COURT OF APPEAL FOR ONTARIO

CITATION: Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario, 2019 ONCA 393
DATE: 20190515
DOCKET: C65397

Strathy C.J.O., Pepall and Fairburn JJ.A.

BETWEEN

The Christian Medical and Dental Society of Canada, The Canadian Federation of Catholic Physicians' Societies, Canadian Physicians for Life, Dr. Michelle Korvemaker, Dr. Betty-Ann Story, Dr. Isabel Nunes, Dr. Agnes Tanguay and Dr. Donato Gugliotta

Applicants
(Appellants)

and

College of Physicians and Surgeons of Ontario

Respondent
(Respondent)

and

Attorney General of Ontario, Dying with Dignity Canada, Canadian Civil Liberties Association, The Evangelical Fellowship of Canada and The Assembly of Catholic Bishops of Ontario and the Christian Legal Fellowship, B'nai Brith of Canada League for Human Rights, Justice Centre for Constitutional Freedoms, Catholic Civil Rights League, Faith and Freedom Alliance and Protection of Conscience Project, Canadian HIV/AIDS Legal Network, HIV & AIDS Legal Clinic Ontario and Canadian Professional Association for Transgender Health

Interveners

Eugene Meehan, Q.C., for the appellants the Christian Medical and Dental Society of Canada, the Canadian Federation of Catholic Physicians' Societies,

Dr. Michelle Korvemaker, Dr. Betty-Ann Story, Dr. Isabel Nunes, Dr. Agnes Tanguay and Dr. Donato Gugliotta

Albertos Polizogopoulos, for the appellant Canadian Physicians for Life

Lisa Brownstone and Ruth Ainsworth, for the respondent

Shaun O'Brien and Karen Segal, for the intervener Women's Legal Education and Action Fund Inc.

Rahool Agarwal and Kate Findlay, for the intervener Canadian Civil Liberties Association

Kelly Doctor and Mary-Elizabeth Dill, for the intervener Dying with Dignity Canada

Emrys Davis and Grace McKeown, for the interveners Catholic Civil Rights League, Faith and Freedom Alliance and Protection of Conscience Project

Timothy D. Chapman-Smith and Shanique M. Lake, for the intervener Ontario Medical Association

Michael Fenrick and Khalid Janmohamed, for the interveners Canadian HIV/AIDS Legal Network, HIV & AIDS Legal Clinic Ontario and Canadian Professional Association for Transgender Health

Alan Honner, for the intervener Justice Centre for Constitutional Freedoms

Deina Warren, Derek B.M. Ross and Sarah E. Mix-Ross, for the interveners The Evangelical Fellowship of Canada, The Assembly of Catholic Bishops of Ontario and the Christian Legal Fellowship

Gregory M. Sidlofsky, for the intervener B'nai Brith of Canada League for Human Rights, the Vaad Harabonim of Toronto and the Centre for Israel and Jewish Affairs

Heard: January 21 and 22, 2019

On appeal from the order of the Divisional Court (Justices Herman J. Wilton-Siegel, Richard A. Lococo and Wendy M. Matheson), dated January 31, 2018, with reasons reported at 2018 ONSC 579, 140 O.R. (3d) 742.

Strathy C.J.O.:

A. OVERVIEW

[1] This appeal requires the court to reconcile a conflict between patients' access to medical services such as medical assistance in dying ("MAiD"), abortion and reproductive health services and physicians' freedom to refuse to participate in services to which they have religious objections.

[2] The appellants challenge the constitutionality of two policies (the "Policies") enacted by the College of Physicians and Surgeons of Ontario (the "College"). The Policies each require physicians who object to providing certain medical procedures or pharmaceuticals on the basis of religion or conscience to provide the patient with an "effective referral". An effective referral is defined as "a referral made in good faith, to a non-objecting, available, and accessible physician, other health-care professional, or agency."[1] The Policies do not require physicians to personally provide the services to which they object, except in an emergency where it is necessary to prevent imminent harm to a patient.

[3] The constitutionality of the Policies' effective referral requirements is the focus of this appeal.

[4] The appellants are individual physicians and organizations representing physicians in Ontario. They brought two separate applications in the Divisional

[1] Policy Statement #4-16, entitled "Medical Assistance in Dying", refers to "nurse practitioner" in place of "other health-care professional".

Court, challenging the Policies on the ground that the effective referral requirements infringe their freedom of conscience and religion under s. 2(a) of the *Canadian Charter of Rights and Freedoms* because the requirements oblige them to be complicit in procedures that offend their religious beliefs. The appellants also claimed that the effective referral requirements discriminate against physicians based on their religions, thus infringing their s. 15(1) equality rights.

[5] The Divisional Court dismissed the appellants' applications. It found that while the Policies infringe their freedom of religion, the infringement is justified under s. 1 of the *Charter*, because the Policies are reasonable limits, demonstrably justified in a free and democratic society. The Divisional Court did not consider whether freedom of conscience is engaged. It dismissed the s. 15(1) claim in its entirety.

[6] The appellants and the College each take issue with the Divisional Court's findings regarding the cost or burden imposed by the Policies on objecting physicians, and the corresponding balancing in the *R. v. Oakes*, [1986] 1 S.C.R. 103 analysis of that cost or burden against the salutary effects of the Policies. They each sought to adduce fresh evidence on this issue. The College denies there is a breach of s. 2(a), but says that if there is, it is justified under s. 1.

[7] The appeal focuses on the s. 1 analysis and turns primarily on the minimal impairment and proportionality branches of the analytical framework outlined in *Oakes*. This requires an appropriate characterization of the nature of the cost or burden imposed by the Policies on objecting physicians, and the balancing of that burden against the benefits of the objective of the effective referral requirements. The appellants' principal submission on appeal is that the effective referral requirements are not minimally impairing of their rights and that alternative measures would achieve the same objective, while respecting their freedom of religion. They contend that a "generalized information" model, in which objecting physicians give patients information concerning publicly-available resources and services, would provide a practical, workable and less impairing alternative to effective referral. The College denies there is a breach of s. 2(a), but says that if there is, the Policies are justified under s. 1.

[8] For the reasons that follow, I substantially agree with the thorough and cogent analysis of the Divisional Court and would dismiss the appeal.

B. BACKGROUND

(1) The Parties and Interveners

[9] The five individual appellants are family physicians, practicing in various parts of Ontario. As I will explain, their religion is central to their lives. It informs everything they do, including their practice of medicine. They care deeply for their

patients and strive to honour their legal and ethical duties to their patients. They also believe in the sanctity of human life. Their evidence, supported by the evidence of other physicians and theologians, is that the effective referral requirements of the Policies contravene their conscientious and religious beliefs, which prevent them from performing some or all of the medical procedures at issue. The scope of their beliefs extends beyond performing such procedures, and includes "being complicit in or an accessory to" those procedures. They believe that complying with the effective referral requirements of the Policies would make them complicit in performing those procedures.

[10] The three appellant organizations represent physicians who object to some or all of abortion, MAiD and other medical procedures and pharmaceuticals on grounds of religion and conscience. These organizations are:

- The Christian Medical and Dental Society of Canada (the "CMDSC"), a national association of Christian physicians and dentists with approximately 500 members in Ontario. The five individual appellants are members of the CMDSC;
- The Canadian Federation of Catholic Physicians' Societies, a national association of Catholic Physicians' guilds, associations, and societies in eleven Canadian cities, including four in Ontario; and
- Canadian Physicians for Life, a non-religious national association of pro-life physicians, retired physicians, medical residents and students, with approximately 1,000 members in Ontario.

[11] The College is the self-governing body for the medical profession in Ontario under the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 ("*RHPA*") and the *Medicine Act, 1991*, S.O. 1991, c. 30.

[12] Nine organizations or groups of organizations, some of which intervened in the Divisional Court, were granted leave to intervene in this appeal. Five intervening organizations and groups supported the position of the appellants: (1) the Catholic Civil Rights League, Faith and Freedom Alliance, and Protection of Conscience Project (the "CCRL et al."); (2) The Evangelical Fellowship of Canada, The Assembly of Catholic Bishops of Ontario, and Christian Legal Fellowship (the "EFC et al."); (3) the Ontario Medical Association (the "OMA") (which did not intervene in the applications below); (4) B'nai Brith of Canada League for Human Rights, the Vaad Harabonim of Toronto, and the Centre for Israel and Jewish Affairs ("B'nai Brith et al."); and (5) the Justice Centre for Constitutional Freedoms (the "JCCF").

[13] Four intervening organizations and groups supported the position of the College: (1) the Canadian Civil Liberties Association (the "CCLA"); (2) Women's Legal Education and Action Fund Inc. ("LEAF") (which did not intervene in the applications below); (3) Dying with Dignity Canada; and (4) the Canadian HIV/AIDS Legal Network, HIV & AIDS Legal Clinic Ontario, and the Canadian Professional Association for Transgender Health (the "Canadian HIV/AIDS Legal Network et al.").

(2) The Policies

[14] The Policies, extracts of which are set out below, require a physician to give an effective referral to another health care provider for medical procedures or pharmaceuticals which the physician objects to providing on the basis of religion or conscience. While each of the individual appellants objects to MAiD and abortion, their objections are not uniform with regard to other procedures and pharmaceuticals, such as contraception, emergency contraception, fertility treatments, and medical treatments for transgender patients.

[15] None of the parties dispute that the *Charter* applies to the Policies. The College says the *Charter* applies, not because it is a state actor and not because the Policies are laws, but rather because it is implementing a specific government objective through the Policies: *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, at paras. 44, 50-51.

[16] The Policies are not “regulations”, nor are they a “code, standard or guideline relating to standards of practice of the profession” adopted pursuant to s. 95(1.1) of the Health Professions Procedural Code, Schedule 2 of the *RHPA*. Accordingly, non-compliance with the Policies is not an act of professional misconduct under the College’s professional misconduct regulation: *Professional Misconduct*, O. Reg. 856/93.

[17] However, the Policies establish expectations of physicians' behaviour and are "intended to have normative force". As such, they may be used as evidence of professional standards in support of an allegation of professional misconduct.

