CITATION: The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario, 2018 ONSC 579
DIVISIONAL COURT FILE NO.: 499/16 / 500/16
DATE: 20180131

ONTARIO

SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

Wilton-Siegel, Lococo, Matheson JJ.

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	*Albertos Polizogopoulos*, for the Applicants
Applicants	
– and –	
College of Physicians and Surgeons of Ontario	*Vicki White, Lisa Brownstone* and *Ruth Ainsworth*, for the 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	*Josh Hunter* and *Emily Bala,* for the Intervenor, Attorney General of Ontario *Jay Cameron*, for the Intervenor, Justice Centre for Constitutional Freedoms *Derek Ross* and *Deina Warren*, for the Intervenors, Christian Legal Fellowship, The Evangelical Fellowship of Canada and The Assembly of Catholic Bishops of Ontario *Laura Freitag*, for the Intervenors, Catholic Civil Rights League, Faith and Freedom Alliance and Protection of Conscience Project
Intervenors	*Rahool Agarwal* and *Kate Findlay*, for the

) Intervenor, Canadian Civil Liberties
) Association
)
) *Kelly Doctor* and *Cynthia Petersen*, for the
) Intervenor, Dying with Dignity Canada
)
) *Gregory Sidlofksy* and *Brendan Donovan*,
) for the Intervenor, B'nai Brith of Canada
) League for Human Rights
)
) *Michael Fenrick, Khalid JaMohamed* and
) *Denise Cooney*, for the Intervenors,
) Canadian HIV/AIDS Legal Network, HIV &
) AIDS Legal Clinic Ontario and Canadian
) Professional Association for Transgender
) Health
)
)
) **HEARD** at Toronto: June 12, 13 and 14, 2017

WILTON-SIEGEL J.

[1] In these two proceedings, the applicants challenge the constitutional validity of two policies of the College of Physicians and Surgeons of Ontario (the "CPSO") that require physicians who are unwilling to provide elements of care on moral or religious grounds to provide a patient requesting such care with an effective referral to another health care provider. The applicants submit that these provisions, and another provision dealing with the provision of emergency care, infringe sections 2(a) and 15 of the *Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982*, 1982, c. 11 (U.K.) (the "*Charter*") and are not saved by section 1 of the *Charter*.

The Parties

[2] The individual applicants, Dr. Michelle Korvemaker, Dr. Betty-Ann Story, Dr. Isabel Nunes, Dr. Agnes Tanguay and Dr. Donato Gugliotta (collectively, the "Individual Applicants"), are physicians licensed by the CPSO to practice medicine in Ontario.

[3] The Christian Medical and Dental Society of Canada ("CMDS") is a national inter-denominational association of Christian doctors and dentists. It has 578 active members in Ontario, 42 of whom are medical students. Each of the Individual Applicants is a member of the CMDS.

[4] The Canadian Federation of Catholic Physicians' Societies ("CFCPS") is a national association of Catholic physicians' guilds, associations and societies, four of which are in Ontario. It has no individual members.

[5] Canadian Physicians for Life ("CPL") is a national association of pro-life physicians, retired physicians, medical residents and students. CPL has approximately 1,000 members in Ontario. CMDS, CFCPS and CPL are herein collectively referred to as the "Institutional Applicants". The Individual Applicants, together with the Institutional Applicants, are herein collectively referred to as the "Applicants".

[6] The CPSO is the self-governing body for the medical profession in Ontario. The role of the CPSO, its authority and powers are set out in legislation, including the *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18 ("*RHPA*") and the *Health Professions Procedural Code*, being Schedule 2 of the *RHPA* (the "*Code*").

The Intervenors

[7] In addition, eight sets of intervenors were granted leave to intervene in these applications.

[8] The following intervenors support the Applicants and submit that the applications should be granted: (1) the Justice Centre for Constitutional Freedoms; (2) the Catholic Civil Rights League, the Faith and Freedom Alliance and the Protection of Conscience Project; (3) B'nai Brith of Canada League for Human Rights; and (4) The Evangelical Fellowship of Canada, the Assembly of Catholic Bishops of Ontario and Christian Legal Fellowship.

[9] The following intervenors support the CPSO and submit that the applications should be dismissed: (1) the Attorney-General for Ontario ("Ontario"); (2) Dying with Dignity Canada; (3) the Canadian Civil Liberties Association; and (4) the Canadian HIV/AIDS Legal Network, HIV & AIDS Legal Clinic Ontario and the Canadian Professional Association for Transgender Health.

The Challenged Policies

[10] These applications involve a challenge to the constitutionality of certain provisions of two policies of the CPSO – Policy Statement #2-15 entitled *Professional Obligations and Human Rights* (the "Human Rights Policy") and Policy Statement #4-16 entitled *Physician-Assisted Death* (the "Maid Policy") (collectively, the "Policies").

The Human Rights Policy

[11] The Applicants challenge the following provisions of the Human Rights Policy:

> 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.

...

> 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.

In these Reasons for Decision, the former provision is referred to as the "Effective Referral Provision of the Human Rights Policy" and the latter provision is referred to as the "Emergency Provision of the Human Rights Policy" or simply as the "Emergency Provision".

