Provincial Jurisdiction over Abortion

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Under Canadian division of powers law, provincial authority to regulate abortion must be found in the powers over health, hospitals, or regulation of the medical profession. Though this observation is frequently made, there has been little in-depth discussion of the concrete and actual limits placed on provincial governments by the requirement for a health nexus. A review of division of powers law and the medical evidence on several abortion restrictions reveals that provincial jurisdiction to regulate abortion is limited.

The author reviews the historical and current regulation governing abortion in Canada and discusses the three appellate-level cases dealing with federalism and abortion. Having established the applicable legal framework, the author considers various types of restrictions enacted or proposed in the United States and in Canada, and reviews medical evidence respecting those restrictions. The author reveals that few restrictions provide medical benefit, undermining arguments that such restrictions could validly be enacted for health purposes. The author also discusses whether governments can reject medical evidence when making jurisdictional claims in court and concludes that courts will not defer to governments' tenuous factual claims when those claims lack a "rational basis". Finally, the author concludes that the potential for provincial regulation to be successfully challenged on the basis of jurisdiction means that division of powers law will likely play a significant role in the future of abortion regulation in Canada.

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Introduction

In this paper, I address provincial competence to regulate abortion pursuant to section 92 of the *Constitution Act, 1867*.[1] This issue has received little in the way of comprehensive, critical treatment in the legal scholarship. Many scholars have canvassed federalism issues associated with health care regulation generally in Canada or particular subsets of health regulation, like epidemic management.[2] The handful of pieces that deal with federalism and abortion specifically are mostly reviews of the Supreme Court of Canada's 1993

1. (UK), 30 & 31 Vict, c 3, s 92, reprinted in RSC 1985, Appendix II, No 5.

2. See e.g. Peter W Hogg, *Constitutional Law of Canada*, 5th ed (Toronto: Thomson Reuters Canada Limited, 2007) (loose-leaf updated 2016) vol 2, ch 32 at 1–13; Guy Régimbald & Dwight Newman, *The Law of the Canadian Constitution*, 1st ed (Markham, ON: LexisNexis Canada, 2013) at 413–23; Martha Jackman, "The Constitutional Basis for Federal Regulation of Health" (1996) 5:2 Health L Rev 3; Martha Jackman, "Constitutional Jurisdiction over Health in Canada" (2000) 8 Health LJ 95; Kumanan Wilson & Harvey Lazar, "Creative Federalism and Public Health" (2008) Queen's University Institute of Intergovernmental Relations School of Policy Studies Working Paper No 2008-01, online (pdf): *Queen's University* <www.queensu.ca/iigr/sites/webpublish.queensu.ca.iigrwww/files/files/WorkingPapers/PublicHealthSeries/Wilson_Harvey__PublicHealth.pdf>; Christopher MacLennan, "Understanding the Role of Intergovernmental Relations on Public Health Policy: A Case Study of Emergency Preparedness and Response" (2008) Queen's University Institute of Intergovernmental Relations School of Policy Studies Working Paper No 2008-03, online (pdf): *Queen's University* <www.queensu.ca/iigr/sites/webpublish.queensu.ca.iigrwww/files/files/WorkingPapers/PublicHealthSeries/MacLenann.Chapter.pdf>.

decision in *R v Morgentaler*[3] (*Morgentaler 1993*) and tend to be somewhat descriptive and conclusory in their treatment of doctrinal federalism issues.[4] The oft-made observation that provinces have jurisdiction to regulate abortion provided the legislative objective is aimed at health, while accurate, does not reveal much about what that regulation may actually look like. Through a discussion of precedent, division of powers law, and a review of the medical literature on abortion restrictions, this paper addresses that overlooked issue.

My concern in this paper is abortion-specific regulation[5] that may have the effect of restricting access to the procedure. Examples of these sorts of restrictions, some of which are found in many American states, include: waiting periods; prohibitions on abortion after a certain gestational age; limits on where abortions can be performed or who can perform the procedure; requiring consent from or notification to spouses of women seeking abortions; or requiring provision of information about health risks, the fetus' health or moral status, or alternatives to abortion.[6] As I discuss in this paper, a review of the medical literature reveals that much of this sort of regulation is, by its very nature, directed at the suppression of abortion on moral grounds, rather than legitimate concerns about women's health. Thus, I argue, division of powers doctrine and relevant precedent likely preclude much provincial regulation of this nature.

Even though no provincial legislature has sought to enact statutory restrictions on abortion in recent years, detailing the scope of provincial jurisdiction is still a timely, important exercise. First, because the issue remains politically contentious, it is possible future provincial legislators could seek to

3. [1993] 3 SCR 463 at 490, 107 DLR (4th) 537 [*Morgentaler* 1993].

4. See e.g. Hogg, *supra* note 2, ch 18 at 6; Régimbald & Newman, *supra* note 2 at 415–16; Claire Farid, "Access to Abortion in Ontario: From *Morgentaler 1988* to the *Savings and Restructuring Act*" (1997) 5 Health LJ 119; Linda A White, "Federalism and Equality Rights Implementation in Canada" (2014) 44:1 Publius: J Federalism 157. One of the few articles that addresses division of powers at length makes a novel argument for federal jurisdiction on the basis of the "national concern" branch of POGG. See Professors Moira McConnell & Lorenne Clark, "Abortion Law in Canada: A Matter of National Concern" (1991) 14:1 Dal LJ 81.

5. This paper does not deal with broad health care legislation that applies generally to physicians, hospitals, and provision of medical services and that makes no explicit reference to abortion (for example, informed consent laws; regulation of medical professionals). This type of regulation clearly falls within provincial health jurisdiction. In contrast, as discussed below, because of the nature of abortion-specific legislation and applicable division of powers doctrine, abortion-specific laws are subject to particular considerations that do not apply to more general health care legislation.

6. See Section II.*B* of this paper for a list of common abortion restrictions and examples of jurisdictions where this legislation can be found.

regulate the procedure. In 2017, several candidates running for leadership of the Saskatchewan Party (which currently forms government in that province) vocalized anti-abortion positions.[7] Similarly, in the 2018 leadership race for the Progressive Conservative Party of Ontario, Doug Ford (now Premier of Ontario) suggested that parental consent should be required for minors seeking abortions.[8] Even though Canadians tend to support liberal abortion policies[9] and restricting access might thus prove politically difficult, comments such as these indicate that provincial leadership may consider the introduction of such legislation or will use the rhetoric or promise of abortion restriction to consolidate partisan support. In other words, politically, abortion restrictions remain "on the table".

Second, while provincial policies have been liberalized in the past several decades, barriers to access continue.[10] As recently as 2016, Prince Edward Island residents had to leave the province to obtain abortions.[11] In other provinces, medicare coverage for abortion is restricted.[12] Institutional issues, like physician training and resource limitations, impose additional hurdles.[13] As several authors have noted, for many Canadian women, accessing abortion remains onerous, decades after abortion has been decriminalized.[14] Given that abortion

7. See Arthur White-Crummey, "Abortion Becomes a Divisive Issue in Sask Party Leadership Campaign", *Regina Leader-Post* (last modified 23 November 2017), online: <leaderpost.com/news/local-news/abortion-becomes-a-divisive-issue-in-sask-party-leadership-campaign> (the candidates later clarified that they did not plan to introduce restrictive legislation if elected leader).

8. See Rob Ferguson, "Doug Ford Reopens Abortion Debate; PC Hopeful Says it's Time to Consider Whether Girls Need Parental Permission", *The Toronto Star* (6 March 2018) A8.

9. See Ipsos, Press Release, "Majority Continue to Support (77%) Abortion in Canada, But Behind Sweden (87%), Belgium (87%), and France (86%)" (6 March 2017), online (pdf): *Ipsos* <www.ipsos.com/sites/default/files/2017-05/7600-pr.pdf> (about three quarters of those surveyed believe women should be able to access abortion; over half of those surveyed believe there should be no restrictions on access to abortion).

10. See Jocelyn Downie & Carla Nassar, "Barriers to Access to Abortion Through a Legal Lens" (2007) 15 Health LJ 143; Rachel Johnstone & Emmett Macfarlane, "Public Policy, Rights, and Abortion Access in Canada" (2015) 51 Intl J Can Studies 97; White, *supra* note 4.

11. See Joanna N Erdman, "A Constitutional Future for Abortion Rights in Canada" (2017) 54:3 Alta L Rev 727 at 728 [Erdman, "Constitutional Future"] (discussing changes to Prince Edward Island's abortion policy).

12. See NB Reg 1984-20, Schedule 2, s (a.1); Man Reg 46/93R, s 28; CNLR 21/96.

13. See Johnstone & Macfarlane, *supra* note 10 at 107.

14. See e.g. Christabelle Sethna et al, "Choice, Interrupted: Travel and Inequality of Access to Abortion Services Since the 1960s" (2013) 71 Labour/Le Travail 29; Downie & Nassar, *supra* note 10; Johnstone & Macfarlane, *supra* note 10 at 108–09.

is a contentious political issue and provincial barriers to access remain in place, legislators, lawyers, and citizens ought to be aware of the jurisdictional constraints on provincial legislatures in this field.

Finally, the jurisdictional question is important for another reason: under the Canadian Constitution, the division of powers is inviolable, unlike many *Charter* rights.[15] There is no federalism equivalent of the *Charter*'s notwithstanding clause. Given the significant *Charter* hurdles associated with abortion regulation, a government seeking to restrict access to the procedure may opt to employ the section 33 notwithstanding clause and avoid the *Charter* issue altogether. The same cannot be done to circumvent federalism constraints. Despite the plethora of academic articles dealing with abortion under the *Charter*, the reality is this: *Charter* rights can be swept away; division of powers restraints cannot. In the long run, the jurisdictional constraints may prove hardier than the *Charter* requirements.

A preliminary matter must be addressed. I approach this paper neutral as to the desirability of abortion regulation, taking no position on whether abortion should be subject to more or less restriction or whether access to it should be made more or less onerous. Nor is the *Charter* considered, except as necessary to provide context for the jurisdictional discussion. I focus on division of powers to cast light on the overshadowed jurisdictional question, but I do not deny the obvious rights implications of abortion regulation. Those interested in *Charter* rights and abortion have a plethora of scholarship to peruse.[16] In this stream of scholarship, little attention is generally given to division of powers issues, and the rare comments about jurisdiction are usually accompanied by criticisms of *Charter*-infringing provincial policies. These discussions cast federalism as a barrier to the realization of *Charter* rights. However, as I discuss in the conclusion of this paper, while provincial laws and policies have historically created obstacles for women seeking abortions, federalism doctrine could be enlisted to facilitate access to abortion through jurisdictional challenges to provincial restrictions.

This paper consists of several parts. In the following section, I briefly set out the history of abortion regulation in Canada and provide an overview of the current regulatory framework. In the next part, I review relevant precedent in order to set out the contours of provincial capacity to regulate abortion. I pay

15. See *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

16. See e.g. Downie & Nassar, *supra* note 10; Johnstone & Macfarlane, *supra* note 10; FL Morton, *Morgentaler v Borowksi: Abortion, the Charter, and the Courts* (Toronto: McClelland & Stewart, 1992); Donna Greschner, "Abortion and Democracy for Women: A Critique of *Tremblay v Daigle*", Case Comment, (1990) 35:3 McGill LJ 633; Martha Shaffer, "Foetal Rights and the Regulation of Abortion" (1994) 39:1 McGill LJ 58.

particular attention to the role colourability played in *Morgentaler 1993*. I then set out the pith and substance doctrine, and I comment in some length on the use of practical effects in determining validity. I then discuss the sorts of abortion restrictions that have been enacted or considered in Canada and the United States. A review of the medical literature reveals that many of these regulations have no demonstrable positive impact on women's health or the regulation of hospitals. I consider various potential heads of power and conclude that provincial capacity to enact these sorts of restrictions is limited. The final part of the paper delves into judicial review of factual claims that accompany jurisdictional claims. I envision a legislature relying in good faith on "bad" medical science and employing a legislative presumption of fact. Parliamentary supremacy suggests these factual claims are not reviewable; federalism suggests they are. I discuss these tensions and the standard in play when a court evaluates whether the factual matrix underlying a jurisdictional claim exists. Finally, I conclude with comments on how federalism concerns could shape Canadian abortion regulation in the future.

I. Historical Developments[17] and Current Law

New Brunswick enacted the first statutory prohibition on abortion in the British colonies in 1810.[18] Throughout the early 1800s, other colonies followed suit, though the scope of prohibitions varied.[19] Many of these statutes mirrored the common law distinction between pre- and post-"quickening", regarding abortion before quickening as less serious (at common law, abortion prior to quickening was not criminal).[20] Additionally, at this time, women were not the subject of prosecution, but rather the laws were used to target abortion providers.[21] Anti-abortion laws became increasingly restrictive and expansive in

17. I have provided only a brief overview here. For a detailed history of abortion regulation in Canada, see Joanna N Erdman, "Constitutionalizing Abortion Rights in Canada" (2017) 49:1 Ottawa L Rev 221; Constance B Backhouse, "Involuntary Motherhood: Abortion, Birth Control and the Law in Nineteenth Century Canada" (1983) 3 Windsor YB Access Just 61; Shelley AM Gavigan, "On 'Bringing on the Menses': The Criminal Liability of Women and the Therapeutic Exception in Canadian Abortion Law" (1986) 1:2 CJWL 279.

