity should be subject to *Charter* review, and that the scope of the *Charter*'s protection should not be determined by the nature of the decision-maker or of the locus of the health care decision-making which impinges upon individual health-related rights.

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1. *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 *Charter*].

2. See for example S. Rodgers, "State Intervention in the Lives of Pregnant Women" in J. Downie & T. Caulfield, eds, *Canadian Health Law and Policy* (Toronto: Butterworths, 1999) 275 at 296-300; L.E. Rozovsky, *The Canadian Law of Consent to Treatment*, 2d ed. (Toronto: Butterworths, 1997) at 99-102; G. Fergusson, "The Canadian Charter of Rights and Individual Choice in Treatment" (1988) 8 *Health Law in Canada* 63.

3. See for example 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); B.F. Windwick, "Health Care and Section 7 of the *Canadian Charter of Rights and Freedoms*" (Spring 1994) 3:1 *Health Law Review* 20; M. Jackman, "The Constitution and the Regulation of New Reproductive Technologies" in Royal Commission on New Reproductive Technologies, *Overview of Legal Issues in New Reproductive Technologies*, Research Studies vol. 3 (Ottawa: Minister of Supply and Services Canada, 1993) 1 at 18-41; M. Hébert, "L'application des Chartes canadienne et québécoise en droit médical" (1989) 30 *C. de D.* 495.

4. [1997] 3 S.C.R. 624.

5. [1986] 2 S.C.R. 573 [hereinafter *Dolphin Delivery*].

6. *Ibid.* at 598.

7. *Ibid.* at 599.

8. [1990] 3 S.C.R. 483 [hereinafter *Stoffman*].

9. *Ibid.* at 513-16.

10. *Ibid.* at 516.

11. *Supra* note 4 [hereinafter *Eldridge*].

12. S.B.C. 1992, c. 76, now *Medicare Protection Act*, R.S.B.C. 1996, c. 286.

13. R.S.B.C. 1979, c. 180, now R.S.B.C. 1996, c. 204.

14. Justice LaForest found that, given the centrality of effective communication to the delivery of medical services, failure to provide publicly funded interpretation services denied the deaf the equal benefit of the provincial medicare system, relative to the hearing; *Eldridge*, *supra* note 4 at 682. For a comment on this aspect of the case, see B. Porter, "Beyond *Andrews*: Substantive Equality and Positive Obligations After *Eldridge* and *Vriend*" (1998) 9 *Constitutional Forum* 71; M. Jackman, "Giving Real Effect to Equality:" *Eldridge v. British Columbia (Attorney General)* and *Vriend v. Alberta*" (1998) 4 *Review of Constitutional Studies* 352.

15. [1989] 1 S.C.R. 1038.

16. *Eldridge*, *supra* note 4 at 649-54.

17. *Ibid.* at 650-651, 654.

18. *Ibid.* at 665.

19. *Ibid.* at 666.

20. See for example *Kennett Estate; Sweeny v. O'Brien* (1999), 99 N.S.R. (2d) 385.

21. For a review of the principles of vicarious liability which apply to health care facilities in relation to the actions of their administrators and staff, see J.J. Morris, *Law for Canadian Health Care Administrators* (Toronto: Butterworths, 1996) at 144-50.

22. For a description of the various types of health care facilities operating within the Canadian system, see Morris, *Law for Canadian Health Care Administrators*, *ibid.* at 1-22.

23. See generally M.G. Taylor, *Health Insurance and Canadian Public Policy*, 2d ed. (Montreal/Kingston: McGill-Queen's University Press, 1987) at 435-36; C.D. Naylor, *Private Practice: Canadian Medicine and the Politics of Health Insurance 1911-1966* (Montreal/Kingston: McGill-Queen's University Press, 1986); A. Crichton & Hsu, *Canada's Health Care System: Its Funding and Organization* (Ottawa: Canadian Hospital Association Press, 1990) at 27-48.

24. *Eldridge*, *supra* note 4 at 665.

25. *Ibid.*

26. R.S.C. 1985, c. C-6.

27. [1993] 3 S.C.R. 768 [hereinafter *Dersch*].

28. R.S.C. 1985, c. C-46.

29. *Ibid.* at 776-777; see also *R. v. Dyment*, [1988] 2 S.C.R. 417, where the Supreme Court held that section 8 of the *Charter* had been violated where a blood sample was taken without the accused's consent, at the request of the police; and *R. v. Stillman*, [1997] 1 S.C.R. 607, where the Court held that an accused's section 7 and 8 rights had been violated when teeth impressions were taken by a dentist, while the accused was in police custody, and without his consent.

30. See the discussion in part 2 of the paper, below.

31. *Eldridge*, *supra* note 4 (Respondent's factum at xx).

32. See the references at note 2, *infra*.

33. For an excellent overview of the Canadian system, see C.M. Flood, "The Structure and Dynamics of Canada's Health Care System" in Downie & Caulfield, *Canadian Health Law and Policy*, *supra* note 2 at 5-50.

34. See generally A. Crichton & D. Hsu, *Canada's Health Care System: Its Funding and Organization* (Ottawa: Canadian Hospital Association Press, 1990) at 27-48; M.G. Taylor, *Health Insurance and Canadian Public Policy – The Seven Decisions that Created the Canadian Health Insurance System and Their Outcomes*, 2d ed. (Montreal/Kingston: McGill-Queen's University Press, 1987); C.D. Naylor, *Private Practice: Canadian Medicine and the Politics of Health Insurance 1911-1966* (Montreal/Kingston: McGill-Queen's University Press, 1986).

35. R.S.C. 1985, c. C-6. See M. Jackman, "The Regulation of Private Health Care Under the *Canada Health Act* and the *Canadian Charter*" (1995) 2 *Constitutional Forum* 54.

36. See National Forum on Health, "Values Working Group Synthesis Report" in *Canada Health Action: Building on the Legacy*, Vol. II, Synthesis Report and Issues Papers (Ottawa: Minister of Public Works and Government Services, 1997) at 5-8; Auditor General of Canada, *Report of the Auditor General of Canada to the House of Commons: Chapter 29 – Federal Support of Health Care Delivery* (Ottawa: Minister of Public Works and Government Services Canada, 1999) at 29-13 - 29-14.

37. *Supra* note 5 at 544.

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