Religion and Health Care in the provinces of Quebec and Ontario

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Introduction:

Although health care in both Quebec and Ontario was first administered by religious groups, both provinces have developed extensive systems now overseen by their respective provincial governments. This report will address several areas of contention within these systems including diversity, religious symbols, spiritual care services and abortion. We will highlight the places in which Quebec and Ontario have developed these issues in different ways and suggest areas of interest for further research.

Historical Background:

The first hospitals in both Quebec and Ontario were built and administered by charities and religious organisations. In Ontario, this consisted of Welfare based 'poor relief' organisations such as the Sisters of Charity in Ottawa. In 1867, constitutional processes turned Ontario's relatively disparate process of voluntary, charitable 'poor relief' by Catholic and Protestant groups into what would be eventually become the public health system, where hospitals were funded on the basis of ensuring universal access to health services. Ontario's health care services were established by the Public Health Act of 1882 and are administered by the Ministry of Health and Long-Term Care. In Quebec, the first hospitals were built and administered by religious orders such as the *Hospitalières de la miséricorde-de-Jésus* (Dickenson & Young, 2003, p. 43). During the Quiet Revolution (1960s), the provincial government created the department of family and social affairs (Dickenson & Young, 2003, p.320) which in 1985 became the Ministry of Health and Social Services with the Adoption of the Act respecting the *Ministère de la Santé et des Services sociaux* (MSSS, 2011). In 1957, there were 205 Public hospitals in Ontario. These included 52 municipal hospitals, 138 non-sectarian hospitals and 47 religious hospitals. By contrast, Quebec at that time had 131 Public Hospitals, 20 of

which were municipal hospitals, 38 were non-sectarian hospitals and 90 were religious hospitals. Although further research is needed, it seems that such divisions continue to underpin Ontario's Health Care system, whereas the system in Quebec no longer appears to have significant divisions along religious lines.

Controversies:

1. Protection of Religious Rights and Diversity

(Ontario)

As far as we can determine, the Ontario Health Care services have made significant effort to accommodate religious diversity. Ontario Health Care provides information regarding its health care provision in 27 different languages, including Arabic, Hindi, Farsi, Oji Cree, Punjabi, and Tamil (Ontario Ministry of Health, 2011).

The Ministry of Health and Long Term Care adheres to the *Ontario Human Right's Code 1990* (OHRC) which allows for the freedom of 'creed' in Ontario and the protection from discrimination by 'creed' (Ontario, 2009). Their definition of the term 'creed' explicitly precludes religions that promote violence or hate. We note that this this could be used to preclude exclusionist religious groups who have particular prejudices towards other religions or sectors of society.

The Religious Rights section of the OHRC's website also includes a document written on the 20th of October 1996[1] entitled *Policy on creed and the accommodation of religious observances.* This document further expands upon and defines by what is meant by the term "creed." Here the definition is expanded to expressly include polytheistic and non-theistic forms of religious belief, as well as Aboriginal spirituality. The only limitation is that a new religion must be deemed to be *bona fide* and that this may

[1] The Ontario Human Rights Commission began reviewing the Code's definition and discussion of religion in January 2012.

preclude New Religious Movements claiming religious status such as Scientologists or the Falun Gong.

(Quebec)

There are two main laws related to the provision of spiritual care in public health institutions[2]. Article 100 ensures services that are respectful of patrons' personal rights and spiritual needs while attempting to reduce or resolve health issues. While Article 7 requires all hospital centers and long-term care facilities to adopt rules around the organization of a spiritual care service in their institution. To this end, they must enter into an agreement with the relevant religious authorities depending on the religious affiliations of their patrons.

This framework protects spiritual care services by making a commitment toward meeting the spiritual needs of patients and families under the care of the institution while requiring them to maintain these services. Patrons are protected from proselytizing by the emphasis on respecting the beliefs of others. Moreover, a tendency toward holistic care is evident in these laws through the government's commitment to respect the spiritual needs of patrons, solve problems in health and well-being as well as meet the needs of different segments of the population. The fact that facilities are required to consult with relevant religious authorities also suggests that these services *should* change with the changing demographics of the Quebec population. In addition, despite a reduced allocation of funds to this service, the government has consistently required that an on-call service be kept in place allowing spiritual care providers to be called upon 24 hours a day, 7 days a week.