18. See Backhouse, *supra* note 17 at 67; *An Act for Making Further Provisions to Prevent the Destroying and Murdering of Bastard Children, and for the Further Prevention of the Malicious Using of Means to Procure the Miscarriage of Women*, SNB 1810 (50 Geo III), c 2. For the act this Act was modelled on, see *Lord Ellenborough's Act* (UK), 1803, 43 Geo III, c 58.

19. See Backhouse, *supra* note 17 at 67–71.

20. *Ibid* at 65–68.

21. See *ibid* at 71–73.

the second half of the 1800s: women became the target of sanction and the quickening distinction was dropped.[22] Constance Backhouse's research suggests that the increasingly punitive legislation did not appear to flow from public outrage over the practice, but likely from a burgeoning medical profession attempting to create a monopoly on the provision of health services.[23] Following Confederation, the federal Parliament, seeking to consolidate provincial criminal statutes, enacted *An Act Respecting Offences Against the Person*.[24] The statute made it an offence to provide or receive an abortion or to supply or obtain any thing knowing that the thing would be used to cause an abortion.[25] The prohibition on abortion was included in the 1892 *Criminal Code* and revisions of the Code in the decades that followed.[26]

In 1969, Parliament amended the *Criminal Code* to introduce an exception which permitted women to seek approval for abortions from "therapeutic abortion committees" established by hospitals for the purpose of reviewing such requests.[27] Committee approval was only forthcoming if "in its opinion the continuation of the pregnancy of such female person would or would be likely to endanger her life or health", though this requirement was not interpreted consistently by committees and abortion was more readily available in some parts of the country than others.[28] The exception required the participation of provincial actors—provincial ministers of health and hospital boards[29]—for its operation and the Code provision itself expressly provided that any consents required by provincial law were not overridden by the federal legislation.[30] Thus, the 1969 amendment created a scheme that employed a federal prohibition and

22. See *ibid* at 69–75. However, even in the latter half of the 1800s, it was uncommon to prosecute women who obtained abortions (*ibid* at 129–30).

23. See *ibid* at 76–82.

24. SC 1869, c 20.

25. See *ibid*, ss 59, 60.

26. See *Criminal Code*, SC 1892, c 29, ss 271–74; *Criminal Code*, RSC 1906, c 146, ss 303–06; *Criminal Code*, RSC 1927, c 36, ss 303–06; *Criminal Code*, SC 1953–54, c 51, ss 237–38. See also *Morgentaler* 1993, *supra* note 3 at 491; *R v Morgentaler*, [1988] 1 SCR 30 at 86–87, 44 DLR (4th) 385 [*Morgentaler* 1988].

27. *Criminal Code*, RSC 1970, c C-34, s 251(4) [*Criminal Code* 1970].

28. *Ibid*, s 251(4)(c); Canada, *Report of the Committee on the Operation of the Abortion Law* (Ottawa: Supply & Services Canada, 1977) (Chair: Robin F Badgley) at 251–79 [Badgley Report]. Inconsistency in interpretation contributed to the regime's demise under the C*harter*. See *Morgentaler* 1988, *supra* note 26 at 68–69.

29. See *Carruthers v Therapeutic Abortion Committees of Lions Gate Hospital* (1983), 6 DLR (4th) 57, 50 NR 373 (FCA).

30. See *Criminal Code* 1970, *supra* note 27, s 251(7).

an accompanying exemption that allowed for and in fact required provincial participation, whether through provincial legislation or through guidelines created and implemented by provincially regulated actors.[31] This development solidified the status of abortion as a matter of double aspect, that is, a legitimate subject for both federal and provincial attention.

Shortly after the 1969 amendment, Dr. Henry Morgentaler was charged with violating the *Criminal Code* for performing an abortion without the approval of a therapeutic abortion committee. His acquittal by a jury was overturned by the Court of Appeal of Quebec and a conviction entered.[32] In his appeal to the Supreme Court of Canada, Dr. Morgentaler challenged his conviction on several grounds, one of which was division of powers. The Supreme Court of Canada unanimously ruled that the provision was *intra vires* in its 1975 decision.[33] Chief Justice Laskin observed that the impugned section treated abortion as a "socially undesirable conduct subject to punishment", a matter well within Parliament's criminal law power.[34]

Over a decade later, Dr. Morgentaler again challenged the provision, this time on *Charter* grounds. A majority of the Supreme Court of Canada in its 1988 *Morgentaler* decision (*Morgentaler 1988*) found that the therapeutic abortion committee regime violated section 7 of the *Charter* and could not be saved under section 1. Several justices also affirmed that the provision was *intra vires*. For example, Beetz J, in a concurring decision, observed that the section was primarily concerned with "protection of the foetus"—a moral objective properly within the scope of the federal criminal law power.[35] Because "the protection of the life or health of pregnant women" was only a secondary objective, he agreed with the Court of Appeal for Ontario and McIntyre J (who dissented on section 7 grounds) that the legislation was not a colourable attempt to intrude into provincial health jurisdiction.[36] However, as noted, the section was struck down pursuant to the *Charter*, and federal efforts to replace it were unsuccessful.

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31. For a description of provincial laws and policies that existed under the section 251 regime, see Badgley Report, *supra* note 28 at 91–99.

32. See *R v Morgentaler (No 5)* (1974), 47 DLR (3d) 211, 17 CCC (2d) 289 (Que CA).

33. See *Morgentaler v R* (1975), [1976] 1 SCR 616, 53 DLR (3d) 161 [*Morgentaler* 1975 cited to SCR].

34. *Ibid* at 627. Note that Parliament can exercise its criminal law power to pursue a wide range of "criminal" objectives, including health risks, moral concerns, public safety goals, or environmental harms. See *Reference Re Validity of Section 5(a) of The Dairy Industry Act*, [1950] 4 DLR 689, [1951] AC 179 (PC) [*Margarine Reference*]; *R v Hydro-Québec*, [1997] 3 SCR 213, 151 DLR (4th) 32; *Reference Re Assisted Human Reproduction Act*, 2010 SCC 61 [*Re AHRA*]. The scope of federal jurisdiction over abortion is not the subject of this paper.

35. *Morgentaler* 1988, *supra* note 26 at 128. See *ibid* at 128–29.

36. *Ibid* at 124.

Provincial attempts to regulate abortion predate the striking down of the *Criminal Code* provision. In 1985, Saskatchewan considered a bill that would have put in place additional obstacles for women seeking abortions. For example, the Bill contained a spousal consent requirement, a waiting period requirement, and mandated the provision of certain information (e.g., a description of the fetus' appearance; the availability of alternatives to abortion).[37] The Bill was never enacted. It was referred to the Court of Appeal for Saskatchewan following second reading in the Legislative Assembly[38] and that Court found it *ultra vires*.[39]

Across the country, New Brunswick passed legislation in 1985 providing that physicians who performed abortions in private clinics could face professional discipline, including licence suspension.[40] These provisions were found *ultra vires* by the Court of Appeal of New Brunswick in 1995.[41] Both of these decisions are discussed in detail in the following section of this paper.

Following the 1988 decision in *Morgentaler*, a wave of provincial legislation introduced restrictions on access to abortion.[42] Many of these measures took the form of limitations or prohibitions on public funding for abortion, either precluding medicare coverage entirely or only covering abortions performed in approved hospitals.[43] Some of these funding restrictions were challenged on

37. See Bill 53, *An Act Respecting Freedom of Informed Choice Concerning Abortions in Saskatchewan*, 4th Sess, 20th Leg, Saskatchewan, 1984–85, ss 3–6 [Bill 53].

38. See "Bill 53, An Act Respecting Freedom of Informed Choice Concerning Abortions in Saskatchewan", 2nd reading, Saskatchewan, *Legislative Assembly Debates*, 20-4, No 28 (11 June 1985) at 3263 [*Hansard*].

39. See *Reference Re Freedom of Informed Choice (Abortions) Act* (1985), 25 DLR (4th) 751, 44 Sask R 104 (Sask CA) [*Bill 53 Reference* cited to DLR].

40. See *An Act to Amend an Act Respecting the New Brunswick Medical Society and the College of Physicians and Surgeons of New Brunswick*, SNB 1985, c 76, ss 1–2, amending *An Act Respecting the New Brunswick Medical Society and the College of Physicians and Surgeons of New Brunswick*, SNB 1981, c 87, ss 56(b.1), 56.2 [*Medical Act*].

41. See *Morgentaler v New Brunswick (Attorney-General)* (1995), 121 DLR (4th) 431, 156 NBR (2d) 205 (NBCA) [*Morgentaler* 1995 cited to DLR].

42. See Johnstone & Macfarlane, *supra* note 10 at 103–05.

43. See e.g. NB Reg 1984-20, *supra* note 12 (abortions performed in private clinics excluded from medicare coverage; still in effect); Erdman, "Constitutional Future", *supra* note 11 (discussing Prince Edward Island's informal policy of prohibiting abortions in the province, no longer in effect); Man Reg 506/88R, Schedule H, s 26 (abortions performed in private clinics excluded from public funding; no longer in effect); Man Reg 46/93R, *supra* note 12, s 2(28) (abortions not covered by provincial health plan unless performed in approved facilities; still in effect); CNLR 21/96, *supra* note 12, s 4(1)(u) (abortion covered only if performed in an approved facility; still in effect).

Charter or administrative law grounds, with varying degrees of success.[44] In 1989, Nova Scotia enacted the *Medical Services Act*, which made it an offence to provide an abortion at a private clinic and restricted public funding for abortions.[45] Dr. Morgentaler challenged this legislation and the Supreme Court of Canada found it *ultra vires* in 1993.[46] This decision is reviewed in detail below.

Other than the above-referenced restrictions on public funding for abortion in some provinces, no provincial legislation in Canada currently expressly restricts access to abortion. The procedure is regulated under general health care legislation and by formal and informal policies developed by hospitals, physicians, and medical professional societies.[47] Some provincial legislation does

44. See e.g. *Jane Doe v Manitoba*, 2005 MBCA 109, leave to appeal to SCC refused, 31225 (23 February 2006) (holding that summary judgment procedure not an appropriate vehicle to determine whether exclusion of abortions performed in private clinics from medicare coverage violates the *Charter*); *Lexogest Inc v Manitoba (Attorney-General)* (1993), 101 DLR (4th) 523, 85 Man R (2d) 8 (Man CA) (invalidating funding exclusion on administrative law grounds); *Province of New Brunswick v Morgentaler*, 2009 NBCA 26 (finding that Dr. Morgentaler has public interest to pursue a *Charter* challenge against New Brunswick's funding restriction). Dr. Morgentaler died in 2013 and the challenge did not proceed. See Rachael Elizabeth Grace Johnstone, *The Politics of Abortion in Canada After Morgentaler: Women's Rights as Citizenship Rights* (PhD Thesis), (Queen's University, 2012) at 92 [unpublished, archived at Queen's University QSpace] [Johnstone, *After Morgentaler* 2012]. Rachael Johnstone's dissertation has subsequently been published as a book. See Rachael Johnstone, *After Morgentaler: The Politics of Abortion in Canada* (Vancouver: UBC Press, 2017). See also Sarah Burningham, "Courts, Challenges, and Cures: Legal Avenues for Patients with Rare Diseases to Challenge Health Care Coverage Decisions" (2015) 1:1 Can J Comparative & Contemporary L 317 (discussing the limited prospects of success for individuals using courts to challenge medicare funding decisions). The federal government has also on occasion used the *Canada Health Act* to pressure provinces to rescind restrictive abortion policies, a tactic which has had mixed success. See Downie & Nassar, *supra* note 10 at 165; White, *supra* note 4 at 165–66; Howard A Palley, "Canadian Abortion Policy: National Policy and the Impact of Federalism and Political Implementation on Access to Services" (2006) 36:4 Publius: J Federalism 565. See also Erdman, "Constitutional Future", *supra* note 11 at 742–44 (noting the federal role in bringing about change to PEI's policy).

45. RSNS 1989, c 281 (prohibiting the performance of "designated medical services" outside hospitals, ss 2–5). A regulation specified that abortions were a designated medical service for the purposes of the Act. See NS Reg 152/1989.