The Maid Policy

[12] The Applicants also challenge the following provision of the Maid Policy (herein, the "Effective Referral Provision of the Maid Policy"):

> 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.

The Effective Referral Provision of the Human Rights Policy and the Effective Referral Provision of the Maid Policy are herein collectively referred to as the "effective referral requirements of the Policies".

Brief History of the Origin of the Policies

[13] The following briefly summarizes the genesis and development of the Policies.

The Human Rights Policy

[14] In 2008, the CPSO adopted the predecessor to the Human Rights Policy – a policy entitled "Physicians and the Ontario Human Rights Code".

[15] This predecessor policy did not include provisions comparable to the Effective Referral Provision of the Human Rights Policy or the Emergency Provision. It did, however, address the expectations of the CPSO for physicians, who, on the basis of moral or religious belief, limited their practice, refused to accept individuals as patients, or ended a physician-patient relationship.

[16] In the summer of 2014, the CPSO commenced a preliminary review of the predecessor policy. For this purpose, it established a working group comprised of three CPSO Council members who were assisted by CPSO staff. In the fall of 2014, the CPSO announced that it intended to review the predecessor policy and commenced a consultation process. In December 2014, the CPSO released a draft policy, which included earlier versions of the Effective Referral Provision of the Human Rights Policy and the Emergency Provision, and commenced a second consultation process.

[17] The draft policy was subsequently revised after the consultation process was completed. The revised draft policy included the text of the Effective Referral Provision of the Human Rights Policy and the Emergency Provision.

[18] In March 2015, the CPSO Council approved the form of the Human Rights Policy, including the Effective Referral Provision of the Human Rights Policy and the Emergency Provision. The Human Rights Policy became effective as of March 20, 2015.

[19] On June 6, 2016, the Executive Committee of the CPSO approved a document entitled "Ensuring Access to Care: Effective Referral" (herein, the "Fact Sheet"). The Fact Sheet provides guidance to physicians regarding what is meant by "effective referral" and, among other things, provides examples of ways in which the CPSO believes physicians can satisfy the effective referral requirements of the Policies.

The Maid Policy

[20] On February 6, 2015, the Supreme Court of Canada released its decision in *Carter v. Canada*, 2015 SCC 5, [2015] 1 S.C.R. 331 striking down portions of the *Criminal Code*, R.S.C., 1985, c. C-46 which prohibited assisted suicide. The Supreme Court noted at para. 132 that what followed was "in the hands of physicians' colleges, Parliament, and the provincial legislatures."

[21] In September 2015, the CPSO established a working group to deal with the developments pertaining to medically-assisted death. In December 2015, the CPSO released a draft document entitled "Interim Guidance on Physician – Assisted Death" (the "Interim Guidance"). The Interim Guidance contained an "effective referral" provision in the same form as the Effective Referral Provision of the Maid Policy when it was subsequently approved. The CPSO also announced an expedited consultation process to produce an interim policy regarding medically-assisted death in light of the timetable imposed on the Government of Canada by the Supreme Court in *Carter* for the enactment of legislation consistent with the decision.

[22] On January 15, 2016, the Supreme Court granted the Government of Canada a four-month extension of the timetable for a legislative response to *Carter* to June 6, 2016.

[23] On January 26, 2016, the CPSO approved the Interim Guidance, including the "effective referral" provision in the same language as the Effective Referral Provision of the Maid Policy.

[24] On or about May 31, 2016, the CPSO adopted Policy #4-16: Physician-Assisted Death (the "PAD Policy") to replace the Interim Guidance. The PAD Policy also contained an "effective referral" provision in the same language as the Effective Referral Provision of the Maid Policy. The PAD Policy was adopted to provide guidance to physicians regarding compliance with the legislative framework established by *Carter*.

[25] On June 6, 2016, the order in *Carter* took effect and the PAD Policy became effective.

[26] On June 17, 2016, Bill C-14, *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, S.C. 2016, c. 3 ("Bill C-14") came into force.

[27] On June 21, 2016, the CPSO adopted the Maid Policy to provide guidance to physicians regarding compliance with the legislative framework established by Bill C-14. The Maid Policy contains the Effective Referral Provision of the Maid Policy at issue in these proceedings.

The Legal Force of the Policies

[28] The Policies have been adopted by the CPSO as policies of general application. The Policies establish broad expectations of physician behaviour and are intended to have normative force. They articulate what the CPSO believes the tenets of medical professionalism require independently of CPSO policy. There is no issue that the *Charter* applies to the Policies.

[29] However, the Policies have not been adopted pursuant to the authority granted to the CPSO under the *RHPA* to enact regulations. Nor are the Policies a "code, standard or guideline relating to standards of practice of the profession" adopted pursuant to section 95(1.1) of the *Code* of which compliance is required pursuant to such provision. Accordingly, non-compliance with the Policies is not a specific act of professional misconduct under the professional misconduct regulation of the CPSO, being *Professional Misconduct*, O. Reg. 856/93. The Policies also do not provide for a penalty for non-compliance with their terms and no mandatory consequences flow from their breach.