[18] The College introduced the Policies in 2015 and 2016. The first was Policy Statement #2-15, entitled "Professional Obligations and Human Rights" (the "Human Rights Policy"), which contains the following effective referral requirement:

> Where physicians are unwilling to provide certain elements of care for reasons of conscience or religion, an effective referral to another health-care provider must be provided to the patient. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, other health-care professional, or agency. The referral must be made in a timely manner to allow patients to access care. Patients must not be exposed to adverse clinical outcomes due to a delayed referral. Physicians must not impede access to care for existing patients, or those seeking to become patients. [Emphasis added.][2]

[19] The Human Rights Policy was the evolution of Policy Statement #5-08, entitled "Physicians and the Ontario *Human Rights Code*", adopted by the

[2] The Human Rights Policy also contains the following provision: "Physicians must provide care in an emergency, where it is necessary to prevent imminent harm, even where that care conflicts with their conscience or religious beliefs." This provision was challenged in the Divisional Court. However, the Divisional Court noted that all the individual appellants agreed that they would not object to performing an abortion where it was necessary to save a pregnant woman's life and the appellant organizations agreed most of their members would take the same position: para. 218. Thus, the Divisional Court found that there was no evidence that the emergency provision would raise a concern even if the provision were interpreted to require the provision of treatment to prevent a serious deterioration of health short of saving a patient's life: para. 218. It dismissed the applications in relation to the emergency provision. The appellants do not pursue the issue in this court.

College in 2008 to address its expectations for physicians who, for moral or religious reasons, refused to accept certain patients, refused to provide medical services, or terminated the physician-patient relationship. While that document did not contain the current effective referral requirement, it did provide that objecting physicians were expected to "[a]dvise patients or individuals who wish to become patients that they can see another physician with whom they can discuss their situation and in some circumstances, help the patient or individual make arrangements to do so."

[20] In 2014, the College undertook a review of the policy and engaged in a consultation process with its membership and other interested parties, revising the policy in March 2015 to include the effective referral requirement.

[21] The stated purpose of the Human Rights Policy is to set "out the legal obligations under the [*Human Rights*] *Code* for physicians to provide health services without discrimination, as well as the College's professional and ethical expectations of physicians in meeting those obligations.… [The] policy outlines physicians' rights to limit the health services they provide for legitimate reasons while upholding their fiduciary duty to their patients."

[22] After the release of the decision of the Supreme Court of Canada in *Carter v. Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331, striking down portions of the *Criminal Code*, R.S.C. 1985, c. C-46, prohibiting assisted suicide,

the College undertook a consultation process, which led to the adoption of a policy to provide guidance to physicians in complying with the legislation permitting MAiD. The stated purpose of the policy, adopted in June 2016, is to articulate "the legal obligations and professional expectations for physicians with respect to medical assistance in dying, as set out in federal legislation, provincial legislation, and relevant College policies."

[23] This was Policy Statement #4-16, entitled "Medical Assistance in Dying" (the "MAiD Policy"), which contained the following effective referral requirement:

> Where a physician declines to provide medical assistance in dying for reasons of conscience or religion, the physician must not abandon the patient. An effective referral must be provided. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, nurse practitioner or agency. The referral must be made in a timely manner to allow the patient to access medical assistance in dying. Patients must not be exposed to adverse clinical outcomes due to delayed referrals. [Emphasis added.]

[24] A "Fact Sheet" released by the College in 2016 gave guidance to physicians on compliance with the effective referral requirements. It states that a physician makes an effective referral "when he or she takes positive action to ensure the patient is connected in a timely manner to another physician, health care provider, or agency who is non-objecting, accessible and available to the patient."

[25] The Fact Sheet provides a non-exhaustive list of examples of how physicians can comply with the effective referral requirements. It notes that the physician can make the referral or assign the task to another, a designate, to make the referral to a non-objecting physician, other non-objecting health care professional or an agency charged with facilitating referrals for the health care service. It also provides suggestions for physicians practicing in a hospital, clinic, or family practice group. The Divisional Court observed, at para. 33, that these "include identification of a point person within the institution or practice group who will facilitate referrals, or provide the health care to the patient, and implementation of a triage system for matching patients directly with non-objecting physicians in the institution or practice group."

[26] Contrary to the submissions on behalf of the OMA, an effective referral is not the same as a formal referral as generally understood within the medical profession. The Divisional Court made this point in describing the scope of the effective referral requirements, at para. 31:

> First, the Policies do not require that a referring physician provide a formal letter of referral to, and arrange an appointment for a patient with, another physician. The CPSO says that the intent of the Policies is to ensure only that patients are not left to finding a willing physician on their own without any assistance from the physician from whom they first sought care. Accordingly, the spirit of the requirements is that the physician take "positive action" to connect a patient with a physician, another health-care professional or an agency. Second, referral may be made to any of a

> physician, another health-care professional or an agency provided the party to whom a patient is referred provides the requested medical services and is "non-objecting, available and accessible". In the case of an agency, a referral may be made to an agency that is charged with facilitating referrals for the health care service. [Emphasis added.]

[27] It is noteworthy that in the case of both Policies, the referral can be made to someone other than a physician, including another non-objecting health care professional (such as a nurse practitioner) or an agency charged with facilitating referrals for patients. It is also noteworthy that the referral can be made by a staff member who is not a physician. As I have noted, the individual appellants and other objecting physicians regard providing an effective referral as complicity in the procedure itself and, therefore, sinful. However, not all of the individual appellants object to having a staff member provide the referral.

(3) The Fresh Evidence

[28] The appellants and the College each brought an application to submit fresh evidence on the appeal and each consented to the admissibility of the fresh evidence of the other. I would exercise the court's discretion to admit all the fresh evidence on appeal.

[29] Some of the appellants' fresh evidence is directed to what they contend was an erroneous assumption of the Divisional Court that objecting physicians could avoid conflicts between their religious beliefs and their obligations under the Policies by changing their practices to other specialties or sub-specialties,

with little or no burden. They contend that the evidence suggests that the process of changing one's practice is, in fact, time-consuming, costly and risky. They argue that the Divisional Court's mistaken assumption resulted in a flawed s. 1 analysis.

[30] The appellants' fresh evidence is also directed to showing that patients can access MAiD through Ontario's Care Coordination Service (the "CCS") and that the publicly-accessible "Telehealth" service in Ontario can provide access to information and referral for MAiD and for other services such as abortion, contraception and other reproductive health services.

[31] In May 2017, Ontario established the CCS to assist patients and clinicians in accessing information and support for MAiD and other end-of-life options, including palliative care and hospice care. At the time the applications were heard by the Divisional Court, the CCS had just been announced. At that time, it was only accessible by physicians. That model has since been replaced by a direct access system that does not require a physician to make a referral.

[32] Through the CCS, patients and their caregivers can be connected with a physician or nurse practitioner who can conduct an assessment of whether a patient's condition meets the eligibility requirements for MAiD and, if appropriate, can provide MAiD and related services. Physicians or nurse practitioners who are

unwilling or unable to provide MAiD can also contact the CCS to refer their patients to medical personnel who can provide such services.

[33] Telehealth provides a free, confidential, telephone-accessed service, in both French and English, and with translation support for some other languages, for health advice and information on a 24 hours per day, 7 days per week basis. A registered nurse will discuss the caller's health issues in order to assess the caller's health concerns and give advice. The nurse will not diagnose the condition or prescribe medication. The nurse will direct the caller to the most appropriate level of care and may put the caller in contact with a health care professional who can advise the caller concerning treatment.

[34] The College's fresh evidence is directed toward two issues. First, to establish that physicians may be able to change their "scope of practice", to practice in areas that do not raise moral and ethical issues, without the need for re-certification. Second, to establish through first-hand patient accounts, the hardship and risks encountered by patients whose physicians refuse to provide an effective referral and the inadequacy and inaccessibility of internet or telephone resources to meet the needs of certain patients.

[35] I shall refer to the fresh evidence in more detail when I turn to the s. 1 analysis.

C. THE DIVISIONAL COURT'S REASONS

[36] To put the issues in context, I will summarize the reasons of the Divisional Court. I will refer to those reasons in more detail, where necessary, in the Analysis section, below.

[37] The Divisional Court considered several preliminary issues before addressing the constitutionality of the Policies. First, it rejected the appellants' submission that the Policies are *ultra vires* the College. This issue is not being pursued in this court. Second, it found that the framework articulated in *Oakes* applied to the s. 1 analysis, rejecting the College's submission that the framework articulated in *Doré v. Barreau du Québec*, 2012 SCC 12, [2012] 1 S.C.R. 395, and *Loyola High School v. Quebec (Attorney General)*, 2015 SCC 12, [2015] 1 S.C.R. 613, applied. The core issue was the constitutionality of the provisions in policies of general application, rather than the decisions to put those policies in place. Third, the Divisional Court found that correctness was the applicable standard for the review of the constitutionality of the Policies.

[38] Turning to the constitutional issues, the Divisional Court found that the effective referral requirements of the Policies infringe the individual appellants' s. 2(a) religious freedom. It rejected the College's argument that there is no infringement because the burden of compliance with the Policies is "trivial or insubstantial". The Divisional Court found that while the suggestions listed in the

Fact Sheet address the concerns of many religious physicians, they do not address the concerns of all the individual appellants. Therefore, the Divisional Court held that the Policies infringe physicians' freedom of religion because the effect of the Policies is that at least some individual appellants are not free to practice medicine in accordance with their religious beliefs.

[39] Having found an infringement of s. 2(a) on the basis of freedom of religion, the court found it unnecessary to consider the appellants' alternative submission based on freedom of conscience.

[40] The appellants also argued that the Policies infringe their s. 15(1) equality rights because they impose a burden on religious physicians that is not imposed on other physicians. Applying the two-part test set out in *Kahkewistahaw First Nation v. Taypotat*, 2015 SCC 30, [2015] 2 S.C.R. 548, the Divisional Court held that even if the effective referral requirements created a distinction between religious physicians and all other physicians, the appellants had failed to demonstrate that the Policies imposed a burden or denied a benefit "in a manner that has the effect of reinforcing, perpetuating or exacerbating their disadvantage."

[41] Having found an infringement of s. 2(a), the Divisional Court considered whether the infringement is justified under s. 1. It found that the effective referral requirements of the Policies constitute limits "prescribed by law", in accordance

with the standard set out in *Greater Vancouver Transportation Authority v. Canadian Federation of Students – British Columbia Component*, 2009 SCC 31, [2009] 2 S.C.R. 295, at paras. 64-65, for binding policies of general application enacted by regulatory entities.

[42] Turning to the first branch of the *Oakes* analysis, the Divisional Court found that the objective of the effective referral requirements of the Policies – which it defined as facilitating equitable access for patients to health care services – is sufficiently pressing and substantial to warrant overriding the individual appellants' religious freedom. Applying *Harper v. Canada (Attorney General)*, 2004 SCC 33, [2004] 1 S.C.R. 827, the Divisional Court found that, while there was no direct evidence that access to health care is a problem caused by physicians' religious objections to providing care, the Policies address a "reasoned apprehension of harm", namely deprivation of equitable access to health care, particularly for vulnerable populations, in the absence of effective referral. The Divisional Court found that the evidence in the record established this risk of deprivation.