46. See *Morgentaler* 1993, *supra* note 3 at 516.

47. See e.g. Laura Eggertson, "Abortion Services in Canada: A Patchwork Quilt with Many Holes" (2001) 164:6 CMAJ 847; Palley, *supra* note 44 at 570; Downie & Nassar, *supra* note 10 at 148; Johnstone & Macfarlane, *supra* note 10 at 107; White, *supra* note 4 at 166–68; Jeff

deal expressly with abortion and attempts to expand access rather than limit it. Legislation in British Columbia provides for an obligation on hospitals to provide abortions to patients.[48] And several provinces have enacted safe-zone legislation, which prohibits protests within a designated proximity of abortion clinics and hospitals where abortions are provided.[49] However, despite the dearth of legislative restriction, in practice, many women seeking to access abortion still face obstacles. These obstacles are often institutional and systemic. For example, lack of physician training in abortion techniques means many physicians are not able to perform the procedure.[50] The service may not be offered at rural hospitals or clinics, meaning women must travel to larger centres in order to obtain the procedure.[51] Finally, as noted, because some provinces have opted to limit coverage under medicare, women accessing abortion may face significant financial burdens.[52] I note that for many of these "on the ground" problems,

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Blackmer, "Clarification of the CMA's Position Concerning Induced Abortion" (2007) 176:9 CMAJ 1310; Canadian Medical Association, "CMA Policy: Induced Abortion", online (pdf): *CMA Policy Base* <policybase.cma.ca/dbtw-wpd/PolicyPDF/PD88-06.pdf>. For examples of these policies and some recent controversies that have accompanied them, see Charlie Fidelman, "MUHC Stands by Decision to Deny Woman a Late-Term Abortion" *Montreal Gazette* (last modified 20 December 2016), online: <montrealgazette.com/news/local-news/muhc-stands-by-decision-to-deny-woman-an-abortion>; Sean Murphy, "Tunnel Vision at the College of Physicians", *National Post* (13 April 2015) A12; Alison Mah, "Doctors' Confusion and Red Tape Keeping Women From Abortion Pill, Planned Parenthood Says", *The Ottawa Citizen* (last modified 2 November 2017), online <ottawacitizen.com/news/local-news/doctors-confusion-and-red-tape-keeping-women-from-abortion-pill-planned-parenthood-says>. A review of informal and formal administrative policies is outside the scope of this paper, which instead focuses on legislative abortion restriction.

48. See e.g. *Hospital Act*, RSBC 1996, c 200, s 24.1; *Hospital Act Regulation*, BC Reg 121/1997, s 18.

49. See e.g. *R v Lewis* (1996), 139 DLR (4th) 480, 24 BCLR (3d) 247 (BCSC) (dismissing a *Charter* challenge to British Columbia's *Access to Abortion Services Act*); *Access to Abortion Services Act*, SNL 2016, c A-1.02; *Safe Access to Abortion Services Act, 2017*, SO 2017, c 19, Schedule 1.

50. See e.g. Downie & Nassar, *supra* note 10 at 148–49; Christabelle Sethna & Marion Doull, "Far From Home? A Pilot Study Tracking Women's Journeys to a Canadian Abortion Clinic" (2007) 29:8 J Obstetrics & Gynaecology Can 640 at 640, 642; Joanna N Erdman, Amy Grenon & Leigh Harrison-Wilson, "Medication Abortion in Canada: A Right-to-Health Perspective" (2008) 98:10 American J Public Health 1764 at 1766.

51. See e.g. Downie & Nassar, *supra* note 10 at 152; Sethna & Doull, *supra* note 50 at 642; Erdman, Grenon & Harrison-Wilson, *supra* note 50 at 1765.

52. See Downie & Nassar, *supra* note 10 at 153.

most of which flow from a lack of resources, federalism doctrine offers no solution. Restrictions on funding are addressed below, but, in my view, they are within provincial jurisdiction.[53]

II. The Scope of Provincial Jurisdiction

In this portion of the paper, I set out and apply the legal framework that governs validity determinations in this area. This discussion has three components. First, I set out in detail the relevant appellate case law: the Supreme Court of Canada's decision in *Morgentaler 1993*, the Court of Appeal for Saskatchewan's decision in *Re Bill 53* (1985), and the Court of Appeal of New Brunswick's decision in *R v Morgentaler* (*Morgentaler 1995*). In the course of this discussion, I comment on the use of colourability in *Morgentaler 1993*, arguing that colourability does not play a critical role in that case. Second, I set out the law on pith and substance, paying particular attention to the role of "practical effects" in validity determinations, in order to set the stage for the discussion of the medical literature that follows. Finally, I ascertain the practical effect of common abortion restrictions, as revealed by a review of the medical literature.

A. Case Law on Provincial Attempts to Regulate Abortion

In the section that follows, I set out the three appellate cases dealing with provincial authority to regulate abortion. These judgments provide context for the analysis in the next sections. In all three cases, the provincial attempts to enact restrictive legislation were unsuccessful. The restrictions chosen by the provinces varied: Nova Scotia opted for an express prohibition on free-standing abortion clinics; Saskatchewan sought to make the consent process more onerous; and New Brunswick dealt with regulation of the medical profession. But in all cases, courts found an inappropriate intrusion into federal criminal law. For provinces seeking to regulate abortion, this precedent is ominous.

(i) The Supreme Court of Canada's Decision in *Morgentaler 1993*

In its decision in *Morgentaler 1993*, the Supreme Court of Canada found that Nova Scotia's *Medical Services Act*—which prohibited performance of

53. Some authors have discussed the prospect of using the *Canada Health Act* to pressure provinces to provide adequate funding for abortion services. See e.g. White, *supra* note 4 at 165–66; Downie & Nassar, *supra* note 10 at 165–66. This issue is outside the scope of this paper.

abortions outside approved hospitals[54]—was in pith and substance directed at "the restriction of abortion as a socially undesirable practice which should be suppressed or punished",[55] a matter within the federal government's criminal law power, thus rendering the law *ultra vires*. Justice Sopinka, for a unanimous Court, rejected the province's argument that the legislation was directed at improving the quality of or reducing the cost of the provincial health care system.[56] He observed that prohibiting abortion under threat of sanction was historically within the domain of the criminal law, and thus on that basis alone, the provincial law was "suspect on its face".[57] Looking beyond the text of the statute itself, he noted that the tenor of the legislative debates and the context in which the legislation arose clearly reflected the Legislature's preoccupation with preventing Dr. Morgentaler from opening a private abortion clinic in the province.[58] Suppression of privatization, reduction of costs, and protection of women's health—any of which would have been legitimate provincial objectives—were "incidental to the paramount purpose of the legislation".[59] Passages dealing with the provincial competence to regulate abortion are worth setting out at length:

> [I]f the central concern of the present legislation were medical treatment of unwanted pregnancies and the safety and security of the pregnant woman, not the restriction of abortion services with a view to safeguarding the public interest or interdicting a public harm, the legislation would arguably be valid health law enacted pursuant to the province's general health jurisdiction.
>
> In addition, there is no dispute that the heads of s. 92 invoked by the appellant confer on the provinces jurisdiction over health care in the province generally, including matters of cost and efficiency, the nature of the health care delivery system, and privatization of the provision of medical services.
>
> . . .

54. *Medical Services Act*, *supra* note 45, s 4. The *Medical Services Act* also prohibited public funding for abortions performed in private clinics, but this aspect of the statute played no role in the Court's reasoning (*ibid*, s 5). See *Morgentaler* 1993, *supra* note 3 at 494–95.

55. *Morgentaler* 1993, *supra* note 3 at 494.

56. See *ibid* at 505–13.

57. *Ibid* at 512.

58. See *ibid* at 499–505.

59. *Ibid* at 506, citing *R v Morgentaler* (1990), 99 NSR (2d) 293 at 302, 270 APR 293 (Prov Ct).

> The two *Morgentaler* decisions [from 1975 and 1988] focus attention on the purpose or concern of abortion legislation to determine if it is truly criminal law: Is the performance or procurement of abortion prohibited as socially undesirable conduct? Is protecting the state interest in the foetus or balancing the interests of the foetus against those of women seeking abortions a primary objective of the legislation? Is the protection of the woman's health only an ancillary concern? And are other provincial concerns such as the establishment of hospitals or the regulation of the medical profession or the practice thereof merely incidental?
>
> . . . [A]ny provincial jurisdiction to regulate the delivery of abortion services must be solidly anchored in one of the provincial heads of power which give the provinces jurisdiction to legislate in relation to such matters as health, hospitals, the practice of medicine and health care policy.[60]

As these paragraphs make clear, provincial regulation must have legitimate health care aims, such as the protection of women's health or the provision of cost-effective medical services. Objectives such as suppression of abortion as an undesirable social practice or defence of the moral status of the fetus fall outside the scope of provincial power.

In a passage that has received much attention, Sopinka J noted that he was not relying on the principle of colourability (a doctrine which is employed when a legislative body attempts to hide its true purpose behind a veneer of legitimacy).[61] He wrote:

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60. *Morgentaler* 1993, *supra* note 3 at 491–94.

61. The meaning ascribed to colourability in this paper implies an improper intent on the part of the legislative body—that is, an intention to act outside jurisdiction. The focus in such circumstances is on the legislature's "actual intent" or "motive", as opposed to the practical or legal effects of legislation or the purpose statement contained in the statute itself. See Elizabeth Edinger, Case Comment on *Reference Re Upper Churchill Water Rights Reversion Act*, [1984] 1 SCR 297, 8 DLR (4th) 1, (1985) 63:1 Can Bar Rev 203 at 208. The meaning of the term is disputed, however. Most notably, Peter Hogg and the Supreme Court of Canada, at times, have suggested that the doctrine has no special content, but rather just confirms that a court is free to look beyond the text of the statute when determining its pith and substance. For example, Sopinka J in *Morgentaler 1993* wrote: "[T]he colourability doctrine really just restates the basic rule, applicable in this case as much as any other, that form alone is not controlling in the determination of constitutional character, and that the court will examine the substance of the legislation to determine what the legislature is really doing". See *supra* note

> I acknowledge that the legislation has the legal effect of preventing privatization by prohibiting the private (i.e., outside a hospital) provision of the designated services. But the legislation expressly prohibits the performance of abortions in certain circumstances with penal consequences, a subject, as I have said, traditionally regarded as part of the criminal law. In *Scowby v. Glendinning*, [1986] 2 S.C.R. 226, a majority of this Court held provincial legislation creating an offence of arbitrary arrest or detention and a right to relief in the form of habeas corpus to be suspect on its face since arbitrary arrest or detention and the availability of *habeas corpus* in such circumstances have been dealt with by Parliament in the criminal law "almost since the advent of Confederation" (at p. 240). Likewise, one of the reasons behind this Court's invalidation of a municipal by-law prohibiting street prostitution in *Westendorp v. The Queen*, [1983] 1 S.C.R. 43, was that conduct relating to prostitution has long been regarded as criminal. The present legislation, prohibiting traditionally criminal conduct, is therefore of questionable validity on its face: cf. *Rio Hotel Ltd. v. New Brunswick (Liquor Licensing Board*), [1987] 2 S.C.R. 59, at p. 80, *per* Estey J. (concurring in the result).
>
> This conclusion makes it unnecessary to invoke the "colourability doctrine".[62]

Peter Hogg, among others, has suggested that Sopinka J was incorrect in his assertion that colourability had no application, and, in fact, *Morgentaler 1993* is often cited as a quintessential example of the doctrine.[63]

It is odd that Sopinka J would disavow reliance on colourability, while actually employing that principle. Taking his comment at face value, it stands to reason that he was invoking some other principle or factor in his decision.[64]

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3 at 496. See also Hogg, *supra* note 2, ch 15 at 20. This understanding of colourability renders the term meaningless and inconsistent with past usage of the term. See Edinger, *supra* note 61 at 206–07.

62. *Morgentaler* 1993, *supra* note 3 at 495–96.

63. See Hogg, *supra* note 2, ch 15 at 20. Contrast this to Moira McConnell's view, which closely aligns with the argument I present here. See Moira L McConnell, Case Comment on *R v Morgentaler*, [1993] 3 SCR 463, 107 DLR (4th) 537, (1994) 73:3 Can Bar Rev 417.

64. One might argue that Sopinka J was hesitant to adopt the label because it "carries a strong connotation of judicial disapproval". See Hogg, *supra* note 2, ch 15 at 20. However, the Court has on occasion called legislative activity "colourable". See e.g. *Reference Re Upper Churchill Water*

This is not to suggest that colourability has no application at all here, but rather, that the route of arriving at the conclusion that the Legislature intended to act outside its jurisdiction is not the usual route taken in colourability cases, where reliance is placed on extrinsic materials, like Hansard statements or committee reports.[65] Rather, the crux of Sopinka J's decision is the existence of a prior federal criminal prohibition, a fact which he repeatedly highlights in his decision. The validity of the provincial law is called into question because of its intrusion into a traditionally criminal subject with a penal sanction that to some degree mirrors the previous criminal law. Justice Sopinka writes:

> There is no need to invoke the doctrine in this case because while the Act states in its title and s. 2 that its aim is to prohibit the privatization of medical services, there are doubts about the legislation's vires on its face due to the fact that it appears to occupy ground historically occupied by the criminal law.[66]

On this reading of the case, much turns on the fact of prior federal prohibition, and the incriminating Hansard statements, rather than being the lynchpin of the decision, are just "icing on the cake". This is not to say that the existence of past federal prohibition is the only relevant factor. Clearly, as the Court states in *Morgentaler 1993*, the pith and substance analysis requires a consideration of multiple factors, including legal and practical effects. Rather, I want to emphasize that Sopinka J's decision is not primarily about colourability and those incriminating Hansard comments. In my view, insofar as commentators explain *Morgentaler 1993* as a colourability decision and emphasize those Hansard comments, they will tend to overstate provincial jurisdiction in this area, by implicitly suggesting that restrictive legislation in the absence of similar comments would be unproblematic. Even without those incriminating statements, provincial legislation in this area will be subject to scrutiny, as per *Morgentaler 1993*'s emphasis on prior federal prohibition.