[30] This raises the applicability of the Policies in respect of any allegation of professional misconduct involving a breach of a provision of the Policies by a physician. Whether a physician's actions amount to such misconduct would require a determination by the Discipline Committee of the CPSO, having regard to the standards of practice and professionalism. The Policies may be used as evidence of such professional standards, and of the conduct expected of a physician in particular circumstances, in support of an allegation of professional misconduct. However, a physician remains entitled to seek to lead contrary evidence and to argue that failure to adhere to the Policies' guidance did not, on the particular facts, constitute professional misconduct.

The Application of the Effective Referral Requirements of the Policies in Practice

[31] Before proceeding, it is important to add some clarity to the content of the effective referral requirements of the Policies. In this respect, two features of the Policies are significant. 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.

[32] In addition, as mentioned, the CPSO has issued the Fact Sheet to assist physicians in compliance with the effective referral requirements of the Policies. The Fact Sheet lists five means of complying with such requirements.

[33] One of the options contemplates a physician's designate making the arrangements for a patient to see a non-objecting physician. For physicians practising in a hospital, clinic or family practice group, other options are available. These options 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.

[34] I also note, that in the case of medically-assisted death, the Government of Ontario has created a Care Co-ordination Service, accessible by patients as well as physicians, which may also provide a less onerous option to some physicians. The Care Co-ordination Service is, however, in its infancy and does not yet constitute a viable agency alternative across the province. In any event, several of the Individual Applicants testified that referral of a patient to this Service would also contravene their religious beliefs.

Preliminary Issues

[35] Before addressing the constitutional issues raised in the applications, I will describe the procedural history of the applications and then consider a number of preliminary matters.

Procedural History of the Applications

[36] The Applicants have brought two separate proceedings respectively challenging the relevant provisions of the Human Rights Policy and the Maid Policy.

[37] In the first application, under court file #499/16 (the "HR Application"), the Applicants challenge the constitutionality of the Effective Referral Provision of the Human Rights Policy and the Emergency Provisions. This application was brought pursuant to Rules 14.05(2) and 38 of the *Rules of Civil Procedure*, R.R.O. 1990, Reg. 194, not as an application for judicial review. The constitutional challenge is based upon sections 2(a) and 15 of the *Charter*. As originally issued, the Applicants sought various relief, including declarations, prohibition and mandamus.

[38] In the second application, under court file #500/16 (the "Maid Application"), the Applicants seek judicial review, pursuant to the *Judicial Review Procedure Act*, R.S.O. 1990, c. J.1 (the "*JRPA*"), of the decision of the CPSO to enact the Maid Policy. They seek relief similar to that sought in the HR Application, also on the basis that the Effective Referral Provision of the Maid Policy infringes sections 2(a) and 15 of the *Charter*. In these Reasons, the HR Application and the Maid Application are collectively referred to as the "Applications".

[39] The HR Application was commenced in the Superior Court of Ontario on March 20, 2015. The Maid Application was commenced in the Divisional Court of Ontario on June 17, 2017. Pursuant to a consent order dated August 26, 2017 of McLeod J. (the "McLeod Order"), the HR Application was transferred to the Divisional Court and ordered to be heard together with

the Maid Application. The McLeod Order did not, however, expressly convert the HR Application into an application for judicial review.

Jurisdictional Issue

[40] These circumstances raise the issue of the jurisdiction of the Divisional Court to hear the HR Application. The Divisional Court derives its jurisdiction by statute, including in particular pursuant to s. 19 of the *Courts of Justice Act* and s. 6(2) of the *JRPA*. However, s. 16 of the *Courts of Justice Act*, R.S.O. 1990, c. C.43, which would apply to a Rule 14 application, provides that a proceeding in the Superior Court shall be heard and determined by one judge of the Superior Court. Accordingly, it has been suggested that the Divisional Court lacks jurisdiction to hear a Rule 14 application seeking a declaration: see *Ontario (Attorney General) v. Hanif*, 2013 ONSC 6991, [2013] O.J. No. 5269 (Div. Ct). However, s. 7 of the *JRPA* provides that an application for an order in the nature of mandamus, prohibition or certiorari shall be deemed to be an application for judicial review and shall be made, treated and disposed of as if it were an application for judicial review.

[41] By letter dated November 10, 2017, the Court invited any submissions from the parties on the Court's jurisdiction to hear the HR Application. The Court received submissions on this issue from the Applicants, the CPSO and Ontario, as well as from Dying with Dignity Canada in support of the CPSO position.

[42] All of the parties wish this Court to determine the HR Application together with the Maid Application as the most expeditious and least expensive manner of doing so. This would also avoid a multiplicity of proceedings and would further the stated objective of s. 38 of the *Courts of Justice Act*. However, the Court may only decide the issues raised in the HR Application if it has the jurisdiction to do so. The parties cannot confer jurisdiction on this Court by their consent alone. With this background, I turn to the effect of the McLeod Order. I conclude that the Divisional Court has the jurisdiction to hear the HR Application for the following reasons.