[43] The Divisional Court found that the effective referral requirements are rationally connected to the goal of equitable access to health care services. It accepted the College's evidence about the important role played by family physicians as "gatekeepers" in the public health care system, particularly in

regions where patients do not have meaningful choices about their primary health care provider. It found, at para. 159, that:

> [P]atients may lack the resources, financial or otherwise, or may not be healthy enough to access the services they seek without the benefit of a physician referral. In many cases, a patient requires his or her physician to act as the patient's "navigator" through the health care system and advocate on their behalf once the patient has expressed his or her healthcare needs and decided upon his or her desired treatment.

[44] The Divisional Court found that some patients, particularly more vulnerable patients, would be deprived of equitable access to health care in the absence of the Policies' effective referral requirements. Thus, there is a rational connection between the objective of the requirements and the means of achieving the objective, because it is reasonable to conclude that the effective referral requirements will facilitate patient access to care, based on physicians' "gatekeeper" function.

[45] With respect to the minimal impairment branch of the *Oakes* analysis, the Divisional Court considered the affidavit evidence of a manager in the College's policy department, which outlined the College's consideration of several alternative models and the reasons why those models had been rejected. The court found that the alternative means proposed by the appellants did not meet the objectives of the College in a real and substantial manner. Each proposal relied on a "self-referral" model, which had been rejected by the College, and the

alternatives were not directed towards the objective of the requirements. The Divisional Court found that “none of these alternative models represents a less drastic means of achieving the objective of the Policies in a real and substantial manner and, therefore, that the rights of the Individual Applicants are impaired no more than necessary.”

[46] The court also rejected the appellants’ argument that the Policies are not minimally impairing because other jurisdictions in Canada do not require objecting physicians to make an effective referral. While other provincial health care regulators may have developed policies less impairing of freedom of religion, the test is whether the provision falls within a range of reasonable alternatives. The legislator is entitled to some leeway. Nevertheless, the Divisional Court found that regulations in a number of other Canadian jurisdictions impose referral requirements similar to those adopted by the College. It found that the effective referral requirements satisfy the *Oakes* minimal impairment test because they fall within a range of reasonable alternatives to address the conscientious and religious objections of physicians.

[47] In the final branch of the *Oakes* analysis, the Divisional Court concluded that the impact of the effective referral requirements on objecting physicians is proportionate.

[48] The Divisional Court noted three contextual considerations relevant to the balancing. First, s. 7 of the *Charter* "confers a right to equitable access to such medical services as are legally available in Ontario and provided under the provincial healthcare system." Second, physicians have no right to practice medicine, let alone a constitutionally-protected right. Third, physicians in Ontario practice in a single-payer, publicly-funded health care system, which is structured around patient-centered care. Physicians have a duty not to abandon patients. In the event of a conflict, the interests of patients come first.

[49] The Divisional Court found that the salutary effects of the Policies ensured equitable access to health care by: preventing a delay in access to medical services; preventing loss of eligibility or denial of care for desired services; and preventing the stigma or emotional distress associated with a physician's denial of the request for medical services.

[50] While compliance with the Policies could have deleterious effects for some physicians, they were not without alternatives. For those physicians whose religious objections could not be addressed by the options identified in the Fact Sheet, the physicians could change the nature of their practice to a specialty or sub-specialty that did not engage the same moral and ethical issues. Given the options available to comply with the Policies, the potential for a conflict between a physician's religious beliefs and the Policies, and any resulting psychological concern, results from a conscious choice of the physician to practice in

circumstances in which such a conflict could arise. The deleterious effects of the Policies, while not trivial, are less serious than outright exclusion from the practice of medicine.

[51] In balancing the salutary and deleterious effects of the Policies, the Divisional Court concluded that "it is reasonable to expect on the evidence and logic that an 'effective referral' requirement will make a positive difference in ensuring access to healthcare, and in particular equitable access to healthcare, in circumstances in which a physician objects on religious or conscientious grounds to the provision of medical services requested by a patient." Particularly for vulnerable individuals, the "self-referral" model proposed by the appellants, would interfere with the ability of such individuals to access the health care services they seek.

[52] In balancing the public benefit against the costs in the context outlined above, the Divisional Court found that "to the extent there remains any conflict between patient rights and physician rights that cannot be reconciled within the Policies, the former must govern."

D. THE PARTIES' SUBMISSIONS

[53] The appellants' core submission is that the Policies impose an unnecessary and therefore unreasonable limit on their religious freedom. They submit that requiring a direct, individualized referral is unnecessary, because

reasonable alternatives can achieve the same result, while respecting their freedom of religion. Providing readily-available, generalized health care information and a referral to the CCS, Telehealth or other informational resources strikes a reasonable balance between religious freedom and equitable patient access to health care.

[54] The appellants submit that the Divisional Court erred in its s. 1 analysis, because: (1) there is no rational connection between the Policies and the objective of promoting equitable access to health care; (2) mandatory, individualized referral does not satisfy the minimal impairment branch of the proportionality analysis and does not fall within a range of reasonable alternatives; and (3) the Divisional Court's balancing of the salutary and deleterious effects of the Policies was flawed by its erroneous assumption that objecting physicians can insulate themselves from the conflict with their religious beliefs by changing their specialty or sub-specialty. The appellants also submit that the Divisional Court erred in its s. 15(1) analysis.

[55] The College contends that: (1) the Divisional Court should have applied the reasonableness standard of review and the framework articulated in *Doré/Loyola* rather than *Oakes*; (2) the Divisional Court erred in finding a s. 2(a) breach, because any interference with the appellants' freedom of religion is "trivial and insubstantial" in light of the availability of practice management alternatives set out in the Fact Sheet; and (3) alternatively, if there is a s. 2(a) breach, regardless

of whether the *Doré/Loyola* or *Oakes* framework applies, any potential interference with freedom of religion is justified under s. 1. The College also says that the Divisional Court correctly found there was no s. 15(1) breach.

[56] I will discuss the submissions of the parties and the interveners further in the Analysis section, below.

E. ISSUES

[57] The appeal raises the following issues:

(1) What is the applicable standard of review and is the *Doré/Loyola* framework or the *Oakes* framework applicable to this case?

(2) Do the effective referral requirements of the Policies infringe the appellants' s. 2(a) freedom of conscience and religion?

(3) Do the effective referral requirements of the Policies infringe the appellants' s. 15(1) equality rights?

(4) If there is an infringement of the appellants' *Charter* rights and/or freedoms, is it justified under s. 1 of the *Charter*?

F. ANALYSIS

(1) Standard of Review and the Framework for Analysis

[58] The appellants agree with the Divisional Court's conclusion that the standard of review to be applied to the Policies was correctness and that *Oakes* provided the applicable framework for analysis. The College disagrees on both points, submitting that the constitutional review of a policy articulating standards

of conduct for members of a profession should be conducted under a reasonableness standard and the *Doré/Loyola* framework.

[59] The normal rules of appellate review of lower court decisions, articulated in *Housen v. Nikolaisen*, 2002 SCC 33, [2002] 2 S.C.R. 235, apply on this appeal. Questions of law are reviewed on a correctness standard, and questions of fact and mixed fact and law are reviewed on a standard of palpable and overriding error: *Housen*, at paras. 8, 10, 36-37. The Divisional Court's selection and application of the correctness standard to the Policies is a question of law and is accordingly reviewed by this court on a correctness standard.

[60] Ordinarily, this court would be called upon to determine whether the Divisional Court chose the correct standard of review and applied it properly: *Agraira v. Canada (Public Safety and Emergency Preparedness)*, 2013 SCC 36, [2013] 2 S.C.R. 559, at paras. 45-47; *Dr. Q v. College of Physicians and Surgeons of British Columbia*, 2003 SCC 19, [2003] 1 S.C.R. 226, at para. 43; and *College of Physicians and Surgeons of Ontario v. Peirovy*, 2018 ONCA 420, 143 O.R. (3d) 596, at para. 52. However, the parties agree that the outcome of this appeal is unaffected by the choice of standard of review and framework for analysis, because the purpose of both frameworks is to determine whether the Policies unreasonably limit the appellants' *Charter* rights or freedoms: *Doré*, at para. 6. Accordingly, I would leave for another day the question of which standard of review and framework ought to be applied in these circumstances.

For the purposes of these reasons, I simply apply the standard and framework chosen by the Divisional Court, which formed the basis of the parties' submissions on appeal. Nevertheless, like the Divisional Court, I would reach the same result applying a reasonableness standard and the *Doré/Loyola* framework.

(2) Section 2(a): Freedom of Conscience and Religion

[61] Section 2(a) of the *Charter* provides:

> Everyone has the following fundamental freedoms:
>
> (a) freedom of conscience and religion

Interference with freedom of religion

[62] In *Law Society of British Columbia v. Trinity Western University*, 2018 SCC 32, [2018] 2 S.C.R. 293, at para. 62, the Supreme Court adopted the definition of religious freedom expressed in *R. v. Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295, at p. 336:

> [T]he right to entertain such religious beliefs as a person chooses, the right to declare religious beliefs openly and without fear of hindrance or reprisal, and the right to manifest religious belief by worship and practice or by teaching and dissemination.

[63] At para. 63, the court set out the requirements of the test:

> [F]irst, that he or she sincerely believes in a practice or belief that has a nexus with religion; and second, that the impugned state conduct interferes, in a manner that

> is more than trivial or insubstantial, with his or her ability to act in accordance with that practice or belief.

This was the test applied by the Divisional Court, referring to *Syndicat Northcrest v. Amselem*, 2004 SCC 47, [2004] 2 S.C.R. 551, at para. 56. See also *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37, [2009] 2 S.C.R. 567, at para. 32.

[64] The sincerity of belief and interference are conceded. But the College contends that the interference is trivial and insubstantial and does not contravene s. 2(a).

[65] I disagree. To explain my reasons, it is necessary to examine the appellants' beliefs and their objections to performing or referring patients for the procedures at issue.

<u>The role of religion in the appellants' lives and the impact of their religious beliefs</u>

[66] While the individual appellants' objections are not uniform, they all have a sincere religious belief that human life is sacred, that abortion and MAiD are sinful, and that complicity in either practice, in the manner required by the Policies, is equally sinful.

[67] The individual appellants' religious faith is central to their identities and their religious beliefs are sincerely held. As one, Dr. Michelle Korvemaker, put it, "[m]y faith is the most important part of my life. It defines who I am, what I do and how I do it. I practice medicine first as a Christian."

[68] The individual appellants gave similar evidence concerning the nexus between their religious beliefs and their objections to providing medical services that are contrary to their beliefs in the sanctity of human life. For them, providing a patient with an effective referral to a physician who provides MAiD or an abortion would be the same as performing the medical procedures themselves. It would make them complicit and would be sinful.

[69] Some of the individual appellants deposed that their religious beliefs would preclude them from prescribing or providing some or all contraceptives, which they regard as morally wrong, and that referring patients for such methods of family planning would also be morally wrong.