While Sopinka J does not ascribe a label to this aspect of his decision or articulate his reasoning in depth, one can plausibly explain his reasoning in terms of application of certain interpretive principles. One interpretative principle in play in constitutional cases is the presumption that the legislating body intended to comply with its constitutional obligations. Ruth Sullivan describes the principle and its interpretive implications:

Rights Reversion Act, [1984] 1 SCR 297 at 332, 8 DLR (4th) 1 [*Water Rights Reference*]. So, one could justifiably wonder why the Court would be willing to do so in some circumstances but not others.

65. See e.g. *Water Rights Reference*, *supra* note 64 at 317–18.

66. *Morgentaler* 1993, *supra* note 3 at 496.

> The first dimension [of the presumption of compliance] is the legislature's presumed intention to respect the rule of law and more specifically the limits on its own jurisdiction. A legislature is presumed to be aware of those limits and as a conscientious constitutional player to remain within those limits when it enacts new law.
>
> . . .
>
> If legislation is open to two interpretations, one of which would render it valid, the courts prefer the validating interpretation.[67]

When a provincial government treads on a matter historically subject to criminal prohibition in a manner that recalls the penal sanction found in federal law, this presumption of compliance with jurisdictional limits is dislodged. In the words of Sopinka J, the legislation in such a scenario will be "suspect on its face".[68] One could still apply the colourability label to this scenario, though the intention to act outside jurisdiction is gleaned from the intrusion into a historically criminal area in a way that is somewhat replicative of the criminal prohibition, in contrast to the usual colourability case where Hansard statements or committee reports reveal an intention to legislate on matters outside jurisdiction.

It is useful to articulate the *Morgentaler 1993* decision in terms of these interpretive principles for two reasons. First, doing so provides clarity on the real substance of the decision: the chief hurdle for the province's validity argument is the intrusion into a historically federal matter, rather than the incriminating Hansard statements. As I noted above, even in the absence of these types of "smoking gun" comments, a province will face an uphill battle acting in this traditionally federal realm. And, in fact, this prediction is borne out by the two appellate cases discussed in the following section. The legislation in both cases was struck down, and, in the Saskatchewan case, the *ultra vires* finding was made without reliance on similar comments made during legislative debate.

Second, it is useful to clarify the Court's reasoning in *Morgentaler 1993* so as to provide an entry point for a richer and deeper critique of the case beyond the propriety of the colourability label. For example, one can argue that the Court's approach in *Morgentaler 1993* is inconsistent with the "dominant tide of modern federalism", which recognizes the appropriateness of overlapping

67. Ruth Sullivan, *Sullivan on the Construction of Statutes*, 5th ed (Markham, ON: LexisNexis Canada, 2008) at 458–61.

68. *Morgentaler* 1993, *supra* note 3 at 512.

jurisdiction.[69] Additionally, *Morgentaler 1993* could have dramatic implications for division of powers law, if the presumption of compliance is rebutted whenever a government acts in an area historically within the other level of government's competence (that is, if the reasoning in *Morgentaler 1993* is not confined to historically criminal matters).[70] I do not seek to defend the approach taken in *Morgentaler 1993* on a normative basis, but rather to clarify it, as Sopinka J's reasoning clearly has ramifications for future provincial attempts at abortion regulation.

(ii) Bill 53 and the Court of Appeal for Saskatchewan

In 1985, the Government of Saskatchewan considered a bill which was designed to supplement the then-existing therapeutic abortion committee framework and which would have introduced additional burdens on women seeking abortions. The Bill provided that a married woman could not receive an abortion unless her husband also provided his consent.[71] If the individual seeking an abortion was a minor, the consent of her parents or guardians was required.[72] A judge could waive the third party consent requirement if the woman's life was in danger or if the third party could not reasonably be found.[73] Prior to granting her consent, the woman (and her husband or parents, if applicable) had to be provided with certain information: about the fetus (its gestational age; about its development (including its "appearance" and "brain and heart functions")); the procedure (including a variety of health risks, such as the "risks of effect on future pregnancy"); and about supports available "to assist the woman to carry her child to term."[74] The Bill required a forty-eight-hour waiting period between the provision of this information and the performance of the procedure.[75] These requirements did not apply in emergency circumstances where an abortion was needed without delay "to prevent the death of the woman".[76] Finally, the Bill mandated that certain information,

69. *Reference Re Securities Act*, 2011 SCC 66 at para 57 [*Securities Reference* SCC].

70. Even if this aspect of *Morgentaler 1993* is confined to historically criminal matters, this has implications for the recent decriminalization of cannabis and physician-assisted suicide and the creation of provincial regimes to govern the same.

71. See Bill 53, *supra* note 37, cl 3(c).

72. See *ibid*, cl 3(d).

73. See *ibid*, cl 7(1).

74. *Ibid*, cl 4.

75. See *ibid*, cl 6.

76. *Ibid*, cl 8.

such as the woman's age and marital status and the fetus' gestational age at the time of the procedure, be gathered and reported to the Minister of Health for Saskatchewan.[77] The Minister was required to release this data in summary form each year.[78] Physicians and hospitals in breach of the Bill's provisions faced a fine.[79]

Concerns about the Bill's constitutionality at second reading led the government to refer the Bill to the Court of Appeal for Saskatchewan.[80] The Court, in a unanimous decision written by Wakeling J, found the Bill *ultra vires*. In his view, the Bill went beyond merely setting out provincial consent requirements,[81] but, rather, sought to "stiffen and make more restrictive the existing criminal law in relation to abortions".[82] Features of the Bill that led him to this conclusion included: the expansive definitions of "abortion" and "unborn child" not found in the *Criminal Code*; the third party consent requirement, which restricted access to the *Criminal Code* exception; the one-sided nature of the information provided (health risks associated with abortion, but not health risks associated with giving birth); and the emergency section which allowed departure from the Bill's requirements only when a woman's life, and not her health, was at risk.[83] He concluded the Bill represented "an overreach of the legislative powers of the legislature".[84] While Wakeling J's decision emphasized the fact that the provincial bill restricted access to the existing *Criminal Code* regime, the concurrent existence of a federal provision is clearly not essential to the invalidity determination. As the Supreme Court of Canada in the 1993 *Morgentaler* case observed, "[t]he absence of operative federal legislation does not enlarge provincial jurisdiction".[85]

Finally, it is worth noting that Sopinka J in *Morgentaler 1993* cited Wakeling J's decision with approval for the proposition that "provinces may not invade

77. See *ibid*, cl 9(1).

78. See *ibid*, cl 9(2).

79. See *ibid*, cl 10 (failure to comply with the substantive provisions of the legislation would attract a maximum $5,000 fine, while failure to provide to the Minister the information required by the legislation entailed a maximum $2,500 fine).

80. See *Hansard*, *supra* note 38 at 3263.

81. Recall that the *Criminal Code* in 1970 preserved provincial consent requirements. See *Criminal Code* 1970, *supra* note 27, s 251(7).

82. *Bill 53 Reference*, *supra* note 39 at 753.

83. See *ibid* at 752–53.

84. *Ibid* at 754.

85. *Morgentaler* 1993, *supra* note 3 at 499.

the criminal field by attempting to stiffen, supplement or replace the criminal law".[86]

(iii) *Morgentaler v New Brunswick*

In 1985, New Brunswick amended its statute governing medical professionals to provide for the possibility of finding that physicians who performed abortions in private clinics were guilty of professional misconduct and subject to licence suspension.[87] The amendment was introduced in response to Dr. Morgentaler's plan to open a free-standing abortion clinic in the province and was the product of co-operation between the government and the College of Physicians and Surgeons of New Brunswick.[88]

In 1995, Dr. Morgentaler, facing sanctions under the provision, challenged its constitutionality. A majority of the Court of Appeal of New Brunswick found the impugned provision *ultra vires*. In a short decision, Hoyt CJ and Ayles J adopted the reasoning of the trial judge, agreeing with Stevenson J that in pith and substance the amendment was aimed at the suppression of "socially undesirable conduct, namely, the procuring of abortions outside of hospitals".[89] Justice Stevenson had focused on the circumstances in which the amendment was enacted and its discordance with the rest of the Act in coming to this conclusion.[90] The legislation was not, therefore, chiefly concerned with professional regulation or the provision of high-quality medical care.[91] The majority of the Court of Appeal of New Brunswick and the trial judge agreed that the factual and legal matrix before them was largely similar to the Supreme

86. *Ibid* at 498. But see *Chatterjee v Ontario (Attorney General)*, 2009 SCC 19 [*Chatterjee*]. Dennis Baker notes that since *Morgentaler 1993*, lower courts have largely found provincial "quasi-criminal laws" to be valid. See Dennis Baker, "The Temptation of Provincial Criminal Law" (2014) 57:2 Can Pub Ad 275 at 284. The "modern tide" of federalism, both in general and in the realm of criminal-like regulation, favours concurrent and overlapping jurisdiction (*ibid* at 290–91). However, given that *Morgentaler 1993* and the other cases discussed here deal directly with abortion regulation (and not other types of criminal-type regulation), the force of the modern tide alone should not unseat this established and binding precedent.

87. See *Medical Act*, *supra* note 40, ss 56(b.1), 56.1–56.4.

88. See *Morgentaler v New Brunswick (Attorney-General)* (1994), 117 DLR (4th) 753 at 755–62, 152 NBR (2d) 200 (NBQB) [*Morgentaler* 1994].

89. *Morgentaler* 1995, *supra* note 41 at 433.

90. See *Morgentaler* 1994, *supra* note 88 at 766–67.

91. See *ibid* at 768.

Court of Canada's 1993 decision in *Morgentaler* and that case was therefore controlling.[92]

Justice Rice dissented. In his view, the amendment in pith and substance was directed "at preventing the criminal practice of medicine in the province".[93] Just because the legislation dealt with abortion did not put it beyond the constitutional competence of the province. Justice Rice wrote:

> That federal and provincial legislation treat of the same "matter" does not necessarily invalidate the provincial legislation. There is not an attempt to create or establish an

92. See *Morgentaler* 1995, *supra* note 41 at 433. The provision provided: "A member may be found to be guilty of professional misconduct if . . . he has been involved in the performance or attempted performance of an act intended to procure the miscarriage of a female person outside a hospital approved by the Minister of Health". See *Medical Act*, *supra* note 40, s 56(b.1); *Morgentaler* 1995, *supra* note 41 at 435. *Cf Re Ringrose and College of Physicians & Surgeons of Alberta (No 3)* (1978), 91 DLR (3d) 653, 13 AR 147 (Alta SC (AD)) [*Re Ringrose* cited to DLR] (another case dealing with the attaching of professional consequences to the performance of abortion). In that case, the Court of Appeal of Alberta dismissed an administrative law challenge to a decision by the College of Physicians and Surgeons of Alberta finding a medical practitioner guilty of "unbecoming conduct" for performing abortions (*ibid* at 654). The provincial legislation in that case left to the College the power to determine what behaviour constituted conduct unbecoming, a feature that distinguishes it from the case at hand. The legislation in *Re Ringrose* provided:

> 34(1) For the purposes of this Act,
>
> (a) unbecoming conduct, whether in a professional capacity or otherwise, or
>
> (b) the determination as to whether a registered practitioner has displayed a lack of skill or judgment in the practice of medicine or osteopathy or is incapable or unfit to practise medicine or osteopathy,
>
> is a question of fact for the sole and final determination of the investigating committee, the council or the Appellate Division of the Supreme Court of Alberta.
>
> (2) Any matter, conduct or thing that in the judgment of the investigating committee, the council or the Appellate Division of the Supreme Court of Alberta, is such as to be inimical to the best interests of the public or the profession, whether or not such act or conduct is disgraceful or dishonourable, is unbecoming conduct on the part of a registered practitioner.

See *The Medical Profession Act, 1975*, SA 1975 (2nd Sess), c 26, s 34; *Re Ringrose*, *supra* note 92 at 655.

93. *Morgentaler* 1995, *supra* note 41 at 436.

> offence that is criminal in character. It is legislation aimed at preventing the criminal practice of medicine in the Province and the prevention of abortion in free-standing clinics is incidental to the primary purpose of the legislation which is aimed at the practice of medicine by a licensed medical practitioner.[94]

He agreed with the majority that the amendment's purpose was to suppress the creation of private abortion clinics.[95] But, he held, this characterization did not render the provision *ultra vires*:

> There is no exclusivity in the domain of criminal law. That a matter is within the domain of criminal law does not preclude the Provinces from legislating on the same matter provided it is done in the exercise of provincial legislative purposes.
>
> . . .
>
> Criminal law in the circumstances of this case had established that performing abortions outside of a hospital was a crime and expressed Canadians' repulsion at the practice. It would be ludicrous to say that the legislators did not treat that activity as a socially undesirable thing. It had been so declared by Parliament and was the law of the land. However, it is another thing to say that by amending the *Medical Act* as they did, the legislators were creating, establishing, stiffening or supplementing a power exclusively assigned to the domain of criminal law. That proposition, in my view, would render impossible any exercise of provincial powers which affects the practice of abortion.
>
> Here civil consequences (suspension of the right to practise medicine) are attached to the criminal activity prohibited by federal legislation.[96]

According to Rice J, the federal prohibition did not preclude provincial efforts to restrict or limit certain practices in this field, as the province employed

94. *Ibid*.