[43] In their submissions, the Applicants argue that the effect of the McLeod Order was to confer jurisdiction on the Divisional Court, as the higher of the two courts, pursuant to sections 107 and 138 of the *Courts of Justice Act*. It appears that the Applicants proceeded on this basis in respect of the motion before McLeod J. It also appears that Ontario took the position in its pre-motion correspondence with the Applicants that the effect of the proposed order would be to constitute the HR Application an application for judicial review. However, none of the parties chose to address the legal effect of the proposed consent order before McLeod J. As a result, as mentioned, the McLeod Order did not expressly address the jurisdiction of the Divisional Court to hear the HR Application.

[44] In its submissions to this Court, Ontario argues that the HR Application is, in substance, an application for judicial review and, as such, was brought in the wrong court but was properly transferred to the proper court by of the McLeod Order in the exercise of authority granted by s. 110 of the *Courts of Justice Act*.

[45] I agree with Ontario that the HR Application should be treated as, in substance, an application for judicial review for two reasons.

[46] First, the remedies sought in the HR Application included broad mandatory injunctive relief as well as a prohibition order. As such, s. 7 of the *JRPA* requires that the application be treated as an application for judicial relief. The Applicants have recently amended the HR Application to delete the request for mandatory injunctive relief. However, as the amendment of the HR Application post-dated both the McLeod Order and the hearing of the HR Application, it cannot affect the jurisdiction of this Court in these proceedings.

[47] Second, and more fundamentally, the declaratory and other relief sought in the HR Application pertains to the exercise of the statutory power of the CPSO to enact the HR Policy. Indeed, the Applicants expressly recognized this in the framing of the Maid Application. The Court of Appeal has stated that, except in cases of emergency that are not applicable in the present circumstances, such an application should be brought by way of an application for judicial review: see *J.N. v. Durham (Regional Municipality) Police Service*, 2012 ONCA 428 at paras. 16, 21 and 23.

[48] Given the foregoing, in my view, the HR Application was wrongly commenced in the Superior Court as an application under Rule 14 as it was, at all times, in substance, an application for judicial review and should be treated as such. On this basis, the McLeod Order constituted a transfer of the HR Application to the proper court, being the Divisional Court, pursuant to s. 110 of the *Courts of Justice Act* where it was heard as an application for judicial review.

[49] As noted above, the Applicants argue that the McLeod Order transferred the HR Application to the Divisional Court to be heard as an application under Rule 14. Ontario supports this position to the extent that this Court does not find that the HR Application was in substance an application for judicial review. I agree that a judge of the Superior Court has the authority under s. 107 of the *Courts of Justice Act* to order consolidation notwithstanding that the court to which the proceeding is transferred would not otherwise have jurisdiction to hear the proceeding. This result is a matter of statutory interpretation based, among other things, on the absence of a definition of the term "court" in the *Courts of Justice Act* and the specific identification in the statute of a number of courts, including the Divisional Court. Given this language in the *Courts of Justice Act*, section 107 would appear to grant a judge of the Superior Court the authority to transfer a proceeding to the Divisional Court even if it is not, in substance, an application for judicial review. I do not consider that *Hanif* foreclosed this result given the particular circumstances of that case – in particular, the absence of any remaining administrative remedy – that rendered consolidation inappropriate.

[50] However, given the finding above regarding the operation of s. 110 of the *Courts of Justice Act* in the present circumstances, it is not necessary to rely upon s. 107 to establish the jurisdiction of the Court to hear the HR Application and, accordingly, I decline to do so. I note, however, that, as discussed below, the treatment of the HR Application as an application for judicial review, rather than as a Rule 14 application, has had no effect on the Court's conclusion regarding the framework for analysis, or the standard of review, of the issues presented by the HR Application.

Framework for Analysis and Standard of Review

[51] The parties have proposed different analytical frameworks for consideration of the constitutional issues engaged in the Applications, with related differing views regarding the standard of review.

[52] The Applicants submit that, for both Applications, the analysis should begin with a determination of whether there is a breach of *Charter* rights, as alleged, and then proceed with the application of s. 1 of the *Charter* as set out at paras. 69-70 of *R. v. Oakes*, [1986] 1 S.C.R. 103. They submit that the standard of review is correctness and that there should be no deference to the decision of the CPSO.

[53] Ontario also submits that the appropriate standard of review is correctness and that the *Oakes* framework should be used. However, Ontario also argues that deference should be shown to the manner in which the CPSO decided to strike the balance between the religious beliefs of physicians and the ability of patients to access medical care.

[54] The CPSO acknowledges that the *Charter* applies to the Policies because they implement governmental activities or policies, but submits that the appropriate framework for analysis of the constitutional validity of the Policies is the approach articulated in *Doré v. Barreau du Québec*, 2012 SCC 12, [2012] 1 S.C.R. 395. The CPSO also submits, relying on *Doré*, that the applicable standard of review is reasonableness. This reflects the CPSO position that the constitutional issues presented in the Applications arise in the context of a regulator's discretionary decisions within the CPSO's area of expertise. The CPSO also relies upon *Loyola High School v. Quebec (Attorney General)*, 2015 SCC 12, following *Doré*, which also involved an administrative decision regarding a specific application for relief.