[70] The appellants' objections that compliance with the Policies would make them complicit in moral wrong is supported by the evidence of expert theologians and ethicists who deposed that the act of referral is a form of direct cooperation in the act which makes the physician complicit. As one, Dr. Daniel Sulmasy, put it, for a religious physician, "[r]eferral is not just a morally neutral get-together."

[71] As noted above, the appellants object to a range of medical procedures and pharmaceuticals. The evidence also demonstrates that individual physicians have different levels of tolerance for the steps required to connect a patient with an alternative provider of the services or pharmaceuticals. In their written submissions, the appellants stated that all of the members of the appellant

organizations would be comfortable providing a patient with the phone number for Telehealth. This appears to be a retreat from the evidence in the Divisional Court, which suggested that at least some appellants would regard this as complicity. In oral argument, counsel for the appellants stated that they would also be comfortable with providing patients with the phone number for the CCS. This, too, appears to be a retreat from the evidence that some of the appellants would not be comfortable with providing the phone number for the CCS to patients. The appellants also submit that the wording of the Policies could be made "*Charter* compliant" through the addition of an option for an objecting physician to connect the patient with "a resource" as an alternative to providing an effective referral as currently defined by the Policies.

Is the interference trivial or insubstantial?

[72] The College submits that there is no *Charter* infringement because the interference with the appellants' freedom of religion is no more than "trivial or insubstantial".

[73] As I have noted, the Divisional Court rejected this submission, finding that having regard to the significance of the appellants' religious beliefs, the burdens and costs of complying with the Policies, viewed objectively, could not be characterized as "trivial or insubstantial." After a lengthy analysis of this issue,

and of the means of complying with the Policies, Wilton-Siegel J. concluded, at para. 114:

> Based on the foregoing, and given the significance of the religious beliefs in question to the Individual Applicants, I therefore find that the burden or cost to the Individual Applicants associated with compliance with the Policies cannot be characterized as "trivial or insubstantial". The effect of the Policies is that at least some of the Individual Applicants are not free to practice medicine in accordance with their religious beliefs or their conscience.

[74] The College submits that this was an error. It submits that in delineating the scope of the freedom, the Divisional Court conflated the two branches of the s. 2(a) test articulated in *Amselem and Multani v. Commission scolaire Marguerite-Bourgeoys*, 2006 SCC 6, [2006] 1 S.C.R. 256, by failing to consider the context in which the freedom is being invoked by the appellants. It points to three contextual features that the Divisional Court allegedly failed to consider: (1) the Policies do not relate to the conduct of the appellants in their personal sphere, but rather as members of a highly-regulated profession operating in a multicultural and diverse society; (2) the Policies relate to access to health care services in a single-payer system where family physicians act as gatekeepers and navigators for patients, care is patient-centered and patient autonomy is respected; and (3) the right to practice medicine is a privilege, which imposes overriding duties and responsibilities on physicians to put the needs of their patients before their own. The College contends that while physicians are free to

subscribe to their beliefs, the freedom to hold beliefs is broader than the freedom to act on them.

[75] The interveners, the Canadian HIV/AIDS Legal Network et al., support this submission, adding that in the context of a public health care system, the expression of the appellants' religious freedom creates a real risk of injury to the physical and mental integrity of already vulnerable and marginalized patients.

[76] In advancing this submission, both the College and some of the interveners point to comments of the Supreme Court that the scope of freedom of religion is internally limited. For example, in *Trinity Western University v. College of Teachers*, 2001 SCC 31, [2001] 1 S.C.R. 772, at para. 36, the court stated that "[t]he freedom to hold beliefs is broader than the freedom to act on them." See also para. 62 of *Amselem*, where the court stated: "Conduct which would potentially cause harm to or interference with the rights of others would not automatically be protected".

[77] In my view, the Divisional Court correctly determined that the contextual features identified by the College are more appropriately considered under the s. 1 analysis, rather than in delineating the scope of the claimed religious freedom. While it is true that s. 2(a) is internally limited, that not all religious conduct is protected by the *Charter*, and that context is important in considering whether interference with religious freedom is "trivial or insubstantial", the specific

contextual features identified by the College are more relevant to the proportionality analysis under s. 1. As noted above, the Divisional Court concluded that at least some of the individual appellants are not free to practice medicine in accordance with their religious beliefs as a result of the effective referral requirements. That interference is not rendered "trivial or insubstantial" simply because physicians practice in a "regulated profession that holds patient-centred care as a core value". However, that context is important when considering whether the effective referral requirements are minimally impairing, and when balancing the salutary and deleterious effects of the requirements. Accordingly, the contextual features identified by the College are considered under the s. 1 analysis, below.

[78] The College also submits that the cost or burden imposed by the Policies on objecting physicians is, at its highest, a minor practice management issue. It only requires administrative changes to the physician's practice, such as using a designate, or hiring support staff. The College suggests that even sole practitioners, a group identified by the Divisional Court as particularly affected by the Policies, "need only implement a system to triage specific patient requests, such as having a staff member connect patients with appropriate care providers or agencies, or partnering with another practitioner or clinic." Physicians operating in rural or remote regions, who cannot partner with a non-objecting physician, may discharge their responsibilities by connecting the patient to a

social service agency. What the Policies require is a personal and good faith effort to ensure that the patient is connected to the service they are seeking. In the College's view, this burden constitutes a trivial or insubstantial interference.

[79] The findings of the Divisional Court on this issue are supported by the record, in which some of the appellants depose that their religious beliefs would preclude them from giving a referral to another physician for MAiD, abortion or certain reproductive procedures and that they would be compelled to abandon their practice area rather than face prosecution for failing to do so. In my view, the Divisional Court correctly concluded that the interference with the appellants' freedom of religion is neither trivial nor insubstantial.

Freedom of conscience

[80] Having found that the Policies infringe the individual appellants' freedom of religion, the Divisional Court declined to rule on the appellants' alternative argument that the effective referral requirements also infringe the appellants' freedom of conscience. The appellants briefly addressed this issue in oral submissions.

[81] The interveners, the OMA and the CCRL et al., assert that the Divisional Court ought to have addressed the freedom of conscience issue and urge this court to do so.

[82] It has been held that freedom of conscience and religion should be "broadly construed to extend to conscientiously-held beliefs, whether grounded in religion or in a secular morality": see *R. v. Morgentaler*, [1988] 1 S.C.R. 30, at p. 179. The scope of freedom of conscience may be broader than freedom of religion, extending to the protection of strongly-held moral and ethical beliefs that are not necessarily founded in religion: *Roach v. Canada (Minister of State for Multiculturalism and Culture)* (1994), 113 D.L.R. (4th) 67 (F.C.A.), at p. 82.

[83] The OMA submits that the Policies apply to physicians who object to the Policies for reasons of conscience and that the court should engage in a thorough analysis of this issue in order to give guidance to the medical profession.

[84] The CCRL et al. submit that the effective referral requirements violate physicians' "preservative freedom of conscience" – the freedom not to do what is perceived to be wrong. Forcing them to participate in perceived wrongdoing is an assault on their human dignity and deprives them of meaningful choice. They submit that this case affords an opportunity to give definition and scope to freedom of conscience, and to incorporate freedom of conscience principles into the *Oakes* analysis.

[85] The evidentiary record in this case is insufficient to support an analysis of freedom of conscience. To the extent the individual appellants raise issues of

conscience, they are inextricably grounded in their religious beliefs. There is an insufficient basis on which to determine whether there are Ontario physicians who would regard the effective referral of patients as equivalent to participating in the medical services at issue and who would object to doing so on the basis of conscience. I find that, at its core, the appellants' claim is grounded in freedom of religion. This is reflected in the factual record and in the way the case was litigated in the Divisional Court. There is an insufficient basis to determine whether the options proposed by the College would meet the concerns of physicians with conscience-based objections and, if not, how the cost or burden on those physicians is to be weighed in the proportionality analysis. It is not appropriate to explore the contours of freedom of conscience in a case that does not have a robust evidentiary record. Like the Divisional Court, given my conclusion that the Policies infringe the appellants' s. 2(a) religious freedom, I find it unnecessary to consider the appellants' alternative argument that the Policies infringe the appellants' s. 2(a) freedom of conscience.

(3) Section 15(1)

[86] Section 15(1) of the *Charter* provides:

> Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

[87] The Divisional Court referred to the two-part test for establishing a breach of s. 15(1) articulated in *Taypotat*, at paras. 19-20: (1) whether, on its face or in its impact, a law creates a distinction on the basis of an enumerated or analogous ground; and (2) whether the impugned law fails to respond to the actual capacities and needs of the members of the group and instead imposes burdens or denies benefits in a manner that has the effect of reinforcing, perpetuating or exacerbating their disadvantage.

[88] The focus of the inquiry is "whether a distinction has the effect of perpetuating arbitrary disadvantage on the claimant because of his or her membership in an enumerated or analogous group" such that it is a "discriminatory distinction": *Taypotat*, at paras. 16, 18; and *Quebec (Attorney General) v. A.*, 2013 SCC 5, [2013] 1 S.C.R. 61, at para. 331.

[89] Applying this test, the Divisional Court dismissed the appellants' claim that the Policies infringe their equality rights under s. 15(1) of the *Charter*. Without deciding whether the Policies create a distinction on the basis of religion, the Divisional Court held that the Policies do not have the effect of reinforcing, perpetuating or exacerbating a disadvantage or promoting prejudice against religious physicians. Nor do they restrict access to a fundamental social institution or impede full membership in Canadian society.

[90] The appellants renewed their s. 15(1) submissions in their factum but did not address this issue in oral argument. Their written submissions were supported by the EFC et al. They say that the Policies draw a distinction between physicians who are religious and those who are not, and impose a burden on religious physicians that will force them to give up the practice of medicine involving direct patient contact rather than sacrifice their religious beliefs. The Policies force them to do so because of their religious beliefs and are, therefore, discriminatory in their effect.

[91] The EFC et al. submit that the Divisional Court erred in finding that the second branch of the *Taypotat* test was not met. They submit that the inquiry under the second branch is whether the impugned Policies have a discriminatory effect. When looking at the effects, it must be considered "whether the distinction restricts access to a fundamental social institution, or affects 'a basic aspect of full membership in Canadian society'." They contend that employment is one such fundamental institution.

[92] The College submits that the Divisional Court correctly found that the Policies do not infringe the appellants' s. 15(1) equality rights. It says there was no evidence establishing a differential impact on religious physicians because the Policies apply to all conscientious objectors – regardless of whether the source of their objection is religious or secular.

[93] On the second branch of the test, the College submits that the appellants have failed to show that any distinctive treatment that may be imposed by the Policies is discriminatory in nature.