95. See *ibid* at 438.

96. *Ibid* at 438–39.

civil, rather than criminal, mechanisms. Though Rice J did not employ the language of double aspect, his decision treats abortion as a matter of double aspect with extensive latitude for provincial regulation.

It is worth noting that, in this case and in the Supreme Court of Canada's decision in *Morgentaler 1993*, Hansard statements and background circumstances played a role in finding the law *ultra vires.* But neither factor was cited in the Court of Appeal for Saskatchewan's decision on Bill 53. Rather, in that case, the Court relied on the restrictive nature of the regulations to find the law unconstitutional.

B. Pith and Substance Doctrine and Use of a Law's "Practical Effects"

The above paragraphs, through a review of precedent, set out the substantive limitations on provincial jurisdiction in this area. Using this as a starting point, I now consider the likely outcome were restrictive measures to be enacted by a Canadian province and subsequently challenged under division of powers law. This paper is concerned with the following types of restrictions (the list is drawn from both proposed and enacted legislation in the United States and in Canada):[97]

i. introducing prohibitions based on gestational age;[98]
ii. requiring multiple physician approval (e.g., a second opinion requirement);[99]
iii. introducing a waiting period;[100]

97. The following footnotes are far from exhaustive, but rather intended to provide a few examples of what this legislation looks like and where it can be found. Many restrictions have been subject to constitutional challenge in American courts. While I do highlight some decisions from the Supreme Court of the United States in the footnotes that follow, I do not comprehensively review American jurisprudence in this area nor do I note the current constitutional status of each type of restriction in that country. See also Downie & Nassar, *supra* note 10 (discussing non-legislative barriers to abortion, for example, lack of physician ability or interest).

98. See e.g. 34 S Dak Stat Ann tit 23A §§ 67, 69–70 (2016–17) (abortion permitted in later stages of pregnancy in cases of "medical emergency"); 41 Miss Stat Ann tit 41 § 141 (2014) (exceptions available if woman's health or life endangered or if fetus not viable); 26 Ala Stat Ann tit 22 § 3(b)(1), tit 23B § 5 (2018) (exception where woman at risk of death or permanent and serious injury). Some statutes expressly exclude self-induced harm or suicide risk as a valid ground to access the exception. See 26 Ala Stat Ann tit 22 § 3(b)(1) (1997); 20 Ark Stat Ann tit 16 § 1802(6) (2017); 90 NC Stat Ann tit 21 § 81(5) (2013).

99. See e.g. Johnstone & Macfarlane, *supra* note 10 at 105.

100. See e.g. 41 Miss Stat Ann tit 41 § 33 (1996); 26 Ala Stat Ann tit 23A § 4(a) (2018); Bill 53, *supra* note 37, cl 6. See also *Planned Parenthood of Southeastern Pennsylvania v Governor*

iv. requiring additional consents (e.g., from a spouse; from the woman's parents or guardians[101]);[102]
v. requiring notification to third parties (e.g., to a spouse; to parents or guardians of a minor);[103]
vi. requiring provision of information on health risks;[104]
vii. requiring provision of information on alternatives to abortion (e.g., adoption; child-birthing and child-rearing supports in the community);[105]
viii. requiring provision of information on the fetus' development or its moral or legal status;[106]

(Pennsylvania), 505 US 833 at 2795 (1992) [*Planned Parenthood v Casey*] (upholding a twenty-four-hour waiting period).

101. This factor refers to an abortion-specific age of consent, rather than consent requirements generally applicable to minors undergoing medical procedures.

102. See e.g. Bill 53, *supra* note 37, cl 3(c)–(d) (requiring consent of husband, if married, and parents, if a minor; can be waived in certain circumstances); 41 Miss Stat Ann tit 41 § 53 (2007) (parental consent for minors required; can be waived in certain circumstances). See also *Planned Parenthood of Central Missouri v Missouri (AG)*, 428 US 52 (1976) (where the Supreme Court of the United States found that a spousal consent requirement was unconstitutional and that a parental consent requirement which provided no avenue for judicial waiver was unconstitutional); *Planned Parenthood v Casey*, *supra* note 100 at 2796 (upholding parental consent requirement that allowed judges to waive the requirement in some circumstances).

103. See e.g. 13 Colo Stat Ann tit 22 §§ 704–05 (2018) (requiring notice to parents if minor seeks an abortion, except in certain circumstances, for example, where minor has been abused and abuse reported in accordance with governing legislation). A law requiring notice be given to the woman's husband was found to be unconstitutional in *Planned Parenthood v Casey*. See *supra* note 100 at 2795. A parental notice requirement for dependent minors was upheld by the Supreme Court of the United States in *HL v Governor (Utah)*. See 450 US 398 (1981).

104. See e.g. 34 S Dak Stat Ann tit 23A § 10.1 (2017); 41 Miss Stat Ann tit 41 § 33(1)(a)(ii), (iv) (1996); 26 Ala Stat Ann tit 23A § 4(b)(2) (2018).

105. See e.g. 26 Ala Stat Ann tit 23A § 4(a) (2018); 41 Miss Stat Ann tit 41 §§ 33(1)(a)(iv), 35(1)(a) (1996).

106. See e.g. 26 Ala Stat Ann tit 23A § 4(b)(3) (2018); 41 Miss Stat Ann tit 41 §§ 33, 35(1)(b) (1996) (certain materials must be made available for pregnant women seeking abortions); 34 S Dak Stat Ann tit 23A (requiring that women seeking abortions be informed "[t]hat the abortion will terminate the life of a whole, separate, unique, living human being"; "[t]hat the pregnant woman has an existing relationship with that unborn human being and that the relationship enjoys protection under the United States Constitution and under the laws of South Dakota"; and "[t]hat by having an abortion, her existing relationship and her existing constitutional rights with regards to that relationship will be terminated", §§ 10.1(1)(b)–(d) (2016)). See also Zita Lazzarini, "South Dakota's Abortion Script — Threatening the Physician–

ix. mandating an ultrasound and making image available for that woman to view;[107]
x. limiting the locations where abortions can be performed (e.g., only in hospitals; only in clinics that meet certain specifications, such as those applicable to "ambulatory surgical centers");[108]
xi. restricting public funding for abortions (e.g., complete prohibition on medicare coverage; providing coverage only if procedure performed at a hospital);[109]
xii. mandating reporting by hospitals to the government on information about the patient and the procedure.[110]

Would provincial legislation containing one or more of these initiatives be *intra vires*? I seek to answer this question in the discussion that follows. To do so, I first set out the law on pith and substance and I then consider the medical literature.

A caveat is in order: because this discussion deals with hypothetical measures, rather than an existing statute or bill, exact statutory terms and legislative history are obviously unavailable, and thus a full pith and substance analysis is not possible. As W.R. Lederman has observed,

> [S]ections 91 and 92 of the BNA Act contain categories of laws, not categories of facts.. . .
>
> [I]f we would reason our way to precise and meaningful conclusions about the significance for the future of our distribution of law-making powers in Canada, we must be

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Patient Relationship" (2008) 359:21 New Eng J Med 2189 (criticizing South Dakota's "script" on the basis that it appears "intended to intimidate pregnant women with vaguely described and legal-sounding consequences" at 2191). See *Planned Parenthood v Casey, supra* note 100 at 2824 (upholding requirement that physicians communicate certain mandatory information about fetus and procedure with patients).

107. See e.g. 26 Ala Stat Ann tit 23A §§ 4(b)(4)–(5), 6(b) (2018) (ultrasound mandated; woman may view image); 41 Miss Stat Ann tit 41 § 34(1)(d) (2007) (ultrasound mandated; woman may view image).

108. See e.g. *Health and Safety Code*, 4(B) Tex Stat Ann tit 245 § 245.010(a) (2015). This law was struck down by the Supreme Court of the United States. See *Whole Woman's Health v Texas (Department of State Health Services)*, 579 US ___ (2016) [*Whole Woman's Health*].

109. See the text accompanying note 43.

110. The type of information collected could be wide-ranging. For example, South Dakota's legislation requires collection of several pieces of information, including the gestational age of

> prepared to be specific about the terms of the proposed laws that we hope to have passed in the federal Parliament or the provincial legislatures. On the whole, vague general questions about legislative jurisdiction cannot be answered with any real clarity or precision.[111]

Accordingly, rather than attempting to provide a definitive ruling on the pith and substance of hypothetical abortion regulation, I intend, through a review of validity doctrine and the scientific literature on the effectiveness of certain types of restrictions, to provide an estimation of the sort of issues that would arise if a province enacted these measures and to assist in revealing probable purposes of this type of regulation.

Determining the validity of legislation requires identification of the law's pith and substance—sometimes expressed as its "true meaning",[112] "essential character",[113] or "main thrust"[114]—which is assessed with reference to the law's purpose and effects. A court undertaking this exercise will consider not only the terms of the statute, but also extrinsic material such as legislative debates, government reports, and the "'mischief'" or background circumstances which prompted the law's introduction.[115] A court will also consider the statute's "legal effects" ("how the legislation as a whole affects the rights and liabilities of those subject to its terms . . . determined from the terms of the legislation itself"[116]) and its "practical effects" ("the actual or predicted practical effect of the legislation in operation"[117]). The law's practical effects are useful only insofar as they aid in determining its true purpose: division of powers law does not require a government to achieve its legislative goals. A legislative body acting

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the fetus, the reason for the abortion, the cost of the abortion and how it was paid for, whether the woman has received an abortion in the past, how many children the woman has birthed, and the woman's race, age, education level, and marital status. See 34 S Dak Stat Ann tit 23A §§ 34, 35 (2004, 2016). See also Bill 53, *supra* note 37, cl 9.

111. WR Lederman, "The Balanced Interpretation of the Federal Distribution of Legislative Powers in Canada" in WR Lederman, *Continuing Canadian Constitutional Dilemmas: Essays on the Constitutional History, Public Law and Federal System of Canada* (Toronto: Butterworth & Co (Canada), 1981) 266 at 268–69.

112. *Reference Re Firearms Act (Can)*, 2000 SCC 31 at para 16 [*Firearms Reference*].

113. *Ibid*.

114. *Securities Reference* SCC, *supra* note 69 at para 63.

115. *Firearms Reference*, *supra* note 112 at para 17; *Morgentaler* 1993, *supra* note 3 at 483–84. See *ibid* at 483–85.

116. *Morgentaler* 1993, *supra* note 3 at 482.

117. *Ibid* at 483.

within its jurisdiction is free to enact ineffective or unproductive legislation. But, in some instances, an outcome at odds with a legislature's purported objective suggests that the law's real pith and substance lies elsewhere. The Supreme Court of Canada in *Firearms Reference* explained:

> Within its constitutional sphere, Parliament is the judge of whether a measure is likely to achieve its intended purposes; efficaciousness is not relevant to the Court's division of powers analysis: *Morgentaler*, *supra*, at pp. 487-88, and *Reference re Anti-Inflation Act*, [1976] 2 S.C.R. 373. Rather, the inquiry is directed to how the law sets out to achieve its purpose in order to better understand its "total meaning": W. R. Lederman, *Continuing Canadian Constitutional Dilemmas* (1981), at pp. 239-40. In some cases, the effects of the law may suggest a purpose other than that which is stated in the law: see *Morgentaler*, *supra*, at pp. 482-83; *Attorney-General for Alberta v. Attorney-General for Canada*, [1939] A.C. 117 (P.C.) (*Alberta Bank Taxation Reference*); and *Texada Mines Ltd. v. Attorney-General of British Columbia*, [1960] S.C.R. 713; see generally P. W. Hogg, *Constitutional Law of Canada* (loose-leaf ed.), at pp. 15-14 to 15-16. In other words, a law may say that it intends to do one thing and actually do something else. Where the effects of the law diverge substantially from the stated aim, it is sometimes said to be "colourable".[118]

In *Morgentaler 1993*, the Court observed that "the only relevance of practical effect is to demonstrate an *ultra vires* purpose by revealing a serious impact upon a matter outside the enacting body's legislative authority and thus either contradicting an appearance of *intra vires* or confirming an impression of *ultra vires*".[119] Note that, pursuant to the doctrine of incidental effects, an intrusion into the other government's jurisdiction—even if quite substantial—does not render the law *ultra vires*, provided the intrusion is secondary or incidental to the primary, *intra vires*, purpose of the statute.[120] To summarize, then, while a statute's practical effects may reveal that a government has acted outside its jurisdiction, inefficiency in pursuing an *intra vires* objective or a significant effect on the other level of government's jurisdiction does not by itself render a statute *ultra vires*.

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118. *Firearms Reference*, *supra* note 112 at para 18.

119. *Supra* note 3 at 486–87.