[55] For completeness, the Catholic Civil Rights League, Faith and Freedom Alliance and Protection of Conscience Project urged the Court to adopt a further alternative framework for analysis based on a distinction between preservative freedom and perfective freedom. I am of the view that the proper context in which to consider such approach is the proportionality analysis under s. 1 of the *Charter*. However, in the circumstances of this case, I have not found this distinction to be of assistance in reaching the conclusions below in respect of that issue.

Conclusion Regarding the Framework for Analysis

[56] In my view, the constitutional issues in the Applications should be analyzed using the *Oakes* framework. The rationale for doing so is found in *Dunsmuir v. New Brunswick*, 2008 SCC 9, [2008] 1 S.C.R. 190 and *Doré* itself.

[57] In *Doré*, the Supreme Court noted at para. 2 that the applicant did not challenge the constitutionality of the provision in the *Code of Ethics* under which he was reprimanded but, instead, challenged the adjudicative decision against him. In these circumstances, the Court addressed whether the *Oakes* framework should be used in such a context, as follows:

> This raises squarely the issue of how to protect *Charter* guarantees and the values they reflect <u>in the context of adjudicated administrative decisions</u>. Normally, if a

> discretionary administrative decision is made by an adjudicator within his or her mandate, that decision is judicially reviewed for its reasonableness. The question is whether the presence of a *Charter* issue calls for the replacement of this administrative law framework with the *Oakes* test, the test traditionally used to determine whether the state has justified a law's violation of the *Charter* as a "reasonable limit" under s. 1.
>
> It seems to me to be possible to reconcile the two regimes in a way that protects the integrity of each. The way to do that is to recognize that an adjudicated administrative decision is not like a law which can, theoretically, be objectively justified by the state, making the traditional s. 1 analysis an awkward fit. ... [Emphasis added.]

[58] In contrast, the essence of the issues presented in the Applications is the constitutionality of particular provisions in policies of general application that apply to all physicians in Ontario. The Applications do arise from decisions to put the Policies into place but it is the Policies themselves that are the focus of the *Charter* challenge. Specifically, it is the substantive content of the effective referral requirements of the Policies, and of the Emergency Provision of the Human Rights Policy, that is challenged. The Applications do not involve a review of any present or prospective administrative adjudicative decision. Rather, the issue is whether specific provisions of the Policies have the effect of unduly infringing the *Charter* rights of the Applicants.

[59] In *Doré*, the Supreme Court identified a number of ways in which the *Oakes* analysis fit poorly with the review of an administrative adjudicative decision. The Supreme Court concluded that, when the question was whether an administrative decision-maker had exercised statutory discretion in accordance with the *Charter*, administrative law principles should apply rather than an approach relying upon an *Oakes* analysis with respect to whether a *Charter* infringement is saved under section 1: see paras. 4-7, 39, 43, 55-58. The current proceedings present the opposite situation from that in *Doré*, even though they are the consequence of action by a regulatory authority. In my view, the considerations identified in *Doré* that weighed in favour of an administrative law approach in the particular circumstances of that case weigh in favour of application of the *Oakes* analysis in the present proceedings for the following reasons.

[60] First, in *Doré*, the Court confirmed that the approach used when reviewing the constitutionality of a law should be distinguished from the approach used for reviewing an administrative decision that is said to violate the rights of a particular individual. When *Charter* values are applied to an individual administrative decision, they are being applied in relation to a particular set of facts. *Dunsmuir* tells us this should attract deference. When a particular "law" is being assessed for *Charter* compliance, on the other hand, a court is dealing with principles of general application: see *Doré* at paras. 36 and 38.

[61] Second, unlike the circumstances of an administrative adjudicative decision, there is no difficulty in identifying the party upon whom the onus of proof of a breach of *Charter* values lies. Nor is there any difficulty in applying the *Oakes* test. The onus of proof of infringement of *Charter* rights lies with the Applicants. The onus of establishing that the requirements of the two-part test in *Oakes* have been met lies on the CPSO. Nor is there any particular difficulty in

applying the requirements of that test to the Policies which, in itself, is a reflection of the substantive reality that it is the content of the Policies that fundamentally is at issue in the proceedings.

[62] Third, as reflected in *Doré* at paras. 5-6, the application of the *Oakes* analysis does not exclude the recognition of the CPSO's expertise, to the extent relevant, in the form of the "margin of appreciation" afforded in the proportionality analysis under *Oakes*. As Abella J. observed in *Doré* at para. 57, "there is a conceptual harmony between a reasonableness review and the *Oakes* framework, since both contemplate giving a 'margin of appreciation', or deference, to administrative and legislative bodies in balancing *Charter* values against broader objectives". Consistent with this view, the parties generally agree that the outcome of the constitutionality challenges in the Applications should be the same regardless of whether an *Oakes* or a *Doré* analysis is applied by the Court.

Conclusion Regarding the Standard of Review

[63] Consistent with the foregoing approach including the application of the *Oakes* test for the s.1 analysis, I also conclude that the applicable standard of review of the constitutionality of the Policies is correctness based upon an analysis of the factors identified in *Dunsmuir*. In reaching this conclusion, I have rejected the following four considerations raised by the CPSO in support of a reasonableness standard.