[94] I would not give effect to the appellants' submissions, largely for the reasons given by the Divisional Court at paras. 128-31. As the Divisional Court stated, the Policies represent an attempt to balance equitable access to health care with physicians' religious beliefs. The Policies, as clarified by the Fact Sheet, provide an appropriate balance for many physicians. Physicians who do not regard the procedures set out in the Fact Sheet as acceptable can transition to other areas of medicine in which these issues of faith or conscience are less likely to arise, if at all.

[95] This takes me to the central issues in this appeal: whether the limits on the appellants' religious freedom can be justified under s. 1 of the *Charter*.

(4) Section 1: The Justification Analysis

[96] Section 1 of the *Charter* provides:

> The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

[97] The onus at this stage is on the College to establish, on a balance of probabilities, that the infringement of the appellants' freedom of religion is a

reasonable limit, demonstrably justified in a free and democratic society: *Multani*, at para. 43.

[98] In *Oakes*, at pp. 135 and 138-39, Dickson C.J. articulated a framework for the s. 1 analysis, which can be summarized as follows:

> (a) the *Charter*-infringing measure must be "prescribed by law";
>
> (b) the objective of the impugned measure must be of sufficient importance to warrant overriding a constitutionally protected right or freedom;
>
> (c) the means chosen must be reasonable and demonstrably justified – this is a "form of proportionality test" which will vary in the circumstances, but requires a balancing of the interests of society with the interests of individuals and groups and has three components:
>
> (i) the measure must be rationally connected to the objective – i.e., carefully designed to achieve the objective and not arbitrary, unfair or based on irrational considerations;
>
> (ii) the means chosen should impair the *Charter* right or freedom as little as possible; and
>
> (iii) there must be proportionality between the salutary and deleterious effects of the measure.

(a) Prescribed by Law

[99] As noted above, s. 1 requires that limits to *Charter* rights and freedoms must be "prescribed by law". The Policies were enacted by the College pursuant to its authority under the *RHPA*. The Divisional Court, citing *Greater Vancouver Transportation Authority*, held, at para. 137, that the *Charter* may apply to

activities of a regulatory entity such as the College to the extent that its activities can be said to be governmental in nature. In particular, where a government policy is "authorized by statute and sets out a general norm or standard that is meant to be binding and is sufficiently accessible and precise, the policy is legislative in nature and constitutes a limit that is 'prescribed by law'" for the purpose of the *Oakes* analysis. The parties do not dispute that this principle applies to the exercise of the College's statutory mandate and that the effective referral requirements of the Policies are limits "prescribed by law".

(b) Pressing and Substantial Objective

[100] It must be established that the objective of the effective referral requirements is sufficiently important to warrant limiting a constitutional right or freedom: see *Multani*, at para. 43; and *Oakes*, at p. 138. This requires the identification of the purpose of the requirements.

[101] The Divisional Court identified the purpose as "the facilitation of equitable [patient] access to [health care] services." This appears to be an amalgam of the purpose identified by the appellants ("ensuring access to health care") and by the College ("the protection of the public, the prevention of harm to patients, and the facilitation of access to care for patients in our multi-cultural and multi-faith society").

[102] The Divisional Court gave context to its description of the purpose of the effective referral requirements, by characterizing physicians as “gatekeepers” in a publicly-funded health care system, with duties not to abandon their patients and to put their patients’ interests ahead of their own. The court said, at para. 146:

> As the CPSO notes, underlying this purpose [of the facilitation of patient access to health care] is the context of a publically funded health care system and a patient-centered environment. In this environment, physicians perform a positive role for their patients as “gatekeepers” to health care services and are subject to the obligation of non-abandonment, as well as the obligation to put the interests of their patient ahead of their own. It is entirely consistent with this environment and these obligations that the Policies seek to ensure that the religious and conscientious objections of physicians do not become a barrier to health care for patients who seek healthcare services to which particular physicians may object.

[103] LEAF submits that the importance of promoting women’s equality rights by facilitating equal access to health care should also be considered in determining whether the objective of the effective referral requirements is pressing and substantial.

[104] Although initially the appellants did not strenuously challenge the Divisional Court’s statement of the purpose of the effective referral requirements, their supplementary factum adopts an argument of the intervener, the JCCF, that the stated purpose of the effective referral requirements is imprecise and too broad,

distorting the minimal impairment and balancing stages of the *Oakes* analysis and immunizing the Policies from meaningful scrutiny. Neither the appellants nor the JCCF propose an alternative formulation of the purpose of the requirements.

[105] The College contends that the Divisional Court did not err and the objective articulated is neither overbroad nor imprecise.

[106] In my view, the Divisional Court did not err in articulating the purpose of the effective referral requirements. The Divisional Court struck an appropriate balance in identifying a purpose that is more specific than the "animating social value" of the Policies, but broader than a "virtual repetition" of the effective referral requirements: see *R. v. Moriarity*, 2015 SCC 55, [2015] 3 S.C.R. 485, at para. 28. The purpose identified is firmly rooted in both the language of the Policies and the history and evolution of the Policies themselves.

[107] The Divisional Court also found, at paras. 142, 146-150, that this purpose was a pressing and substantial objective for the purpose of the *Oakes* analysis and, at para. 150, that, "the evidence in the record establishes a real risk of a deprivation of equitable access to health care, particularly on the part of the more vulnerable members of our society, in the absence of the effective referral requirements of the Policies."

[108] The appellants concede that it was open to the Divisional Court to rely on a reasoned apprehension of harm to find that the Policies serve a pressing and

substantial objective. However, they submit that a reasoned apprehension of harm cannot be relied on in the last two branches of the *Oakes* proportionality analysis. They say that evidence of actual harm is required for the minimal impairment and proportionality analyses. This submission is addressed below.

(c) Proportionality

[109] The third requirement of the *Oakes* analysis is that the means chosen to limit the right or freedom in question must be reasonable and demonstrably justified. As noted, this requires an analysis of whether: (1) there is a rational connection between the means and the objective; (2) the means are minimally impairing; and (3) there is proportionality between the salutary and deleterious effects of the measure: *Oakes*, at p. 139; and *Carter*, at para. 94.

(i) Rational Connection

[110] The first step in the proportionality analysis asks whether the means limiting the *Charter* right or freedom are rationally connected to the objective. That is, whether they are designed to further the objective. They must not be arbitrary, unfair or based on irrational considerations: *Oakes*, at p. 139.

[111] The College must show, by reason and logic, and on a balance of probabilities, that the restriction on the *Charter* right or freedom serves its intended purpose: *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3

S.C.R. 199, at para. 153. This prevents arbitrary interference with the right or freedom: *Hutterian Brethren*, at para. 48.

[112] The Divisional Court found a rational connection between the effective referral requirements and the stated purpose. The limits on physicians' religious freedom would likely further the goal of equitable access to health care. At para. 154, the Divisional Court stated:

> In this case, the effective referral provisions of the Policies guide physicians on how to uphold their professional and ethical obligations of patient-centered care and non-abandonment within the context of the public healthcare system in the Province. It is reasonable to conclude that, in doing so, the Policies will facilitate patient access to care, based on the "gatekeeper" function of physicians in Ontario. As such, there is a rational connection between the objective of the Policies and the means of achieving that objective.

[113] I agree with the Divisional Court that, as a matter of logic and common sense, requiring objecting physicians to give an effective referral for MAiD, abortion or reproductive health care services will promote equitable patient access to those health care services.

(ii) Minimal Impairment

[114] At this step in the analysis, the College is required to show that the Policies impair freedom of religion as little as reasonably possible in order to achieve their objective: *RJR-MacDonald*, at para. 160. As the Supreme Court observed in *Hutterian Brethren*, at para. 53, this question asks "whether there are less

harmful means of achieving the legislative goal." The appellants say that there are less harmful means, namely a "generalized information" model and the means employed in other jurisdictions.

Evidence of harm

[115] Relying on the Supreme Court's decision in *Multani*, the appellants submit that a reasoned apprehension of harm is not sufficient to justify an impugned measure at this stage of the *Oakes* analysis. They contend that evidence of actual harm is required and that the College did not meet this evidentiary burden.

[116] The College submits that "actual harm" is not required. The same evidentiary standard applies for every branch of the *Oakes* analysis, including the minimal impairment and proportionality branches and the Divisional Court correctly found that there was sufficient evidence at each stage to support its conclusions. There was evidence that, in the absence of the Policies, vulnerable patients would experience harm due to interference or delay in accessing care, shame and stigma associated with a physician's refusal to provide care, and loss of faith in physicians and in the health care system. These circumstances could result in complete denial of care in some cases.

[117] The issue of harm must be considered in context.

[118] The record confirms the pivotal role of family physicians, such as the appellants, as the key point of access to the services at issue for the majority of

patients. This is highlighted in the supplementary affidavit of Dr. Danielle Martin, filed by the College. Dr. Martin is the Vice President of Medical Affairs and Health Systems Solutions at Women's College Hospital in Toronto. She is herself certified as a family physician and is a Fellow of the College of Family Physicians of Canada. She deposed as follows:

> The reality of health care in Ontario outside hospitals is that patients are deeply reliant on their family physicians to connect them with the resources they need, and the way in which that connection occurs is through a referral. This is especially true in moments of medical and emotional vulnerability, such as the end of life and in the case of an unwanted pregnancy.

[119] Dr. Martin also deposed that:

> This includes rural communities and cultural/ethnic neighbourhoods with unilingual community members, where patients do not have meaningful choices about their primary care provider, and they cannot access specialty care through other channels.
>
> …
>
> In most communities citizens do not have direct access to multiple different specialists for second and third opinions; they rely on their family physicians to refer them to a specialist whose scope of practice meets their needs, and specialists refer to one another on the same basis.

[120] The evidence also bears out Dr. Martin's observations that, given the manner in which health care is currently practiced and made available in Ontario, effective referral is the key to accessing health care services of all kinds,

including the wide variety of services to which some physicians have religious objections.

[121] The medical procedures to which the appellants object (an objection shared to varying degrees by the individual appellants and members of the appellant organizations) include: abortion, contraception (including emergency contraception, tubal ligation, and vasectomies), infertility treatment for heterosexual and homosexual patients, prescription of erectile dysfunction medication, gender re-assignment surgery, and MAiD. It is impossible to conceive of more private, emotional or challenging issues for any patient. The evidence establishes that these issues are difficult for patients to raise and to discuss, even with a trusted family physician. The evidence also establishes that some of these decisions frequently confront already vulnerable patients: patients with financial, social, educational or emotional challenges; patients who are old, young, poor or addicted to drugs; patients with mental health challenges or physical or intellectual disabilities; patients facing economic, linguistic, cultural or geographic barriers; and patients who do not have the skills, abilities or resources to navigate their own way through a vast and complicated health care system.