120. See *Canadian Western Bank v Alberta*, 2007 SCC 22 at para 28 [*Canadian Western*].

C. Measures Restricting Access to Abortion and the Medical Literature

Provincial legislative activity on abortion runs the risk of crossing into the realm of criminal law. Suppression of moral evils and socially undesirable conduct falls to the federal government under its power over the criminal law, as does "protection of the state interest in the foetus".[121] Provincial governments are not entirely precluded from enacting laws with a moral cast or gleam, but they must be rooted in a section 92 head of power. In the case of abortion regulation, the most obvious candidates are the provincial health care powers, namely protection of women's health, regulation of hospitals or the medical profession, or provision of safe, cost-effective medical services. This paper also discusses the possibility of enacting abortion regulation through provincial powers over the family, fetal health, or local morality.

Any provincial law regulating or restricting abortion must in pith and substance deal with one of these subjects. An inquiry into the validity of abortion regulation will usually turn on whether the provincial law is truly aimed at one of these objectives. As discussed above, a review of the practical effects of these measures will assist in determining the real purpose of these measures.

(i) Women's Health

Few of the above measures would have the effect of safeguarding women's physical health. For example, a woman's physical health is not improved by requiring her spouse or parents' consent to a medical procedure she seeks. Notifying third parties—her spouse or her parents—about that procedure does not promote her physical health. A mandated delay, in the form of a waiting period, does not improve a woman's health, and, in fact, could increase health risks.[122] Even a one-week delay in obtaining an abortion increases risks

121. *Morgentaler* 1993, *supra* note 3 at 493. See *ibid* at 488–89; *Margarine Reference*, *supra* note 34 at 50.

122. Risk to women's health is increased when undergoing abortion procedure in later stages of pregnancy compared to earlier stages of pregnancy. See E Steve Lichtenberg & Maureen Paul with administrative assistance of Laura Dodge, "Surgical Abortion Prior to 7 Weeks of Gestation", Clinical Guidelines, (2013) 88:1 Contraception 7 at 7; Elizabeth G Raymond et al, "First-Trimester Medical Abortion with Mifepristone 200 mg and Misoprostol: A Systematic Review" (2013) 87:1 Contraception 26 at 28; S Wadhera, "Early Complication Risks of Legal Abortions, Canada, 1975-1980" (1982) 73:6 Can J Public Health 396 at 396; Surinder Wadhera & Wayne J Millar, "Second Trimester Abortions: Trends and Medical Complications" (1994) 6:4 Health Reports 441; Linda A Bartlett et al, "Risk Factors for Legal Induced Abortion-Related Mortality in the United States" (2004) 103:4 Obstetrics & Gynecology 729 at 731;

to a woman's health.[123] Similarly, requiring multiple physician consents could have the effect of delaying the procedure, again increasing risk to the woman's health. The fact that these sorts of requirements are not in place for other medical procedures suggests that they are not directed at physical well-being generally. If they led to improved health outcomes across the board, presumably they would be commonly required for other medical procedures.

Additionally, prohibitions on private abortion clinics do not serve women's health, as private clinics are as safe as hospitals.[124] Requiring that abortion clinics meet specifications applicable to ambulatory surgical centres does not produce better health outcomes.[125]

Insofar as these laws require provision of information that is irrelevant to the woman's health—for example, information about the possibility of adoption or information about the fetus' growth or development—they cannot be said to improve the woman's health. Information about the medical risks associated with the procedure clearly impacts women's health. However, it is worth noting that informed consent laws already require physicians to provide patients with information about health risks. An abortion-specific law requiring provision of health risks does not clearly further any health goal not already accomplished by other legislation or existing common law. While a legislature need not act efficiently, duplication in the abortion context may suggest a concern with something other than women's health. It may be indicative of an intention to make the consent process more onerous and to permit the provision of questionable material,[126] with the ultimate goal of deterring abortion. In other words, one may expect to find this sort of requirement in colourable legislation. Reaching this conclusion however, in the absence of additional extrinsic evidence, may involve a deeper reading into a legislature's motives than a court is willing to make in light of the principle of sovereignty within a government's constitutional competence.

Bonnie Scott Jones & Tracy A Weitz, "Legal Barriers to Second-Trimester Abortion Provision and Public Health Consequences" (2009) 99:4 American J Public Health 623 at 623.

123. See Bartlett, *supra* note 122. The delay may be caused by the waiting period itself, or it may be caused by logistical obstacles, like the need to take time off work or travel to an urban centre on multiple occasions (*ibid* at 735).

124. See David A Grimes, Willard Cates Jr & Carl W Tyler Jr, "Comparative Risk of Death from Legally Induced Abortion in Hospitals and Nonhospital Facilities" (1978) 51:3 Obstetrics & Gynecology 323 at 326; David A Grimes, Willard Cates Jr & Richard M Selik, "Abortion Facilities and the Risk of Death" (1981) 13:1 Family Planning Perspectives 30 at 30–31.

125. See Jones & Weitz, *supra* note 122 at 627; *Whole Woman's Health*, *supra* note 108 at 30.

126. See Cynthia R Daniels et al, "Informed or Misinformed Consent? Abortion Policy in the United States" (2016) 41:2 J Health Pol Pol'y & L 181 (this study found that 30% of the information provided to pregnant women under these laws was "medically inaccurate" at 194).

Mandating data gathering and reporting could lead to improved health outcomes, as this data could be put to a variety of health-related uses. Similarly, gestational limits on abortion lead to improved health outcomes as there is an increase in risk to women undergoing abortion in the later stages of pregnancy.[127] Thus, these few measures (provision of health risks, gestational limits, and data reporting) promote and protect women's health. But the other measures either do not bear on physical health or negatively affect women's health. Nor could one argue that discouraging abortion generally promotes women's health, as abortion is a very safe medical procedure and in fact is safer than childbirth.[128]

Similarly, these measures generally have no positive impact on women's mental health.[129] Take for example the waiting period requirement, a measure that is often assumed to advance women's mental health, on the theory that it gives women an opportunity to change their mind, reducing incidences of

127. See Lichtenberg & Paul, *supra* note 122. See also Raymond, *supra* note 122; Wadhera & Millar, *supra* note 122 at 7; Barlett, *supra* note 122; Jones & Weitz, *supra* note 122.

128. See Sam Rowlands, "Misinformation on Abortion" (2011) 16:4 European J Contraception & Reproductive Health Care 233 at 235; Elizabeth G Raymond & David A Grimes, "The Comparative Safety of Legal Induced Abortion and Childbirth in the United States" (2012) 119:2 Obstetrics & Gynecology 215 at 216; Maarit Niinimäki et al, "Immediate Complications After Medical Compared With Surgical Termination of Pregnancy" (2009) 114:4 Obstetrics & Gynecology 795 at 803. There is widespread scientific consensus that abortion does not cause breast cancer or later infertility. See e.g. Rowlands, *supra* note 128 at 235–37; Karin B Michels & Walter C Willett, "Does Induced or Spontaneous Abortion Affect the Risk of Breast Cancer?" (1996) 7:5 Epidemiology 521 at 525, 527; Matti A Rookus & Flora E van Leeuwen, "Induced Abortion and Risk for Breast Cancer: Reporting (Recall) Bias in a Dutch Case-Control Study" (1996) 88:23 J National Cancer Institute 1759 at 1762; Yongchun Deng, Hua Xu & XiaoHua Zeng, "Induced Abortion and Breast Cancer: An Updated Meta-Analysis" (2018) 97:3 Medicine: Baltimore e9613; World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems*, 2nd ed (Geneva: WHO Press, 2012) at 49; "Abortion, Miscarriage, and Breast Cancer Risk: 2003 Workshop" (12 January 2010), online: *National Cancer Institute* <www.cancer.gov/types/breast/abortion-miscarriage-risk>; Alison Lowit, Sohinee Bhattacharya & Siladitya Bhattacharya, "Obstetric Performance Following an Induced Abortion" (2010) 24:5 Best Practice & Research: Clinical Obstetrics & Gynaecology 667 at 669 (reviewing other studies to conclude that abortion does not cause infertility, but observing that the picture is not clear with respect to the association between abortion and later miscarriage or ectopic pregnancies); Caitlin Gerdts et al, "Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy" (2016) 26:1 Women's Health Issues 55 at 59.

129. While this paper presumes a neat division between mental and physical health, one could challenge this: a negative impact on a woman's physical health could negatively impact her mental health.

regret, guilt, and other mental health problems. Researchers studying Arizona's twenty-four-hour wait period concluded in 2016 that the majority of women believed a waiting period would impose additional hardship on them without any corresponding emotional or psychological benefit.[130] A 2017 study of 309 women found that, for 74% of the participants, a seventy-two-hour waiting period did not impact their certainty about receiving an abortion.[131] The majority of the remaining quarter of participants became "more certain" about their decision, rather than less certain.[132] Because waiting periods have little impact on women's decision making and increase stress and anxiety, it would seem that this measure does not bring about positive mental health outcomes.

Nor is it clear that restriction or prohibition of the procedure generally would bring about mental health benefits. The evidence regarding the impact of abortion on women's mental health is mixed. Some studies have found a correlation between abortion and mental health problems, such as depression, suicide, and drug use.[133] However, many of these studies have been criticized for poor methodology. One problem, in particular, has been identification of the appropriate control group (better quality studies draw comparison between women with unwanted pregnancies who receive requested abortions and women with unwanted pregnancies who desire but are denied access to abortion (rather than, for example, women with wanted pregnancies who give birth or who

130. See Deborah Karasek, Sarah CM Roberts & Tracy A Weitz, "Abortion Patients' Experience and Perceptions of Waiting Periods: Survey Evidence Before Arizona's Two-Visit 24-Hour Mandatory Waiting Period Law" (2016) 26:1 Women's Health Issues 60 (379 women participated in the survey: only 10% of those surveyed indicated "that they would not experience any of the negative effects" from the waiting period (such as being required to take additional time off work); 8% indicated that the waiting period would have a positive impact on "their emotional and psychological well-being"; while 53% stated that the law would negatively impact their well-being at 62–63).

131. See Sarah CM Roberts et al, "Do 72-Hour Waiting Periods and Two-Visit Requirements for Abortion Affect Women's Certainty? A Prospective Cohort Study" (2017) 27:4 Women's Health Issues 400 at 403.

132. *Ibid*.

133. See e.g. Priscilla K Coleman, "Abortion and Mental Health: Quantitative Synthesis and Analysis of Research Published 1995–2009" (2011) 199:3 British J Psychiatry 180 at 185; Carlo V Bellieni & Giuseppe Buonocore, "Abortion and Subsequent Mental Health: Review of the Literature" (2013) 67:5 Psychiatry & Clinical Neurosciences 301 at 307; David M Fergusson, L John Horwood & Joseph M Boden, "Abortion and Mental Health Disorders: Evidence from a 30-Year Longitudinal Study" (2008) 193:6 British J Psychiatry 444 at 447; Priscilla K Coleman et al, "A History of Induced Abortion in Relation to Substance Use During Subsequent Pregnancies Carried to Term" (2002) 187:6 American J Obstetrics & Gynecology 1673.

suffer miscarriages; or women who have never been pregnant)).[134] Another issue has been failure to control for pre-existing mental health issues.[135] Once these methodological problems are addressed, the medical literature indicates that women with unwanted pregnancies who seek and are granted abortions do not have worse mental health outcomes than women with unwanted pregnancies who are denied access to the procedure.[136] Thus it seems that prohibiting abortion or introducing regulations designed to deter women from accessing it would not generally led to improved mental health outcomes.

(ii) Hospital Regulation, Professional Regulation, and the Health Care System

The above-identified measures generally do not entail hospital or professional regulation, as they single out abortion rather than dealing generally with the obligations and responsibilities of medical professionals or hospitals. They focus

134. See the text accompanying note 136.

135. See e.g. Julia R Steinberg, "Later Abortions and Mental Health: Psychological Experiences of Women Having Later Abortions—A Critical Review of Research" (2011) 21:3S Women's Health Issues S44 at S46.

136. See Vignetta E Charles et al, "Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence" (2008) 78:6 Contraception 436 at 448–49; Sara Levine Kornfield & Pamela A Geller, "Mental Health Outcomes of Abortion and its Alternatives: Implications for Future Policy" (2010) 20:2 Women's Health Issues 92 at 93; Gail Erlick Robinson et al, "Is There an 'Abortion Trauma Syndrome'? Critiquing the Evidence" (2009) 17:4 Harvard Rev Psychiatry 268 at 276; Steinberg, *supra* note 135 at S46; Sharon Cameron, "Induced Abortion and Psychological Sequelae" (2010) 24:5 Best Practice & Research: Clinical Obstetrics & Gynaecology 657 at 661; Brenda Major et al, "Abortion and Mental Health: Evaluating the Evidence" (2009) 64:9 American Psychologist 863 at 878; M Antonia Biggs et al, "Women's Mental Health and Well-Being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study" (2017) 74:2 JAMA Psychiatry 169 at 170; Sarah CM Roberts, Corinne H Rocca & Diana Greene Foster, "Receiving Versus Being Denied an Abortion and Subsequent Drug Use" (2014) 134 Drug Alcohol & Dependence 63. See also Corinne H Rocca et al, "Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study" (2015) 10:7 PLoS ONE e0128832; Brenda Major et al, "Report of the APA Task Force on Mental Health and Abortion: Executive Summary" (2008), online (pdf): *American Psychological Association* <www.apa.org/pi/women/programs/abortion/executive-summary.pdf>. "The best scientific evidence published indicates that among adult women who have an *unplanned pregnancy* the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion than if they deliver that pregnancy. The evidence regarding the relative mental health risks associated with multiple abortions is more equivocal" (*ibid* at 1 [emphasis in original]).

on the procedure, rather than on the medical professional providing it or the facility in which the procedure occurs. This feature distinguishes abortion-specific regulation from more general health care legislation.