In their Ministerial Orientations for spiritual care, the Quebec government asserts that everyone has a spiritual dimension and therefore spiritual needs, which revolve around making sense of our lives. We find it problematic that these spiritual needs are

[2] It is interesting to note that a search for spiritual care on the MSSS website yields links to documents in the following areas: published documents, home support, palliative care and how to file a complaint.

linked to issues of the soul, a concept that is not found all religious traditions let alone among all people who profess no religious affiliation. Even more problematic however, is the assertion that all people have religious needs which are linked to a person's relationship to God or a supreme being. Certainly, this is not an affirmation which would be supported by all religious traditions or religious nones. Although recent documents recognize that various religious traditions support a spiritual journey in different ways, the language used in these documents seems related to the Christian heritage (and perhaps hegemony) present in Quebec.

2. Places of Worship/Religious symbols

(Ontario)

We have found that Christian accommodations of "other" religious groups are being made in some Ontario hospitals. We use the term accommodate here, because we have found some evidence which indicates that in some cases this process is a Christian accommodation of 'others.' For example at St Vincent's hospital in Ottawa Ontario proudly displays its Catholic history, Christian values and symbols while at the time publically advertising its spiritual care services as being open to other groups. This Christian accommodation of the "other" also happens physically inside the St Vincent's hospital where on its 5th floor there is both a Chapel and a Multifaith room.

St Vincent's is not the only Catholic hospital in which this strange acceptance of diversity is apparent. A review of the website of St Mary's Hospital in Kitchener Ontario also points to the same type of accommodation occurring, but with a twist. Here we see repeated the same services, facilities and values offered by St Vincent's. However when we look at St Mary's General Hospital's Credo for its spiritual services we get a more specifically Christian understanding of Health provision which include references to God and Jesus Christ.

We argue that these particular religiously oriented institutions appear to be genuinely attempting to "accommodate" other religious groups (they use the term faiths)

from within a position of institutional power and belief. I find it extremely interesting that these hospitals are making room for other faiths both semantically and physically within the institutions, while at the same time protecting their own beliefs. This process appears both progressive and limiting. It is progressive in that shows that these hospitals are thinking about how to deal with the spiritual needs of others. It is limiting in that "other religions" are labelled as such and remain guests within these publically funded hospitals.

(Quebec)

In Quebec, the 2010 Ministerial Orientations on the organization of spiritual care services in health care institutions specifies that the place of worship must not only be adapted to the needs of clientele but must also take into consideration the needs of the relevant religious authorities and, depending on the area, might need to be non-confessional. In addition, each institution is to develop links with the religious authorities that are representative of the area they serve including the local Catholic Bishop, the United Church, the Anglican Church and the Jewish community. It is interesting that throughout the government documents reviewed these four faith groups are considered to be the representative religious authorities in Quebec and are consistently consulted in matters related to spirituality and health care.

However, data from the 2001 census[3] shows that other groups are increasing in number in Quebec. Roman Catholicism remains the most prominent religious group with 83.2% of the population claiming affiliation to it. The second most prevalent affiliation is no religion at 5.6%, followed by the Anglican Church at 1.2 %, and the United Church at 0.7%. At 1.3%, affiliation to the Jewish faith is the third largest non-Christian affiliation, no religion being the first, and Islam being the second at 1.5%. In addition, other non-Christian faiths such as Buddhism, Hinduism and Sikhism are growing exponentially. This raises questions about how to best consult and serve an increasingly diverse society.

[3] All statistics retrieved from http://www12.statcan.gc.ca/english/census01/products/highlight/Religion/Page.cfm?Lang=E&Geo=PR&View=1a&Code=24&Table=1&StartRec=1&Sort=2&B1=Canada&B2=1

In addition, the 2001 portrait of spiritual care services shows that 12% of institutions do not offer a place of worship and of the 88% that do, many do not seem to be easily accessible to users (Service régional de pastorale de la santé, 2002, p.20-22). The authors of this document are also concerned by the fact that the place of worship is sometimes used as a multifunctional space for activities not related to spirituality or religion. They warn that this risks a trivialization of the space and the spiritual dimension of individuals themselves (Service régional de pastorale de la santé, 2002, p. 57). We think that these are valid concerns. We would also add that though the suggestion in the 2010 Ministerial Orientations that some spaces be made multi-confessional is a noble goal, we are not sure the goal takes into consideration the fact that the majority of hospitals in Quebec were once run by religious orders and often have places of worship with Christian symbols fitted into the walls and window. Removing some of these might be structurally impossible but perhaps even more problematical is the likely opposition to their removal by those who feel strongly that they must be preserved as part of our cultural heritage; as was the case of the crucifix in Quebec's national assembly. Putting aside religious symbols for a moment, on a practical level the very presence of pews that cannot be moved negates the possibility of certain other groups, who do not worship in either a sitting or standing position, using that space. Due to a shortage of space there may be little that can be done in existing institutions, however, it will be interesting to see how new hospitals[4] being built incorporate a multi-confessional place of worship.