[122] The evidence also establishes that decisions concerning many of these procedures are time-sensitive – obviously so in the case of MAiD, abortion and

emergency contraception. Delay in accessing these procedures can prevent access to them altogether.

[123] Abortion and MAiD carry the stigmatizing legacy of several centuries of criminalization grounded in religious and secular morality. The evidence discloses that this stigmatization is still evident in some quarters of the medical community and that it can serve, unintentionally or not, as an obstacle, or an outright barrier to these procedures.

[124] The vulnerable patients I have described above, seeking MAiD, abortion, contraception and other aspects of sexual health care, turn to their family physicians for advice, care and, if necessary, medical treatment or intervention. Given the importance of family physicians as "gatekeepers" and "patient navigators" in the health care system, there is compelling evidence that patients will suffer harm in the absence of an effective referral.

[125] I do not agree that *Multani* supports the appellants' argument that "actual harm" must be demonstrated. Justice Charron, who spoke for the majority, did not require that harm itself be conclusively established. What she said, at para. 67, was: "I agree that it is not necessary to wait for harm to be done before acting, but the existence of concerns relating to safety must be unequivocally established for the infringement of a constitutional right to be justified" (emphasis added). In this case, concerns relating to the safety of vulnerable patients as a

result of deprivation of access to health care services were, and have been, conclusively established. The next issue is whether those concerns could have been addressed by less impairing means.

Less impairing means

[126] In the Divisional Court, the appellants asserted that there were less impairing means of achieving the objective of the effective referral requirements. These included maintaining a public information line for information regarding particular procedures or pharmaceuticals to which physicians object, and requiring physicians to provide information to patients about how to access abortion and contraception and establishing a coordination service or registry for MAiD, as was ultimately done through the CCS. They also pointed to policies of regulators in other provinces, which they claimed were less impairing because they do not require objecting physicians to provide a direct, individualized referral. I will discuss the latter argument in the next section.

[127] The Divisional Court carefully examined the College's evidence concerning its studies and consultations preceding the adoption of the Policies. These included an analysis of alternatives, including variants of the "self-referral" model advocated by the appellants. The Divisional Court found, at para. 167, that, "none of these alternative models represents a less drastic means of achieving the objective of the Policies in a real and substantial manner and, therefore, that

the rights of the Individual Applicants are impaired no more than necessary." That finding of fact attracts deference in this court.

[128] After conducting a detailed review of the evidence regarding the College's Working Groups on both the Human Rights Policy and the MAiD Policy, Wilton-Siegel J. concluded, at para. 170, that the "self-referral" model "inevitably entails a real risk that vulnerable individuals and populations will not be able to access the requested medical services or will not be able to do so in a timely manner." He added that, in any event, there was evidence that the "self-referral" model would not satisfy some of the individual appellants. He stated, at para. 170:

> [I]n my view, these reasons also amply justify the CPSO's conclusion that the Applicants' specific proposals for alternative means to ensure a patient's access to requested medical services would not be effective. As discussed further below, each of the Applicants' proposals relies on a "self-referral" model which inevitably entails a real risk that vulnerable individuals and populations will not be able to access the requested medical services or will not be able to do so in a timely manner. In fact, while the Applicants argue that a physician's obligation should be limited to providing information to patients regarding access to health care services, the Individual Applicants do not hold the same views regarding a satisfactory informational requirement. Several of the Individual Applicants would object to the provision of information regarding the telephone number and address of non-objecting physicians, other health care providers or agencies including the Care Co-ordination Service. Further, while the Care Co-ordination Service described above has recently been established in accordance with the requirement under Bill C-14, the Applicants testified that referral of a patient to the Service would entail the

> same concerns for many religious physicians as referral to a non-objecting physician. Attaching these limitations to alternatives based on the "self-referral" model reinforces the fact that such model does not point to a "significantly less intrusive and equally effective measure" for ensuring access to healthcare.

[129] He also noted, at para. 171, that the appellants' proposals were designed to preserve their rights, and were not directed – as they should have been – to promoting the objective of equitable access to health care:

> Thirdly, as a related matter, while the Applicants have proposed alternative means of addressing the infringement of their rights of freedom of religion, they have not done so on a basis that is directed toward preserving patients' *Charter* rights of equitable access to health care, that is, with a view to furthering the objective of the Policies. As discussed below, the Applicants do not acknowledge that the issues in these proceedings engage any *Charter* rights of patients. Accordingly, the objective of the alternatives proposed by the Applicants is the preservation of the *Charter* rights of religious physicians to the extent necessary to avoid participation in the services to which they object. The significance for present purposes, where the issue is whether the means chosen impair the right no more than is necessary to achieve the objective of patient access to health care, and in particular the objective of equitable access to health care, is that the Applicants have failed to establish that their proposed alternatives are directed toward this objective, much less that such objective could be achieved on the basis of less impairing means.

[130] I have quoted these extracts from the Divisional Court's reasons at some length because they include findings of fact that are firmly rooted in the evidence.

The appellants have not demonstrated any error in these findings. In my view, they are fatal to the appellants' submissions on the issue of minimal impairment.

[131] As I have noted, the appellants advance what they now call a "generalized information" model as a less impairing alternative, which they claim meets the College's objective. They acknowledge, however, that "generalized information" is essentially a different label for what they described as "self-referral" in the Divisional Court, and which the Divisional Court rejected. This model would permit physicians to provide patients with information concerning resources, such as the CCS or Telehealth, to enable patients to locate a non-objecting physician who would provide abortion, MAiD, or other services. They say this is a reasonable and less drastic alternative to an effective referral.

[132] The College argues that the appellants' "generalized information" model is flawed because it does not respond to the realities of the vulnerable patient population and will not achieve the objective of equitable access to health care. The "generalized information" model places the burden on the patient to self-refer to find a physician who will provide the health care they seek. As discussed earlier, this may result in delay in obtaining time-sensitive medical services or it may foreclose access to care altogether. One can reasonably anticipate that the loss of the personal support of a trusted physician would leave the patient with feelings of rejection, shame and stigma. Left to their own devices when he or she

most needs personal support and advice, the patient would be left to negotiate the health system armed with brochures, telephone numbers and websites.

[133] The issue of shame and stigma is not theoretical. One of the individual appellants was asked on cross-examination what she would do if a patient came to her office seeking an abortion. The physician in question has a sign posted in her office telling patients that she will not refer for abortions or assist in obtaining an abortion, and will not assist with other "'medical' practices" such as MAiD, because she "cannot in good conscience" assist patients with those services. Nevertheless, she stated that if a patient sought an abortion she would ask why the patient was interested in abortion and whether there was anything that could help the patient carry the baby to term. She would also discuss the "very obvious implications" of an abortion, including that "the baby dies" and that there might be some "psychiatric issues" after an abortion. Finally, she might refer the patient to a resource that offered counselling, but not one that would provide an abortion. By using this example, I do not suggest that the physician was unsympathetic to the circumstances of the hypothetical patient. What I do suggest is that the physician's views could reasonably be expected to have a deterrent and stigmatizing effect on that patient, impeding her access to the medical services she had requested.

[134] The College contends that there is no evidence in the record that supports the appellants' position that Telehealth functions as a "patient navigator" or

actually connects patients with the service they are seeking, particularly the services at issue in this proceeding. Moreover, the appellants' proposal does not account for the Divisional Court's finding of fact that at least some objecting physicians would refuse to provide patients with "generalized information" on the grounds that it would make them complicit in the acts.

[135] The College's position is supported by the interveners, Dying with Dignity Canada, the Canadian HIV/AIDS Legal Network et al., and LEAF. These interveners highlighted the needs and vulnerabilities of the patients they serve, their dependence on their health care providers and their need for a direct, personal and effective referral to a health care professional in the event of a religious or conscientious objection by their physician.

[136] Dying with Dignity Canada notes that communication itself is a significant barrier for many patients seeking MAiD. Those patients are entitled to access MAiD in a manner that protects their privacy rights. They rely on the confidential and personal assistance of their physicians to make the necessary contacts with a medical service for MAiD. Some may not have friends, family or caregivers who will help connect them with a clinician or the CCS. Some may not wish to involve others in their care decisions. Expecting patients who qualify for MAiD to navigate themselves through the medical system is unrealistic in many cases.

[137] Dying with Dignity Canada also notes that delay is a significant practical concern for patients seeking MAiD. If a patient loses capacity to consent, they are no longer eligible for MAiD. Once a patient is connected to a willing clinician, the process for actually obtaining MAiD can take time. By placing the onus on patients to contact the CCS or Telehealth, the appellants' model increases the possibility of front-end delay in accessing MAiD.

[138] The vulnerability of patients seeking MAiD is self-evident, but it is firmly established in the evidentiary record. Dr. Kevin Imrie is a physician at Sunnybrook Health Sciences Centre in Toronto, who gave evidence on behalf of the College. Dr. Imrie observed that when patients meet the criteria for MAiD they are necessarily vulnerable physically and psychologically. They are also exceptionally dependent on their health care providers. At the time his affidavit was sworn, Dr. Imrie had participated in three cases of MAiD. He deposed that,

> Patients who find themselves in the position of seeking MAiD are often in the most vulnerable of positions, are very sick, and facing all of the physical, mental and emotional burdens and trauma associated with facing the end of their lives. During such a time, they are enormously dependent upon their doctors and the health care system for what quality of life they do have.

[139] Similarly, Dr. Edward Weiss, a family physician and the contact person for MAiD for the William Osler Health System in Brampton and Etobicoke, deposed that at least seven patients whom he had seen for MAiD in the previous year

would not have easily, or perhaps not at all, been able to access the CCS without the assistance of a health care professional.

[140] The interveners, the Canadian HIV/AIDS Legal Network et al., point out that patients living with HIV/AIDS face stigmatization and discrimination related to their health care needs. The same is true of transgender patients who encounter challenges in accessing appropriate health care, hormonal treatments and transition-related services. These barriers add to the challenges of patients with HIV/AIDS or transgender patients in accessing MAiD and other health care services and accentuate the need for direct and personal referrals.

[141] The appellants' own evidence illustrates these challenges. One of the individual appellants described how she had responded to a transgendered patient who sought assistance in transitioning. She explained her religious convictions to the patient: "I believe that God has created us male and female, and that choosing to change your gender is working against how God has made you. And ultimately when people change their gender they think that life is going to be better but there's a high suicide rate when people change their gender." The physician referred the patient to a psychiatrist for "gender dysphoria". Again, I do not doubt the physician's sincerity or her dedication to her patient. Her evidence demonstrates, however, how physicians' religious objections can be a barrier to access to health care for marginalized groups. Such remarks could reasonably be expected to cause the patient stigma and shame.