Nor would most of these measures impact the quality, cost, or integrity of the health care system. Third party consents or notifications, provision of information, waiting periods, and similar measures have no real bearing on these objectives. Restricting the procedure to hospitals would not produce any financial benefit to the health care system, as private abortion clinics appear to be generally less costly than hospital-only approaches.[137]

In contrast, prohibition or restriction of public funding would have the effect of reducing health care costs to the state.[138] It is within provincial jurisdiction to determine the scope of coverage of provincial health care plans.[139] Mandatory data gathering and reporting could also positively impact the quality, cost and integrity of the health care system. For example, such data could be used to identify and remedy system inefficiencies or health risks. However, contrary to the position taken here, a mandatory data gathering and reporting requirement was found to be *ultra vires* in the Court of Appeal for Saskatchewan's decision on Bill 53.[140] The Court did not discuss that provision in isolation from the rest of the Bill, so it is not clear whether its reasoning would apply to a stand-alone data reporting requirement. But it is clear that statutory context matters when assessing a law's pith and substance: surrounding provisions may reveal the true, invalid purpose of a provision that in some other statutory context might not have been problematic.

(iii) Other Bases for Jurisdiction

Health is often cited as the basis for provincial jurisdiction over abortion, but the above review has demonstrated that the health power does not grant free rein to the provinces to act in this area. This section of the paper discusses other plausible bases of jurisdiction, besides the health power. Because authoritative

137. See Stanley K Henshaw, "Freestanding Abortion Clinics: Services, Structure, Fees" (1982) 14:5 Family Planning Perspectives 248 at 255 (an American study finding that private clinics have lower fees than hospitals); *Morgentaler* 1993, *supra* note 3 at 508.

138. Note that, while this policy may not result in overall savings to the state (a decrease in abortions and a corresponding increase in births can have other costs to the state such as the costs of prenatal care, health care, and education for children), a government need not act efficiently.

139. See *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 624 at para 24, 151 DLR (4th) 577.

140. See *Bill 53 Reference*, *supra* note 39 at 754.

precedent is lacking, the discussion on some of these powers is quite speculative and general.

Perhaps jurisdiction to enact abortion-specific regulation could be found in the provincial power to make laws in relation to the family and the domestic sphere. Section 92(13), which empowers provinces to make laws respecting "Property and Civil Rights", and section 92(16), which grants the provinces jurisdiction over local matters, includes the power to legislate on family relations and family status.[141] While the scope of this power is uncertain[142] and no cases or Canadian academic commentary deal with it at length,[143] it is possible that some of the above-discussed measures could be enacted pursuant to this power. In particular, requiring notice to or consent from spouses or parents may be aimed at the protection of family harmony or the promotion of family decision making. However, it should be noted that, in practice, such legislation may not in fact achieve family harmony or promote family cohesiveness.[144] Consider, for example, a legislative requirement that a woman disclose her pregnancy and desire to get an abortion to an abusive spouse or, if the pregnancy was the result of rape, to her rapist; or a law that requires a minor to obtain the consent of an abusive parent.[145] This mismatch between purported purpose and actual outcome may reveal that a legislature's true purpose is suppression of abortion, rather than the stated objectives of promoting family harmony or some similar variation. Additionally, other measures, such as waiting periods or prohibitions on private clinics, do not clearly relate to the family unit, and so, even if "family" provides a legitimate route to some abortion regulation, it does not grant the province unlimited authority.

Another possible route for provincial regulation is section 92(16), which grants the provinces authority over "all Matters of a merely local or private Nature in the Province".[146] While this is one of the bases of the provincial health

141. *Constitution Act, 1867*, *supra* note 1, ss 92(13). See *ibid*, s 92(16); Hogg, *supra* note 2, ch 21 at 3, ch 27 at 1.

142. An anonymous peer reviewer observed that this power may not be recognized at all by courts, given its expansive and fuzzy nature, or, in other words, because it is "totally lacking in specificity". See *Reference Re Anti-Inflation Act (Canada)*, [1976] 2 SCR 373 at 458, 68 DLR (3d) 452, Beetz J, dissenting [*Re Anti-Inflation Act*]. See also *R v Crown Zellerbach Canada Ltd*, [1988] 1 SCR 401 at 456–59, 49 DLR (4th) 161, La Forest J, dissenting.

143. For a view on the American context, see Courtney G Joslin, "Federalism and Family Status" (2015) 90:2 Ind LJ 787 (discussing federal and state jurisdiction over the family).

144. Thanks to an anonymous peer reviewer for these observations.

145. Narrow crafting of the legislation in issue may temper some of these concerns. For example, Colorado's legislative requirement that parents be informed when minors seek abortions provides an exception to this requirement if the minor is a "victim of child abuse or neglect". See 13 Colo Stat Ann tit 22 §§ 704–05 (2018).

146. *Constitution Act, 1867*, *supra* note 1, s 92(16).

power, it is also the source of a local morality power, which could conceivably ground abortion restriction: it is this use of the power that is of interest here. The exact scope of section 92(16) has not been definitively set out, but clearly it (paired with section 92(13)) empowers provinces to act preventively to deter criminal activity.[147] Chief Justice Dickson in *Schneider v R*[148] (a case upholding the validity of a provincial law providing for the mandatory detention and treatment of drug addicts) described the power as follows: "[i]t is true that one of the objects of the Act is the suppression of 'local evil'—local conditions giving rise to crime—but this is a matter of merely local nature in the Province and within s. 92(16) of the *B.N.A. Act*."[149] As far as section 92(16) providing a free-standing power to legislate on local morality, Ritchie J suggested as much in *Nova Scotia (Board of Censors) v McNeil*,[150] a case involving a challenge to a provincial film censorship regime. He wrote:

> In a country as vast and diverse as Canada, where tastes and standards may vary from one area to another, the determination of what is and what is not acceptable for public exhibition on moral grounds may be viewed as a matter of a "local and private nature in the Province" within the meaning of s. 92(16) of the *B.N.A. Act*, and as it is not a matter coming within any of the classes of subject enumerated in s. 91, this is a field in which the Legislature is free to act.[151]

Such a broad reading of section 92(16) would enable a province to pass laws tailored to reflect local morals, and a province could attempt to support abortion regulation on this basis. This argument requires the province to lean into the moral purpose of an abortion-restricting law (somewhat counterintuitively, given the Supreme Court of Canada's *Morgentaler 1993* decision), by arguing that it is using its power under section 92(16) to enact a statute that protects

147. See *Montréal (City of) v Arcade Amusements Inc*, [1985] 1 SCR 368 at 420–21, 18 DLR (4th) 161; *Chatterjee*, *supra* note 86 at paras 25, 28.

148. [1982] 2 SCR 112, 139 DLR (3d) 417 [cited to SCR].

149. *Ibid* at 132. Somewhat oddly, this use of section 92(16) seems tied to criminal law. Does it still empower a province to act if there is no underlying crime (in this case, no federal prohibition of abortion) to be prevented? It would be odd if the absence of federal law could contract provincial jurisdiction, as "[t]he absence of operative federal legislation does not enlarge provincial jurisdiction". See *Morgentaler* 1993, *supra* note 3 at 499.

150. [1978] 2 SCR 662, 84 DLR (3d) 1 [cited to SCR].

151. *Ibid* at 699. But see George H Rust-D'Eye, "Morality and Municipal Licensing: The Untouched Constitutional Issues in *City of Prince George v Payne*", Case Comment, (1978) 16:3 Osgoode Hall LJ 761 at 765 (arguing in support of a broad provincial morality power).

the local or provincial interest in the fetus and reflects the local appreciation of the fetus' moral status. However, this argument is unlikely to be successful. First, this expansive understanding of section 92(16) has not been subsequently developed by the Supreme Court of Canada. The Court struck down a municipal bylaw targeting prostitution as an invalid exercise of the criminal law power a few years later in *Westendorp*,[152] and Estey J expressed further doubt about Ritchie J's comments in *Rio Hotel*.[153] Given this more recent precedent, it seems unlikely a court will take section 92(16) in this direction.[154] Second, *Morgentaler 1993* poses an obstacle. If the provinces had a free-standing power to suppress abortion on morality grounds, surely it would have been used in that case to uphold the provincial legislation.[155] However, perhaps one can distinguish *Morgentaler 1993* on the basis of the form of the legislation: if this hypothetical provincial legislation took a non-prohibitory form, a court may be more inclined to see it as something other than the exercise of the federal criminal power.

The final possibility is that of fetal health, which, being more speculative, is discussed here, rather than in the section on health above. Could a provincial government restrict abortion on the basis that it is harmful to the health of the fetus, arguing it is acting on the basis of a legitimate health interest, rather than a moral interest, in its future citizens? The first objection to this line of reasoning may be that fetuses lack legal personhood.[156] However, this should not preclude the province from exercising its health jurisdiction. A comparison might be drawn to a provincial fetal screening program implemented to detect genetic anomalies in unborn children and ensure the provision of proper health care upon birth. It stands to reason that the provinces would have jurisdiction to enact such a scheme on the basis of health. Why not then a prohibition on abortion? The answer to this question may lie in the double aspect doctrine. There is a health dimension or aspect to abortion prohibition, but this aspect is overwhelmed by the criminal aspect of the measure. A province that makes a claim about the health status of a fetus is simultaneously making a claim about the moral status of the fetus, namely, that it is a being entitled to protection whose health trumps the interests of the woman carrying it. The moral status of the fetus is so bound up in any effort to protect its health that the health aspect is subsumed by that larger consideration.

152. See *Westendorp v R*, [1983] 1 SCR 43, 144 DLR (3d) 259.

153. See *Rio Hotel Ltd v New Brunswick (Liquor Licensing Board)*, [1987] 2 SCR 59 at 75–76, 44 DLR (4th) 663.

154. But see *Chatterjee*, *supra* note 86 at paras 25, 28; Baker, *supra* note 86 at 278.

155. Thanks to an anonymous peer reviewer for this observation.

156. See *Tremblay v Daigle*, [1989] 2 SCR 530 at 570, 62 DLR (4th) 634.

D. Division of Powers and the Establishment of Medical Facts

I want to consider a final matter, which concerns the proper role of the judiciary in a federal state. As the above review of the scientific literature establishes, on some subjects, the scientific evidence is mixed or unclear. On other topics, inconsistent studies exist, but scientific consensus has emerged. The question arises: to what extent must a provincial government accept medical evidence when legislating? Can it legislate on the basis of bad science (e.g., poor-quality research; minority scientific viewpoints) or from belief in a factual state that is not grounded in evidence at all? I am envisioning in this scenario a government that acts in good faith (rather than a government that is trying to extend its jurisdiction, knowing it has no legitimate basis to do so and thus hides its true purpose (e.g., is acting colourably)).[157] For example, could a provincial legislature rely on the few dated and poorly designed studies that found a correlation between breast cancer and abortion, despite the now existing widespread consensus in scientific and medical communities that abortion does not increase a woman's risk of developing breast cancer?[158] Could it point to those dated studies to contend it is pursuing a legitimate health objective by suppressing and deterring abortion? In particular, I am imagining a scenario in which a government makes use of a legislative factual claim. For example, it enacts a statute which provides that, for the purposes of that statute, a court is to find as a fact that abortion causes breast cancer. Another way of asking this question is to ask whether the fact that a provincial government acts on a good faith belief about the existence or arrangement of certain background facts is sufficient to imbue it with jurisdiction in division of powers law. I give my tentative answer to this question below.

Under the parliamentary supremacy model, courts would not be empowered to probe such legislative factual claims. Albert Venn Dicey describes parliamentary supremacy as empowering Parliament with "the right to make or unmake any law whatever; and, further, that no person or body is recognised

157. Clearly, one mechanism available to prevent reliance on bad science is the principle of colourability. As the reasoning goes, the endorsement of debunked studies indicates that a provincial government is acting nefariously, reaching into matters outside its jurisdiction while attempting to cloak its actions in legitimacy. Additionally, the ballot box is another constraint on provincial reliance on bad science. The public can vote against a government that legislates in way that ignores reality. However, this part of the paper investigates whether courts also have a supervisory role in evaluating a government's factual claims.

158. See Rowlands, *supra* note 128 at 236; Michels & Willett, *supra* note 128 at 525; Rookus & van Leeuwen, *supra* note 128 at 1762; Deng, Xu & Zeng, *supra* note 128 at 7; World Health Organization, *supra* note 128 at 49; National Cancer Institute, *supra* note 128.

by the law . . . as having a right to override or set aside the legislation of Parliament".[159] However, Canada is a system of constitutional supremacy; the existence of a constitutionalized division of powers changes matters. In a constitutionalized federation, courts are empowered to police jurisdiction and preserve the constitutional division of powers.[160] In the Canadian federation, the federal and provincial governments "are coordinate and not subordinate one to the other" and each is supreme within its sphere.[161] Because this arrangement is constitutionalized, the players are not permitted to unilaterally expand their jurisdiction through good faith assertion. Such a result would threaten the sovereignty of the other government and undermine the federal arrangement itself.