[64] First, while the Policies do not establish legally binding rules of professional misconduct and therefore do not provide any penalty for non-compliance, the more important consideration is that the Policies set broad expectations of physician behaviour and are intended to have normative force. As the CPSO acknowledges, the Policies seek to articulate the tenets of medical professionalism required in various circumstances and, therefore, are expected to be persuasive in disciplinary hearings alleging professional misconduct. The Policies thereby engage a constitutional question of law that is of general importance – the appropriate balance between the right of religious freedom or equality rights of a medical professional and the right of patients to equitable access to health care services. As noted in *Dunsmuir* at para. 58, "constitutional issues … are necessarily subject to correctness review because of the unique role of s. 96 courts as interpreters of the Constitution". I note as well that the Supreme Court confirmed in *Doré* at para. 43 that there is no doubt that when a tribunal is determining the constitutionality of a law, the standard of review is correctness.

[65] Second, the CPSO submits that, in enacting the Policies, it did not make a determination of the constitutionality of a law or decide a question of law of general importance to the legal system. While it is correct that the CPSO did not address the constitutionality of the law, as mentioned, it is the constitutional question of law engaged by the Policies that is at the heart of the issues before the Court, rather than the CPSO decision to adopt the Policies. This is a question of law of general importance to our legal system.

[66] Third, the discretionary decision of the CPSO to adopt a policy does not automatically engage deference with respect to the content of such policy, even if the decision to adopt the policy rather than a more binding regulation or guideline might do so. Similarly, the absence of written reasons for the decision to adopt a policy is not determinative for the same reason. The

real issue is the constitutionality of any such policy based on its specific language, for which written reasons are unnecessary as the issue is presented in the language of the policy itself.

[67] Fourth, the CPSO did not interpret its home statutes to any significant extent in the creation of the Policies. As the CPSO acknowledges, the Policies address the tenets of medical professionalism which exist beyond the CPSO's policies and regulations. Nor does the CPSO have any particular expertise in the interpretation, protection and balancing of *Charter* rights.

[68] Lastly, the fact that the Policies involve a delicate balancing of the interests of patients and of physicians which is informed in part by the CPSO's expertise regarding professional conduct is also not determinative of the standard of review. Given that the CPSO does not have any particular expertise in the *Charter*, this balancing, including the input of the CPSO's expertise, is appropriately addressed in the proportionality exercise under the *Oakes* test notwithstanding the operation of a correctness standard. In this context, as Abella J. noted in *Doré*, the margin of appreciation afforded a regulator in the conduct of the proportionality analysis under *Oakes* provides scope for deference to the area of expertise of the CPSO, being an understanding of the realities of medical practice.

[69] For clarity, however, I note that the foregoing analysis relates solely to the standard of review in respect of the constitutionality of the impugned provisions of the Policies. It does not apply to the standard of review of the authority of the CPSO to enact the Policies, which is addressed in the next section.

Are the Policies *Ultra Vires?*

[70] The Applicants argue that the enactment of the Policies exceeds the legal authority of the CPSO and, accordingly, that the Policies do not constitute a limitation on rights that is "prescribed by law" for the purposes of section 1 of the *Charter*.

[71] The Applicants argue that the stated principal goal of the Policies is to ensure access to health care and that such objective is not included among the objectives of the CPSO set out in the *RHPA*. Broadly, the Applicants say that the objectives of the CPSO set out in the *RHPA* are directed toward ensuring the quality of medical care rather than the accessibility of health care.

[72] The objectives of the CPSO are set out in section 3 of the *Code*. Of relevance are the objective in s. 3(1)3 – to develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession – and the objective in s. 3(1)11 – any other objects relating to human health care that the Council considers desirable. In addition, section 3(2) of the *Code* provides that in carrying out its objects, the CPSO "has a duty to serve and protect the public interest". Further, section 2.1 provides that it is the duty of the College to work in consultation with the Minister of Health and Long-Term Care "to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals."

[73] The Applicants say that the text of the *RHPA* and the *Code*, the legislative history of these laws, and the decision of the Court of Appeal in *College of Physicians and Surgeons of Ontario v. Sazant*, 2012 ONCA 727, [2012] O.J. No. 5076 all indicate that the statutory purpose

of the CPSO is to protect the public by regulating the medical profession in terms of competence, qualifications, knowledge, skill and ethics. The Applicants say that the language of the *RHPA* and the *Code* indicates a legislative intention that the Minister of Health and Long-Term Care for Ontario is responsible for ensuring individual access to health care while the CPSO is responsible for ensuring that there is, generally, an adequate number of qualified health professionals to meet the needs that are determined by the Minister. With the foregoing approach in mind, they argue that ss. 3(1)11 and 3(2) of the *Code* should be read to include only those objectives that fall within this narrow statutory mandate, rather than broadly to include areas that they characterize as involving policy and budget considerations that fall outside of the CPSO's areas of competence and are specifically left to the Minister of Health and Long-Term Care.

[74] I do not agree for the following reasons.