[142] LEAF submits that many women, particularly women from marginalized communities, may lack the necessary knowledge of the health care system, skills, or resources to seek out and obtain reproductive health services independently. The inability to access appropriate reproductive health care can result in unwanted pregnancies, psychological stress and increased risk of morbidity. LEAF submits that due to historic inequalities in accessing the medical system, many women are dependent on physician approval in order to access reproductive services. For these women, an effective referral from their primary health care provider may be the only channel to access the care they need.

[143] LEAF's submission is supported by the evidence, which establishes that access to abortion and contraception continues to be "uneven" in Canada, in the words of Dr. Martin, and that the invocation of conscientious and religious objections by physicians impedes access to abortion, contraception and other reproductive medical procedures and pharmaceuticals.

[144] Dr. Sheila Dunn is the Research Director of the Family Practice Health Centre of Women's College Hospital and an active member of the clinical staff. She spent approximately 13 years as the Medical Director of the Bay Centre for Birth Control in Toronto, a clinic that offers comprehensive sexual and reproductive health care to women, including contraception, abortion, treatment, testing, information, counselling and referral for other sexual health services.

[145] Dr. Dunn's evidence demonstrates that issues of reproductive health are particularly impactful for new immigrants, youth, Indigenous women, women in remote or rural communities and people with limited economic means. Many of these patients are reluctant to raise issues of sexual and reproductive health on their own – as a result, they have higher rates of unmet needs for contraception, unintended pregnancy and abortion.

[146] The evidence underscores the impact of a physician's refusal to provide such services for religious reasons. Dr. Barbara Bean is a counsellor at the Choice in Health Clinic, a non-profit abortion clinic in Toronto. She has over 45 years' experience in the reproductive health field and has counselled thousands of women. Dr. Bean spoke to the impact on patients of their physicians' religious and moral beliefs, including delay, trauma, shame and self-doubt:

> I estimate that hundreds of these women came to us having suffered delays in finding us after first contacting their family physicians or others in the health care sector seeking information about, and possibly a referral for, abortion services. In many cases, women would tell me that not only would their doctors not refer them or help them find care, but their doctors would voice their own personal feelings and religious or moral objections to abortion when the patients raised the issue with them. In other cases, the reasons for the doctors failing to assist their patients were not necessarily tied to religious or moral reasons.
>
> …[Patients whose physicians refused to provide assistance in accessing abortions] felt traumatized and actively denigrated by their physicians' denial of assistance. Their doctors' lack of support and lack of

> empathy in refusing to provide a referral for abortion care caused them to doubt their decisions to seek abortions, and to feel shame and guilt about their decisions. They deeply felt their doctors' lack of respect for them and their choices.

[147] In my view, the appellants' fresh evidence fails to demonstrate that a "generalized information" model, providing patients with information about the CCS, Telehealth or other similar resources, would address the needs of vulnerable patients seeking the most intimate and urgent medical advice and care. Ultimately, the College considered and rejected "self-referral" models like the model proposed by the appellants. Based on the College's evidence, the Divisional Court found that "self-referral" models could not achieve the objective of ensuring equitable access to health care given the inevitable risk to vulnerable patients that such models entail. That finding remains uncontroverted.

[148] I turn now to the appellants' submission that the policies adopted in other jurisdictions provide models that would be reasonable and less impairing alternatives to the Policies.

Policies in other jurisdictions

[149] The appellants, supported by the interveners, B'nai Brith et al., submit that in the face of less impairing and equally effective means adopted in other jurisdictions, the College was required to prove that these alternatives were not a suitable option. They rely on the following passage from para. 160 of *RJR-Macdonald*: "if the government fails to explain why a significantly less intrusive

and equally effective measure was not chosen, the law may fail." The appellants say that objectives of policies in place in other jurisdictions which adopt alternative means are substantially similar to the objective being advanced by the College and thus represent "significantly less intrusive and equally effective measures".

[150] The College disagrees with the appellants' reliance on policies in other jurisdictions as a matter of law and fact. It submits that the Divisional Court correctly found that other Canadian medical regulators have substantially similar requirements to those imposed by the Policies. They point in particular to the policies in place in Saskatchewan, Quebec and Nova Scotia. For example, the policy in Nova Scotia requires that the physician complete an "effective transfer of care". Counsel for the appellants acknowledged that this requirement is similar to the Policies and that it could well be unacceptable to some religious physicians.

[151] In any event, the College submits that case law governing minimal impairment accounts for the fact that different provinces may draw the line at different places. The fact that some provinces may have done so does not establish that the College's chosen means are not minimally impairing.

[152] The law does not require that the College choose the least intrusive or the least restrictive means, but only that the means chosen fall within a range of

reasonable alternatives, while limiting the *Charter* right or freedom as little as reasonably possible: *Gordon v. Canada (Attorney General)*, 2016 ONCA 625, 351 O.A.C. 44, at para. 261, leave to appeal to S.C.C. refused, [2016] S.C.C.A. No. 444 and [2016] S.C.C.A. No. 445, citing *R. v. Swain*, [1991] 1 S.C.R. 933, at p. 983.

[153] The fact that other jurisdictions have established policies that the appellants regard as less impairing is not persuasive. As the Divisional Court noted, the parties did not agree on the manner in which those policies operate. Some of the policies can be interpreted to mean that, in some cases, a physician may be required to give an effective referral to ensure that a patient receives the medical services he or she requests or requires. There was also evidence to support the Divisional Court's conclusion referred to above that regulations in a number of other Canadian jurisdictions impose referral requirements similar to those adopted by the College.

[154] The College was not bound to accept the "lowest common denominator", whether it is labelled "self-referral" or "generalized information", when it found, through its own studies, that that model would not protect patients. I agree with the observation of the Divisional Court, at para. 174, citing to *Irwin Toy Ltd. v. Quebec (Attorney General)*, [1989] 1 S.C.R. 927, at p. 999, that legislative action to protect vulnerable groups is not "necessarily restricted to the least common denominator of actions taken elsewhere" and that minimal impairment does not

"require legislatures to choose the least ambitious means to protect vulnerable groups."

[155] A measure of deference is owed to the College's policy judgment regarding how best to balance the competing interests of physicians and their patients. The Policies represent a difficult policy choice, one which the College, as a self-governing professional body with institutional expertise in developing policies and procedures governing the practice of medicine, was in a better position to make than a court: *M. v. H.*, [1999] 2 S.C.R. 3, at paras. 78-79; and *Green v. Law Society of Manitoba*, 2017 SCC 20, [2017] 1 S.C.R. 360, at para. 25. The College was uniquely qualified to craft the Policies in a manner sensitive to the conditions of the practice of medicine in Ontario: *Trinity Western*, at para. 37. Courts must be cautious not to overstep the bounds of their institutional competence in reviewing such decisions. Often, as in this case, the proper course of judicial conduct is to afford a measure of deference to the College's judgment: *Wynberg v. Ontario* (2006), 82 O.R. (3d) 561 (C.A.), at para. 184, leave to appeal to S.C.C. refused, [2006] S.C.C.A. No. 441; and *Carter*, at paras. 97-98.

[156] There is more, however. The fundamental problem with the appellants' proposed alternative model is the same as identified by the majority of the Supreme Court in *Hutterian Brethren*. The Hutterian claimants objected to having their photographs taken, which the province required in order to hold a driver's licence. The province, which was concerned about the misuse of drivers' licences

for identity theft, proposed that those who objected on religious grounds could have their photographs held in a central photo bank. The claimants proposed instead that their licences could be stamped, “Not to be used for identification purposes”. The Supreme Court observed, at paras. 57-60, that the deficiency in the claimants’ proposal was that it compromised the province’s objective of minimizing the risk of misuse of drivers’ licences for identify theft. The proposal, “instead of asking what is minimally required to realize the legislative goal, asks the government to significantly compromise it”: *Hutterian Brethren*, at para. 60. Accordingly, the alternative proposed by the Hutterian claimants was not appropriate for consideration at the minimal impairment stage of the analysis.

[157] The same is true here. The alternatives proposed by the appellants and some of the interveners are directed to minimizing the burden of the Policies on objecting physicians, not to advancing the goal of equitable access to abortion, MAiD, contraception and sexual and reproductive health care. The appellants’ alternatives would compromise the College’s goal, because they would require already vulnerable patients to attempt to navigate the health care system on their own, without any direct personal assistance from their physicians, whom they entrust to act as their navigators for health care services. This would impair equitable access to health care.

[158] At para. 177 of his reasons, Wilton-Siegel J. concluded:

> [T]he Policies fall within the range of reasonable alternatives for addressing physicians' conscientious and religious objections to particular medical procedures and pharmaceuticals given the objective of the effective referral requirements of the Policies. As such, I find that the effective referral requirements of the Policies satisfy the minimal impairment test under *Oakes*.

[159] That conclusion was supported by the evidence before the Divisional Court. It is confirmed by the College's fresh evidence before this court.

Conclusion on minimal impairment

[160] On the basis of the evidence before the Divisional Court, the findings of the Divisional Court, the fresh evidence adduced in this court and the submissions of the parties and the interveners, I am satisfied that the alternatives identified by the appellants are fatally flawed. While arguably less impairing of their rights, they are focused on their rights and not on the objective of the effective referral requirements or the interests of vulnerable patients. The evidence shows that the appellants' "generalized information" model, like other "self-referral" models, will impair equitable access to health care rather than promote it. It will impair equitable access to health care because it will enable objecting physicians to abandon their role as patient navigators without an appropriate transfer of the patient to another physician or service. In view of the vulnerability of the patients, this is just not adequate. I will not repeat the Divisional Court's reasons at para. 171, cited earlier, but they are equally apt here.

[161] I am also satisfied that if something more than a reasoned apprehension of harm is required at this stage of the analysis, the College has proven that harm will, in fact, occur to vulnerable groups in the absence of the effective referral requirements. Ultimately, I am satisfied that the College, before this court and the Divisional Court, discharged its onus of proving that the effective referral requirements are minimally impairing of the appellants' religious freedom.

(iii) Balancing the Salutary and Deleterious Effects

[162] The final requirement of the *Oakes* proportionality analysis is that "there must be a proportionality between the effects of the measures which are responsible for limiting the *Charter* right or freedom, and the objective which has been identified as of 'sufficient importance'": *Oakes*, at p. 139. At para. 73 of *Hutterian Brethren*, McLachlin C.J. articulated the question as being: "are the overall effects of the law on the claimants disproportionate to the government's objective?" At para. 76, she explained the utility of this stage of the *Oakes* analysis:

> It may be questioned how a law which has passed the rigours of the first three stages of the proportionality analysis — pressing goal, rational connection, and minimum impairment — could fail at the final inquiry of proportionality of effects. The answer lies in the fact that the first three stages of *Oakes* are anchored in an assessment of the law's purpose. Only the fourth branch takes full account of the "severity of the deleterious effects of a measure on individuals or groups".