However, recognizing that courts can evaluate the factual claims that underpin jurisdictional claims does not indicate the degree of judicial scrutiny to which factual claims are properly put. The Supreme Court of Canada has not addressed this question head-on. However, I attempt in the following paragraphs to provide an answer. One factor that must be considered is the presumption of constitutionality—that judges are to interpret laws from the starting point that the enacting body has complied with its constitutional obligations.[162] This certainly means that the burden of establishing that the factual matrix was other than what was claimed would be on the challenging party, rather than the enacting government.

One might say that factual claims are a part of jurisdictional claims, and thus the investigation into the factual matrix is an investigation into validity generally. In other words, no special considerations accompany judicial scrutiny of factual claims. A challenging party can prove the law's invalidity on a balance of probabilities by tackling either the jurisdictional assertion (e.g., the province does not have jurisdiction to act in this manner to suppress incidence of breast cancer) or the underlying factual assertion (e.g., abortion does not cause breast cancer).

However, one could argue that factual claims deserve some deference, given lingering fidelity to parliamentary supremacy. Governments are able to act on the facts they find most compelling; they and the voters have extensive freedom to choose the factual reality they live in, particularly given that social science and medical evidence can be complex and messy. Under this version, a court will hesitate to intervene on factual claims if there is some rational basis for that

159. Hon AV Dicey, *Introduction to the Study of the Law of the Constitution*, 10th ed (London, UK: Macmillan & Co, 1961) at 40.

160. See *ibid* ("[f]ederalism . . . means legalism—the predominance of the judiciary in the constitution" at 175).

161. *Securities Reference* SCC, *supra* note 69 at paras 7, 71.

162. See Sullivan, *supra* note 67 at 458–61.

factual claim. Note that a rational basis standard does not lightly invite review, but it does require that an evidential foundation be in place, and, further, that the evidence relied on to establish the facts in issue must be somewhat credible.[163] The mere fact that the evidence is in conflict or is inconsistent does not mean that the government lacks a rational basis for its factual assertion,[164] but, in my view, reliance on studies or premises that are widely accepted in relevant scientific or medical communities to be debunked or disproven would not pass this threshold.

As noted above, the Supreme Court of Canada has not addressed this issue directly. However, some hints from its jurisprudence suggest it would endorse the latter approach were it to consider this issue head-on. The Court's reasoning in *Securities Reference, Reference Re Assisted Human Reproduction Act* (*Re AHRA*), and *Re Anti-Inflation Act* support the view that judges will probe factual claims, but with a deferential standard of scrutiny. First, in *Securities Reference*[165] (which

163. Note that this rational basis standard should not be confused with instrumental rationality found in sections 1 and 7 of the *Charter*. The latter requires demonstration that the chosen measure is logically designed to achieve its identified purpose, whereas the former requires that the facts alleged to provide a basis for jurisdiction are supported by some evidence.

164. Hogg describes the "rational basis test":

> The rational basis test . . . erects a presumption of constitutionality that is exceedingly difficult for the challenger of legislation to overcome. The rational basis test enables a court to uphold the validity of legislation without the necessity for strict proof of the underlying facts. It enables a court to resolve conflicting evidence without the need to make a definitive ruling on the conflict. Therefore, the rational basis test could be regarded as a justification for the reception of unsworn factual material.

See Hogg, *supra* note 2, ch 60 at 19.

165. In the Court of Appeal of Quebec and in the Court of Appeal of Alberta in *Securities Reference*, the federal government argued that "a presumption of constitutionality applies . . . and that meeting the standard of proof consists in establishing a rational basis for the impugned statutory power, rather than rigorously proving all the facts alleged". See *Québec (Procureure générale) c Canada (Procureure générale)*, 2011 QCCA 591 at para 31 [unofficial English translation] [*Securities Reference* QCCA]; *Reference Re Securities Act (Canada)*, 2011 ABCA 77 at para 16 [*Securities Reference* ABCA]. Both courts rejected this argument. According to the Court of Appeal of Quebec, the "rational basis" test and an accompanying presumption of validity are not available in the context of the trade and commerce power which "call[s] for an assessment of complex factual evidence, not policy choices". See *Securities Reference* QCCA, *supra* note 165 at para 53. Rather, proof of underlying facts on a balance of probabilities was required. See *ibid*. The Court of Appeal of Alberta found the "rational basis" standard

dealt with the federal trade and commerce power), the Supreme Court of Canada refused to accept Parliament's argument that the "factual matrix" had changed so significantly as to pave the way for federal jurisdiction in an area historically subject to provincial oversight.[166] The Court observed that "[t]his argument requires not mere conjecture, but evidentiary support. The legislative facts adduced by Canada in this reference do not establish the asserted transformation."[167] This statement suggests that mere assertion of facts is not sufficient to ground jurisdiction. Some evidence is needed, though the Court does not say to what standard those facts must be proven.

Secondly, in *Re AHRA*, the Court split in a 4-4-1 decision over the scope of Parliament's criminal law jurisdiction. The division turned largely on disagreement over to what standard risks and harms had to be present before the criminal power was triggered. However, importantly, no justice suggested that it was sufficient for Parliament to merely assert, divorced of any evidential foundation, that it found as a fact health or moral harms flowed from certain activity. Chief Justice McLachlin, in her discussion of moral harms, held that Parliament did not need "hard evidence" but rather a "reasonable basis to expect that its legislation will address a moral concern of fundamental importance".[168] In her discussion of health, she referred to a "reasonable apprehension of harm".[169] Justices LeBel and Deschamps employed the language of "concrete basis" to establish health and moral risks.[170]

Thirdly, the Supreme Court of Canada's reasoning in *Re Anti-Inflation Act* provides support for a rational basis standard. In that case, Laskin CJ held that the federal government, in relying on its emergency power to enact measures to counter a period of rapid and high inflation, need not prove that there was in fact an emergency to which it was responding.[171] Rather, all that was required was for Parliament to have a "rational basis for regarding the *Anti-Inflation Act* as a measure which, in its judgment, was temporarily necessary to meet a situation of economic crisis imperilling the well-being of the people of Canada as a whole and requiring Parliament's stern intervention in the interests of the country as a whole".[172] Peter Hogg in his seminal text has applied the "rational

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inapplicable, because the identification of the law's pith and substance was a question of law, not an evidential one. See *Securities Reference* ABCA, *supra* note 165 at para 16. The Supreme Court of Canada did not address the issue in the same level of detail as the lower courts.

166. *Securities Reference* SCC, *supra* note 69 at paras 115–16.

167. *Ibid* at para 116.

168. *Re AHRA*, *supra* note 34 at para 50.

169. *Ibid* at para 56.

170. *Ibid* at para 238.

171. See *Re Anti-Inflation Act*, *supra* note 142 at 426–27.

172. *Ibid* at 425.

basis" standard articulated in *Re Anti-Inflation Act* to all exercises of jurisdiction, writing that "the proponent of legislation need show no more than a rational basis for legislative facts that are prerequisite to the validity of the legislation".[173] He expresses it this way in another part of his text: "[W]here the validity of a law requires a finding of fact (for example, the existence of an emergency), that finding of fact need not be proved strictly by the government; it is enough that there be a 'rational basis' for the finding".[174] While *Re Anti-Inflation Act* thus suggests a rational basis standard for proof of underlying facts, I do note that it dealt with the emergency power, which is exceptional, and perhaps distinguishable on this basis (that is to say, the rational basis standard may not apply to the other heads of power).

I have suggested in the above paragraphs that courts can evaluate factual claims—including factual claims found in legislation—made in the course of jurisdictional claims, and that these will be subject either to usual division of powers analysis or scrutiny on a rational basis standard. This is significant, because it means that the medical literature tells us more about abortion restrictions than just the likelihood of finding colourability or the likely practical effects of such legislation. It also tells us that a provincial government cannot legislate in certain ways because the underlying factual matrix is absent. A review of the medical literature reveals consensus on the safety of abortion and the lack of health benefits associated with many restrictive measures. A province putting forward regulation on the basis of poorly established or non-existent medical facts lacks the evidential foundation necessary to substantiate jurisdiction.

Conclusion

The above discussion details the federalism limits on provincial authority to enact restrictions on abortion. While many (including myself, in other commentary) have correctly observed that provincial abortion legislation must be directed at legitimate health objectives, this statement fails to assess what that means for provincial capacity in concrete terms. A review of the medical literature suggests that very few abortion restrictions promote women's health or increase the quality or efficiency of the health care system. This misalignment between effect and objective may suggest colourability, revealing a legislature actually concerned with the suppression of a moral evil, rather than the stated advancement of women's health. Furthermore, I have argued that, even in the absence of colourability, provinces have a limited competence

173. Hogg, *supra* note 2, ch 60 at 18.

174. *Ibid*, ch 15 at 23.

to act in this field. First, the validity doctrine requires ascertainment of the practical effects of the legislation to shed light on its pith and substance: the medical literature reveals the absence of beneficial health impact associated with many of these restrictions, suggesting their true purpose lies elsewhere. Second, the Supreme Court of Canada's decision in *Morgentaler 1993* indicates that provincial restrictions in a field historically subject to federal criminal prohibition will garner immediate judicial suspicion. Finally, because courts are engaged in evaluating factual claims in their roles as arbitrators of Canada's constitutionalized federal arrangement, a court can intervene even if a provincial legislature acts in good faith on the basis of bad medical science. All of these factors pose barriers to provincial restriction of abortion.

It is important to emphasize that the provinces clearly have some room to legislate in this field through their health power and possibly through one of the more speculative bases suggested above. However, the sorts of abortion-specific restrictions a province could enact would seem to be rather limited. Provinces must navigate a complex and nuanced legal landscape as they butt up against federal criminal law in this area.

Admittedly, the picture I have sketched here is at odds with the "'dominant tide' of modern federalism" and the Court's recognition and promotion of concurrent and overlapping jurisdiction.[175] The constitutional framework governing jurisdiction over abortion—as I have understood it in this paper—appears to be one of fairly watertight compartments, which is in tension with the common view that health and abortion are matters of double aspect. My answer to that oddity is this: abortion is subject to double aspect, but that does not empower any jurisdiction to enact any laws on it. As Binnie and LeBel JJ explained in *Canadian Western Bank*, "[t]he double aspect doctrine recognizes that both Parliament and the provincial legislatures can adopt valid legislation on a single subject depending on the perspective from which the legislation is considered, that is, depending on the various 'aspects' of the 'matter' in question."[176] Each level of government must still deal with the subject according to its jurisdictional capacity.

Some academic articles on this topic view provincial regulation as rights-eroding and federalism as a barrier to the full realization of *Charter* rights.[177] However, in my view, despite the suppression tactics employed by provinces in the past, opponents of abortion restriction ought to consider the fruitful avenue that division of powers law offers to challenge these restrictions. There are limits to this pursuit, of course, given the principle of exhaustiveness of

175. *Securities Reference* SCC, *supra* note 69 at para 57.

176. *Supra* note 120 at para 30.

177. See e.g. White, *supra* note 4 at 163–65; Johnstone & Macfarlane, *supra* note 10 at 99, 100, 108–10; Ian T Urquhart, "Federalism, Ideology, and Charter Review: Alberta's Response to Morgentaler" (1989) 4 CJLS 157.

powers: that is, jurisdiction denied to one level of government must belong to the other level of government. There may be temptation to see the division of powers argument as a stopgap measure, which, by prohibiting one level of government from acting, only temporarily thwarts the legislation, until the other level of government chooses to implement it. The corollary of this is to see *Charter* challenges as bringing about long-term change. Certainly, this dynamic has often played out. As Patrick Monahan observed in the late 1980s in his empirical review of cases, federalism "operates as a relatively weak constraint on governments",[178] as governments facing unfavourable division of powers rulings have tended to employ substitute mechanisms to accomplish the same policy goals.[179] However, in the realm of abortion regulation, this usual practice may be stymied by political and legal hurdles that greatly complicate the federal government's ability to act. Abortion is a contentious political issue and the federal government has already failed to enact legislation on the subject. And, pursuant to division of powers doctrine, exercises of Parliament's criminal law power must take on a prohibitory form and pursue a proper criminal law purpose.[180] Crafting nuanced legislation to operate in the health and hospital context without crossing into provincial jurisdiction over health may be somewhat challenging. All of this suggests that there is good reason to think that division of powers arguments in this sphere will have substantial impact.[181]

178. Patrick Monahan, *Politics and the Constitution: The Charter, Federalism and the Supreme Court of Canada* (Toronto: Carswell Co, 1987) at 9.

179. See *ibid* at 9–11, 160–63, 221–44.

180. See *Margarine Reference*, *supra* note 34 at 19.

181. Some abortion rights advocates may not be satisfied with my pragmatic suggestion here, on the basis that an approach that fails to recognize or engage with a right to abortion fails to truly secure women's equal membership in Canadian society. See e.g. Johnstone, *After Morgentaler* 2012, *supra* note 44 at 83.