[75] The applicable standard of review of the authority of the CPSO to enact the Policies, which does not directly raise a constitutional issue, is reasonableness rather than correctness. In this regard, the fact that the issue entails the CPSO reviewing and interpreting its home statute, the *RHPA* and the *Code,* is highly persuasive. However, I would reach the conclusion expressed herein even if the standard of review were correctness based on the considerations which follow. In my view, the CPSO not only has the authority but is obligated to provide guidance to its members, by policies or otherwise, regarding the manner of compliance with *Charter* values in their practice of medicine, including the furtherance of equitable access to health care services that are legally available in Ontario. The following considerations support this conclusion.

[76] First, as a matter of statutory interpretation, the plain language of ss. 3(1) and 3(2) of the *Code* provide ample authority to the CPSO to enact the Policies. The Policies address both the need to respect patient dignity in the provision of health care and patient access to health care. These considerations clearly fall within the language of section 3(2), which, in turn, governs the objects set out in section 3(1). Accordingly, the programs and standards of practice contemplated in ss. 3(1)3 and 3(1)11 must be read to extend to these considerations.

[77] Second, in addition, the broad language of s. 3(1)11 grants authority to the CPSO to address the professional obligations of physicians including the manner of complying with *Charter* values in their practice of medicine.

[78] Third, the Supreme Court decision in *Green v. Law Society of Manitoba*, 2017 SCC 20, [2017] S.C.R. 360, at paras. 28-30 reaffirmed the importance of taking a "broad and purposive approach" to interpreting the mandate of a self-governing professional regulator that has been given a broad public interest mandate and broad regulatory powers to accomplish that mandate.

[79] Fourth, conversely, the case law upon which the Applicants rely does not exclude the authority of the CPSO to enact the Policies. The Court of Appeal's statement in *Sazant* at para. 94 that the main purposes of the *RHPA* and the *Code* are the proper regulation of the medical profession and the protection of the public supports, rather than excludes, the authority of the CPSO. Both the regulation of the medical profession and the protection of the public contemplate a role for the CPSO in articulating standards of professionalism for doctors in Ontario, which necessarily must address respect for *Charter* values in practicing medicine.

[80] Fifth, as discussed further below, the objectives of promoting respect for patient dignity and access to health care are reflected in a patient's right to equitable access to all health care services that are legally available in Ontario. The Applicants' reliance on the statement of the Supreme Court in *Chaoulli v. Quebec (Procureur Général)*, 2005 SCC 35, [2005] 1 S.C.R. 791 at para. 104 - to the effect that the *Charter* does not confer a freestanding constitutional right to health care - misses the point. The Supreme Court also stated in that paragraph that "[h]owever, where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*." Accordingly, while there may be no right to any particular medical service under the provincial health system, there is a right to equitable access to such services as the government chooses to make available under such system.

[81] Lastly, the Applicants acknowledge that, consistent with the foregoing statement in *Chaoulli*, s. 3(1)6 of the *Code* may authorize the CPSO to pursue programs to ensure that health services are provided without discrimination. The Policies address this very purpose insofar as they are directed toward ensuring equitable access to the medical services covered by the Policies.

[82] Based on the foregoing, I find that the Policies are not *ultra vires* the authority of the CPSO.

Analysis and Conclusions Regarding the Constitutional Issues Raised in the Applications: The Effective Referral Provisions

[83] I turn then to the constitutional issues presented by these Applications. The following discussion addresses the Applicants' principal claim that the Effective Referral Provision of the Human Rights Policy and the Effective Referral Provision of the Maid Policy contravene the *Charter* and are therefore unconstitutional. The Applicants' claim regarding the constitutionality of the Emergency Provision of the Human Rights Policy is addressed separately later in these Reasons. In the discussion below, the analysis is to be understood as being equally applicable to both of the Effective Referral Provisions except to the extent specifically provided otherwise.

Applicable Provisions of the *Charter*

[84] The following provisions of the *Charter* are relevant for the issues in these proceedings:

> 1. 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.
>
> 2. Everyone has the following fundamental freedoms:
>
> (*a*) freedom of conscience and religion;
>
> ...
>
> 15. (1) 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.

Section 2(a)

Freedom of Religion

[85] The Applicants object on religious grounds to the provision of, or participation in, certain medical procedures or pharmaceuticals. The particular elements of care to which the Individual Applicants object varies among them but includes in all cases (1) the provision of abortions; and (2) medical assistance in dying; and also includes, in some cases, other medical treatments such as contraception, fertility treatments, prenatal screening and transgender treatments.

[86] The Individual Applicants believe such conduct is sinful or immoral and further believe that they are required by God to refrain from engaging in such conduct. They say that the action of providing their patients with an "effective referral" in respect of elements of care to which they object constitutes complicity in the provision of such elements of care. The Individual Applicants say that they are entitled to protection of their religious beliefs and practices which, in this case, means not being coerced or compelled to engage in the provision of such services.

[87] I am of the opinion that the Policies infringe the rights of religious freedom of the Individual Applicants as guaranteed under the *Charter* for the following reasons.