3. Spiritual Care Services

(Ontario)

The Government of Ontario has paid for chaplaincy services since 1949 (Ontario Provincial Interfaith Committee, 1992, p. 5). The subsequent expansion of chaplaincy services under the Ministry's of Health, Correctional Services and Social and Community

[4] The new MUHC and CHUM are due to be completed in 2014 and 2019 respectively. Each plan to have a place of worship in the new institution and discussions and decisions about what this space will look like are already in progress.

Services led in 1972 to chaplains in these organisations being combined under the banner of Chaplaincy Services Ontario and the Ontario Provincial Interfaith Committee on Chaplaincy. On the 3rd of December 1992 the Ontario Provincial Interfaith Committee on Chaplaincy was replaced by the Ontario Multifaith Council on Spiritual and Religious Care (Ontario Provincial Interfaith Committee, 1992, p. 1). The roles of the two organisations are:

> The Ontario Multifaith Council on Spiritual and Religious Care is established to advocate for the spiritual and religious needs of those in need of care of the province... (Ontario Provincial Interfaith Committee, 1992, p. 11).
> Chaplaincy Services Ontario consists of government funded provincial and regional chaplaincy staff who coordinate the provision and access of and to spiritual and religious care of those in need in the care of the province (Ontario Provincial Interfaith Committee, 1992, p. 11).

Definitions of faith groups and spiritual dimensions of human existence were provided in the 1992, the Memorandum of Understanding which served to create Ontario Multifaith Council on Spiritual and Religious Care. The Memorandum argued that there is a basic spiritual dimension to human existence (Ontario Provincial Interfaith Committee, 1992, p. 8). A faith group is defined as "A denomination or identifiable group of people organized around a specific set of beliefs, practices and tradition. Members of a faith group share a common view of spirituality or religion." Here again, we see a definition that attempts to be inclusive which remains potentially narrower than the definition of religion used by the Ontario Human Rights Commission,

Currently, the provision of chaplaincy services in Ontario is understood to be a partnership between faith groups and government institutions and agencies (Ontario Provincial Interfaith Committee, 1992, p. 5). This means that the government provides the funding for chaplaincy services and perceives a role for

these services within Ontario's public hospitals. It is the task of the Ontario Multifaith Council on Spiritual and Religious Care to broadly administer the overall direction that this spiritual care will take.

Services offered at the level of the Ontario Multifaith Council on Spiritual and Religious Care include: an annual "Spiritual and Religious Care Awareness Week." This week promotes a toolkit entitled "Honouring Diverse Beliefs in Our Communities"[5] The Council also promotes a guidelines document for "Christians and others" who want to host multi-faith gatherings.[6] Much of the language in these two documents mirrors the religious diversity language used by the two Catholic hospitals discussed above. The Council also stocks a Multifaith Library to support the work of spiritual and religious caregivers in their efforts to understand the many faiths represented in our population. It also runs its own online journal "OMNI Journal of Spiritual and Religious Care." which has somewhat scholarly articles relating to chaplaincy and care.[7]

(Quebec)

In Quebec, spiritual care providers are government employees working within the health care system. In 2005, as required by the provincial government, spiritual care providers were unionized and are now represented by the *Alliance du personnel professional et technique de la santé et des services sociaux* (APTS) (Cloutier, 2004). Prior to this event, in addition to education requirements, all spiritual care providers were required to obtain a pastoral mandate (or its equivalent) from their religious group which acted as a licence to practice (MSSS, 2001, p. 4). After 2005, this practice was abolished. Although the majority of spiritual care providers hold at minimum a relevant bachelors degree, only just over half report having received any clinical training prior to employment (Service régional de pastorale de la santé, 2002, p.41-42). This shows an

[5] See http://www.omc.ca/sandrcare/2011/ResourceSheet_HonDiverseBeliefs_2011.pdf
[6] See http://www.omc.ca/sandrcare/2011/GUIDELINES%20FOR%20MULTIFAITH%20GATHERINGS.pdf
[7] See http://www.omc.ca/omni/articles.html

important shortcoming in the implementation of the 2001 government protocols and might explain why clinical training in spiritual care was downgraded from required to desired in the 2010 Ministerial Orientations.

