

Alberta Doctors' Digest

Physician commentary on the notwithstanding clause

Physicians have traditionally maintained a measured distance from legislative debates. When policy raises ethical or rights-based concerns, there has often been an implicit assumption that the courts will serve as a backstop. If legislation overreaches, it can be challenged, reviewed and, if necessary, corrected.

That approach is becoming less tenable.

The increasing use of the notwithstanding clause changes how that system functions in practice. Courts may still hear challenges and identify Charter infringements, but their ability to ensure that legislation is altered in response may be limited. A law can be found to infringe rights and yet still remain in force.

This is not simply a constitutional nuance. It changes the timing of when concerns are most effectively addressed.

In a system where courts provide a meaningful corrective, there is space for issues to be identified and resolved after legislation is enacted. In a system where that corrective may not occur, concerns that are not addressed during the legislative process can persist in practice, even if they are later recognized as Charter violations.

For physicians, this has practical implications.

Medical practice is shaped by legislation and regulation. Decisions about access to care, professional obligations and the conditions under which care is delivered are often determined not at the bedside, but through policy. When those policies engage ethical or rights-based concerns, the question is not only what the policy says, but how — and when — it can be challenged.

This is particularly relevant in the context of how governments structure relationships with physicians and other health care professionals. In recent years, provinces have demonstrated a willingness to legislate in areas traditionally addressed through negotiation, including altering contractual frameworks and working conditions.

While these measures are often framed as necessary for system management, they may engage Charter considerations related to association, mobility and equitable treatment. Where override is used or contemplated, the ability to challenge those measures through the courts becomes less certain in terms of practical effect.

For physicians, many of whom function as independent contractors within publicly funded systems, this raises a specific concern. Contracts and compensation structures are not simply administrative details. They shape access to care, scope of practice and the sustainability of clinical work. If legislative changes affecting those structures cannot be meaningfully challenged after the fact, the point at which physician input may carry the greatest weight shifts earlier in the process.

The experience of other sectors illustrates this dynamic. When legislation is enacted with limited opportunity for negotiation, and with the potential to withstand Charter challenge,

those affected are left operating within frameworks they had little ability to influence. For physicians, the assumption that concerns can be addressed through later legal review may no longer hold in the same way.

Beyond contractual and structural considerations, similar questions arise in the ethical dimensions of clinical practice.

A clear example is the area of conscientious objection. Physicians have long operated with the understanding that freedom of conscience and religion, as protected under the Charter, provides a framework within which they can navigate ethically complex areas of practice. At the same time, they operate within a publicly funded system that carries expectations around access to care.

That balance has typically been worked out through a combination of professional regulation, policy and, where necessary, judicial oversight. Courts have played a role in clarifying the boundaries between individual rights and system obligations, allowing for an ongoing adjustment of that balance over time.

When the notwithstanding clause is introduced into this landscape, the nature of that balance changes. It is no longer only a question of how rights and obligations are interpreted, but whether the protections underlying those rights can be set aside as part of a broader policy approach. In that context, the expectation that tensions will be resolved through legal clarification becomes less certain.

This does not eliminate the ethical complexity of these issues, nor does it resolve the competing interests involved. But it does shift where and how those questions must be addressed. If the legal framework that has traditionally mediated these tensions becomes less predictable in its effect, the importance of engagement at the policy stage correspondingly increases.

For physicians, this matters because these are not abstract questions. They shape day-to-day decisions about participation in care, scope of practice and the conditions under which services are provided. A framework that is perceived as stable allows those decisions to be made with a degree of confidence about where the boundaries lie. A framework that is subject to override introduces a different kind of uncertainty — one that is not easily resolved through later challenge.

Recent debates over Quebec's secularism law have focused on restrictions on religious expression in public-facing roles. While that context is specific, it illustrates a broader shift. The same legal mechanism has been invoked or contemplated in other areas, including labour legislation and aspects of health policy, and has been raised in discussions around issues such as medical assistance in dying and gender-related care. In many of these areas, there has been an implicit expectation that courts would provide a meaningful check if legislation extended too far. When override is used, that expectation becomes less certain.

The result is a change in where responsibility effectively sits.

If physicians assume that problematic legislation will be corrected through legal challenge, there may be less urgency to engage early. Advocacy can be deferred, with the understanding that concerns can be addressed through the courts if needed. But when that pathway is constrained, the consequences of that delay become more significant.

In that context, engagement at the legislative stage is no longer entirely optional in the same way. It becomes the point at which concerns are most likely to influence outcomes.

This does not mean that physicians must take positions on every policy issue, nor that professional advocacy should become partisan. But it does require a recognition that the structure within which policy is reviewed and corrected is evolving. The assumption that courts will resolve concerns after the fact is no longer sufficient.

Advocacy in medicine is often framed as a matter of individual inclination. Some physicians engage actively in policy discussions; others do not. But when the mechanisms that traditionally provide downstream correction begin to change, the timing of engagement becomes more consequential.

For individual physicians, this may be a matter of choice. For professional associations, it is increasingly a matter of responsibility.

If concerns are not raised before legislation is enacted, they may not be meaningfully addressed afterward. Once enacted under an override framework, even legislation that is found to infringe Charter rights may remain in force.

The courts may still speak. But they may no longer be able to ensure that what they say necessarily changes what happens next.

Editor's note: The views, perspectives and opinions in this article are solely the author's and do not necessarily represent those of the AMA.