[163] She observed, at para. 85, that the proponent of the measures is not required to produce positive proof that the measure will be beneficial and that it is enough to show by reason and evidence that it will be.

Salutary and deleterious effects

[164] Prior to engaging in the balancing process, the Divisional Court identified the salutary and deleterious effects of the effective referral requirements of the Policies. I have mentioned these above. In broad overview, the requirements enhance equitable access to MAiD, abortion and other services and reduce or eliminate barriers, delays, anxiety and stigmatization of vulnerable patients in circumstances in which their physicians object to the services on grounds of religion or conscience.

[165] The deleterious effects of the requirements for objecting physicians are the burden and anxiety associated with a choice between their deeply-held religious beliefs and complicity in acts which they regard as sinful. For some objecting physicians, but not all, the options set out in the Fact Sheet are not compatible with their beliefs and they are faced with the additional burdens of choosing between leaving the field of medicine in which they practice, leaving Ontario to practice elsewhere, or leaving the practice of medicine altogether.

Balancing

[166] The Divisional Court noted that three contextual considerations are relevant to the proportionality analysis. First, the right of patients to equitable access to lawful and provincially-funded health care services engages a s. 7 *Charter* right of patients. This observation signals that in the proportionality analysis, the court must consider not only the *Charter* rights and freedoms of objecting physicians, but also the interests of patients.

[167] Second, the Divisional Court observed that physicians have no right to practice medicine, let alone a constitutionally-protected right to do so. Third, it noted that Ontario physicians practice in a single-payer, publicly-funded health care system, which is structured around patient-centered care. In the case of a conflict, the interests of patients come first, and physicians have a duty not to abandon their patients.

[168] Turning to the balancing, the Divisional Court noted the evidence that the goals of the Policies will be compromised if patients are simply given information and then expected to access services themselves.

[169] The Divisional Court described the costs or burdens on objecting physicians. It noted that for many Ontario physicians, referral of a patient for the procedures at issue does not raise religious or ethical concerns. The concerns of others with religious objections, including some of the individual appellants, can

be addressed by the options in the Fact Sheet. This is particularly the case for physicians who practice in a hospital, a clinic or a family practice group. Thus, the effective referral requirements are primarily a concern for those who do not practice in such a setting or those who find the options unacceptable. The principal, and perhaps the only, means of addressing these concerns would be to focus their practice in a specialty or sub-specialty that would not present circumstances in which the Policies would require an effective referral of patients in respect of medical services to which they object. While this is not a trivial impact, it permits an objecting physician to continue to practice medicine and is less serious than outright exclusion from practice.

[170] The Divisional Court concluded that "to the extent there remains any conflict between patient rights and physician rights that cannot be reconciled within the Policies, the former must govern."

[171] The appellants make two objections to the Divisional Court's proportionality analysis.

[172] First, they submit that in order for a *Charter* violation to be found to be proportionate, there must be actual evidence of the salutary effects flowing from the means chosen. In this case, they say that there is no evidence that the Policies will have any salutary effect. Far from improving access to health care, they say, the Policies will force physicians like the appellants to leave family

practice, move to other practice areas, leave Canada, or even cease practicing medicine altogether. They say that the Policies will harm, not help, the public.

[173] Second, the appellants challenge the Divisional Court's conclusion that objecting physicians could change the nature of their practice so as to avoid coming into contact with issues addressed by the Policies.

[174] Turning to the first point, I have already reviewed much of the evidence, which was accepted by the Divisional Court and which supports its conclusion at para. 186, that:

> [I]t is reasonable to expect on the evidence and logic that an "effective referral" requirement will make a positive difference in ensuring access to healthcare, and in particular equitable access to healthcare, in circumstances in which a physician objects on religious or conscientious grounds to the provision of medical services requested by a patient.

[175] The individual appellants themselves gave evidence that they cannot take steps which make them complicit in the provision of services to which they object. The evidence of the College was that the Policies were necessary to provide equitable access to health care.

[176] The Divisional Court concluded based on the evidence before it that it was not in a position to evaluate the impact on health care and patients due to physicians leaving family practice or the practice of medicine in Ontario. The appellants have not adduced evidence before this court to undermine that

conclusion. Accordingly, it remains unclear whether such a response to the Policies either has occurred or is likely to occur in any meaningful ways.

[177] The second issue relates to the burden on physicians of changing their practice. Much of the fresh evidence was directed to this issue. The appellants take the position that the burden imposed on objecting physicians amounts to a bar from practicing direct patient care. They submit that the fresh evidence shows that while it is theoretically possible for a physician to change specialty or sub-specialty, there are significant practical challenges in doing so.

[178] They further submit that in addition to the deleterious effects on the physicians, the overall effect of the Policies is reduced access to health care for patients due to physicians leaving Ontario, leaving the practice of medicine, or entering a retraining program.

[179] The position of the appellants is supported by the OMA. The OMA submits that the Divisional Court's balancing of the salutary and deleterious effects was not based on an appropriate evidentiary record. It submits that the balancing must be revisited in light of the fresh evidence regarding the practical difficulties of changing a physician's specialty or scope of practice. Those difficulties include the limited number of retraining positions available, the duration of retraining, family considerations, financial constraints, and uncertainty about new practice opportunities.

[180] The EFC et al. submit that the Policies assume that religious accommodation would only have deleterious effects and overlook the salutary effects for the "greater public good" associated with accommodating religious minorities in the medical profession.

[181] On the issue of the cost or burden imposed by the Policies, the appellants rely on the fresh evidence of Dr. Parveen Wasi, the Associate Dean, Postgraduate Medical Education, at the Faculty of Health Sciences at McMaster University in Hamilton. Dr. Wasi explains how Ontario's Re-Entry Program works in practice, what the consequences are for working physicians, and the associated costs and risks to a physician who applies to that program. He explains that re-entry applicants face hurdles, including "a high demand for positions from recent graduates, funding constraints, internal university priorities, and overall uncertainty about acceptance." Not only is it difficult to be admitted to the re-entry program, there are financial and other burdens associated with going through a residency program, which range in length from two to seven years.

[182] The appellants also rely on the evidence of Dr. Nuala Kenny, Emeritus Professor at Dalhousie University and Founding Chair of the Department of Bioethics. Dr. Kenny comments on the costs and burdens for physicians who might be expected to change the nature of their practice to a "safe specialty". She opines that "there is no way for physicians involved in direct patient care to be protected from a request for an effective referral."

[183] The College submits that, at its highest, the impact of the Policies is minimal and the burden or cost imposed does not require a physician to change their speciality or sub-speciality. The burden is one of practice management and can be addressed through administrative measures such as implementing a system to triage specific patient requests, partnering with another non-objecting physician, or hiring support staff. Physicians who cannot implement such measures have the option to change the scope of their practice, an action which does not require retraining.

[184] The College relies on the evidence of Dr. William McCauley, a Medical Advisor at the College, who states that a change in speciality or sub-specialty is not the only option for physicians. He makes the point that physicians may be able to change or narrow their “scope of practice” without engaging in specialist retraining through formal residency. He points to the following areas as areas of medicine in which physicians are unlikely to encounter requests for referrals for MAiD or reproductive health concerns, and which may not require specialty retraining or certification: sleep medicine, hair restoration, sport and exercise medicine, hernia repair, skin disorders for general practitioners, obesity medicine, aviation examinations, travel medicine, and practice as a medical officer of health. He also points to other roles in which a physician would be shielded from patient requests for referrals, such as administrative medicine or surgical assistance.

[185] In resolving the balancing exercise, I find much assistance in the submissions of the intervener, Dying with Dignity Canada, which observes that in balancing the salutary effects of the Policies against the deleterious effects on objecting physicians, it was appropriate for the College and the Divisional Court to conclude that patients should not bear the burden of managing the consequences of physicians' religious objections. It bears noting that the "compromise" arrived at by the College is not optimal for patients, who must accept being referred for MAiD if their physician objects to the procedure. As Dying with Dignity Canada notes, the burden imposed by the Policies is minimal and is acceptable for some of the appellants and for many other physicians. But, as it said:

> If a doctor is unwilling to take the less onerous step of structuring their practice in a manner that ensures that their personal views do not stand in the way of their patients' rights to dignity, autonomy, privacy and security of the person, then the more onerous requirement of a transfer into a new specialty is a reasonable burden for that doctor to bear.

[186] The Fact Sheet identifies options that are clearly acceptable to many objecting physicians. Those who do not find them acceptable may be able to find other practice structures that will insulate them from participation in actions to which they object. If they cannot do so, they will have to seek out other ways in which to use their skills, training and commitment to patient care. I do not underestimate the individual sacrifices this may require. The Divisional Court

correctly found, however, that the burden of these sacrifices did not outweigh the harm to vulnerable patients that would be caused by any reasonable alternative. That conclusion is not undermined by the fresh evidence before this court. Even taking the burden imposed on physicians at its most onerous, as framed by the appellants, the salutary effects of the Policies still outweigh the deleterious effects.

[187] As the Divisional Court observed, the appellants have no common law, proprietary or constitutional right to practice medicine. As members of a regulated and publicly-funded profession, they are subject to requirements that focus on the public interest, rather than their interests. In fact, the fiduciary nature of the physician-patient relationship requires physicians to act at all times in their patients' best interests, and to avoid conflicts between their own interests and their patients' interests: College of Physicians and Surgeons of Ontario, *The Practice Guide* (Toronto: CPSO, September 2007), at pp. 4-5, 7; *McInerney v. MacDonald*, [1992] 2 S.C.R. 138, at p. 149; and *Norberg v. Wynrib*, [1992] 2 S.C.R. 226, at pp. 270-72, 274. The practice of a profession devoted to service of the public necessarily gives rise to moral and ethical choices. The issues raised in this proceeding present difficult choices for religious physicians who object to the Policies, but they do have choices. While the solution is not a perfect one for some physicians, such as the individual appellants, it is not a perfect one for their patients either. They will lose the personal support of their physicians at a time

when they are most vulnerable. Ordinarily, where a conflict arises between a physician's interest and a patient's interest, the interest of the patient prevails. The default expectation is that the physician is to personally provide their patient with all clinically appropriate services or to provide a formal referral. Patients expect that their physicians will do so. However, the Policies do not require this. They represent a compromise. They strike a reasonable balance between patients' interests and physicians' *Charter*-protected religious freedom. In short, they are reasonable limits prescribed by law that are demonstrably justified in a free and democratic society.

G. CONCLUSION

[188] For these reasons, I would dismiss the appeal. Costs may be addressed by written submissions in the event they have not been resolved.

Released: "G.R.S." MAY 15 2019

"George R. Strathy C.J.O."
"I agree. S.E. Pepall J.A."
"I agree. Fairburn J.A."