The demographic portrait[8] of spiritual care providers in the province shows that these providers are male dominated and aging. The vast majority (62%) are between the ages of 50 – 69 years old (Service régional de pastorale de la santé, 2002, p. 26). The average age of a spiritual care professional is 58 years old which is quite high if compared to that of other professionals: 39.4 years for nurses, 37.3 years for physiotherapists, 42.3 years for psychologist and 40.2 years for social workers (Service régional de pastorale de la santé, 2002, p. 27). Not surprisingly this is a predominantly male domain (72%), which is likely because in Quebec these positions were traditionally occupied by Catholic priests; who continue to be the majority employed (63%) (Service régional de pastorale de la santé, 2002, p. 29-30).

Interestingly, the Quebec Association of Spiritual Care (AIISSQ) uses government definitions of spirituality and religion to argue that the role of spiritual care providers is not in contradiction with the philosophy of open Laïcité in Quebec but is actually integral to it (AIISSQ, 2007, p.5). By arguing that spirituality is an important dimension of all human beings AIISSQ contends that to prohibit the expression of religious and/or spiritual beliefs in public spaces, such as hospitals and long-term care centers, is to deny a captive clientele a fundamental dimension of their being; one that often emerges as particularly meaningfully during difficult situations such as illness or death. Not surprisingly, they argue that the best way to support this dimension in health care institutions is through spiritual care services offered by professionals using a non-confessional approach to the service. Regardless of their confession, AIISSQ maintains that trained spiritual care providers are able to care for patients without trying to impose their own beliefs or worldviews on said patient (AIISSQ, 2007, p.7). Finally, AIISSQ

[8] The last demographic portrait of spiritual care services in health and social services is representative of facts in 2001. It should be noted that Jean-Marc Charron and Michel Nyabenda are currently working on a project intended to provide a more current portrait.

has created a ‘ *Table de concertation’* on spiritual care, which it hopes can serve as an advisory committee to the MSSS helping to find practical solutions to issues related to spiritual care in Quebec

4. Abortion

(Ontario)

Our investigation into the public health services offered by Ontarian religious hospitals indicated that abortion access is a potential area of research both within Ontario and throughout Canada. We have found that in Ontario access to abortion services is a contested ground where public health services, human rights arguments and motivated religious actors overlap. The ground is contested because it appears that religious actors have the potential to restrict women’s and girls’ access to abortion services in Ontario. By religious actors we refer to: Catholic Hospitals, religious individuals and pro-life organisations. We use the term ‘potential to restrict’ because this preliminary research currently does not provide sufficient evidence to show that religious restriction of abortion services is a fact. However, we believe that on the basis of this preliminary work that there is ground for further investigation and in the final section of this report we make some recommendations for further research.

Currently, we have identified four places in which religious actors can potentially prevent women’s and girls’ access to abortion services in Ontario:

1. Catholic Hospital policy
2. Individuals in secular hospitals obstructing abortion access
3. Unresolved questions regarding whether the rights of a patient supersede the right of a medical practitioner to freedom of conscience
4. The harassment by Pro-life groups of women seeking abortions and those people conducting operations.

Point 1 provides the strongest ground for showing that religiously motivated actors are restricting access to abortion services. Points 2 and 3 are interrelated, with Point 3 being

an ethical discussion of some of the rights that are being transgressed in Point 2. Finally, Point 4 is a well-documented issue, but we include it because it is relevant to the other Points and it supplies an additional way in which religious actors are able to reduce access to abortion services for women and girls.

(Quebec)

In light of our findings regarding abortion services in Ontario, we also reviewed some of the equivalent policies in Quebec and found significantly different results. In Quebec, the Ministry of Health and Social Services has recently implemented an expanded program for access to emergency oral contraception. This means that women can now obtain the morning-after pill directly from the pharmacist without a prescription. This is covered by Quebec public health insurance, making it free to all women with a Medicare card. On their website the Ministry of Health states that, "Teenage girls also have access, as do all women in Québec, to elective abortion services. These are offered in all regions of Québec." This appears to be supported by the *Fédération du Québec pour le planning des naissances* (Quebec federation for birth planning) which shows the availability of abortion, contraception, emergency contraception, infertility treatments, ITSS, and sterilization by region in Quebec.

Areas for future research:

1. The use of religious symbols in hospitals and other health care institutions.
2. The role of religious actors in determining access to abortion in Ontario.
3. The accommodation of the religious other by the Christian majority in hospitals across both provinces.

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