[88] The Supreme Court addressed the concept of freedom of religion under section 2(a) of the *Charter* as follows at paras. 94 and 95 in *R. v. Big M Drug Mart Ltd.* [1985] 1 S.C.R. 295:

> ... The essence of the concept of freedom of religion is the 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. But the concept means more than that.
>
> Freedom can primarily be characterized by the absence of coercion or constraint. If a person is compelled by the state or the will of another to a course of action or inaction which he would not otherwise have chosen, he is not acting of his own volition and he cannot be said to be truly free. One of the major purposes of the Charter is to protect, within reason, from compulsion or restraint. Coercion includes not only such blatant forms of compulsion as direct commands to act or refrain from acting on pain of sanction, coercion includes indirect forms of control which determine or limit alternative courses of conduct available to others. Freedom in a broad sense embraces both the absence of coercion and constraint, and the right to manifest beliefs and practices. Freedom means that, subject to such limitations as are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others, no one is to be forced to act in a way contrary to his beliefs or his conscience.

[89] In this case, the Applicants allege, in effect, that they are subject to coercion in the form of indirect control which determines or limits the courses of conduct available to them in their practice of medicine – specifically, that the Policies force them to act in a manner that is contrary to their religious beliefs and conscience.

[90] In *Syndicate Northcrest v. Amselem*, 2004 SCC 47, [2004] 2 S.C.R. 551 at para. 56, the Supreme Court articulated a two-part test in considering whether freedom of religion is engaged in a particular claim:

1. Do the Applicants have a practice or belief, having a nexus with religion, which calls for a particular line of conduct? and

2. Are the Applicants sincere in their religious belief?

[91] Since the hearing of the Applications, the Supreme Court has released its decision in *Ktunaxa Nation v. British Columbia (Forests, Lands and Natural Resource Operations)*, 2017 SCC 54. At para. 68 of that decision, the Supreme Court stated the test as follows citing para. 34 of *Multani v. Commission scolaire Marguerite Bourgeoys*, 2006 SCC 6, [2006] 1 S.C.R. 256:

> To establish an infringement of the right to freedom of religion, the claimant must demonstrate (1) that he or she sincerely believes in a practice or belief that has a nexus with religion, and (2) that the impugned state conduct interferes, in a manner that is non trivial or not insubstantial, with his or her ability to act in accordance with that practice or belief: …

[92] I see no substantive difference between the test as set out in *Amselem* and the test set out in *Ktunaxa Nation*. I have therefore approached the issue under section 2(1) in accordance with the formulation of the test in *Amselem* to reflect the submissions of the parties before the Court.

[93] With respect to the first part of the test, it is not disputed that the Individual Applicants hold the religious belief that they cannot engage in the provision of abortion and medically-assisted death on the grounds that they are sinful or immoral and that referral of a patient requesting such services to a non-objecting physician constitutes participation or complicity in the provision of such procedures.

[94] With respect to the second part of the test, the Supreme Court stated in *Amselem* at para. 53 that sincerity of belief is a question of fact based on several non-exhaustive criteria. In this case, there is no evidence that suggests that the Individual Applicants are not sincere in their belief and the CPSO has not suggested otherwise. The fact that other Christian physicians may not share their belief, or that the Individual Applicants themselves may draw the line in different places with respect to medical care apart from abortion and medically-assisted death, is irrelevant to the sincerity of their belief: see *Multani* at para. 35.

[95] While the CPSO and Ontario do not dispute that the requirements of the test in *Amselem* are otherwise met, they argue that the burden upon the Individual Applicants of compliance with the Policies is "trivial or insubstantial". They submit that, therefore, the Policies do not

contravene section 2(a) of the *Charter* to such an extent that the rights of religious freedom of the Individual Applicants are protected under that provision.

[96] In this regard, all parties refer to the following dicta of Dickson C.J. regarding the concept of "trivial or insubstantial" interference at para. 97 of *R v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713:

> This does not mean, however, that every burden on religious practices is offensive to the constitutional guarantee of freedom of religion. It means only that indirect or unintentional burdens will not be held to be outside the scope of *Charter* protection on that account alone. Section 2 (a) does not require the legislatures to eliminate every miniscule state-imposed cost associated with the practice of religion. ... The purpose of s. 2 (a) is to ensure that society does not interfere with profoundly personal beliefs that govern one's perception of oneself, humankind, nature, and, in some cases, a higher or different order of being. These beliefs, in turn, govern one's conduct and practices. The Constitution shelters individuals and groups only to the extent that religious beliefs or conduct might reasonably or actually be threatened. For a state-imposed cost or burden to be proscribed by s. 2 (a) it must be capable of interfering with religious belief or practice. <u>In short, legislative or administrative action which increases the cost of practising or otherwise manifesting religious beliefs is not prohibited if the burden is trivial or insubstantial:</u> see, on this point, *R. v. Jones*, [1986] 2 S.C.R. 284, per Wilson J. at p. 314. [Emphasis added]

I note that this concept has now been expressly incorporated by the Supreme Court into the second requirement of the test set out in *Ktunaxa Nation*.

[97] The Individual Applicants do not dispute that the determination of whether the burdens resulting from the Policies are "trivial or insubstantial" is to proceed on an objective basis, rather than on their subjective views, regarding the extent of the burdens or costs imposed on them.

[98] The Individual Applicants say that compliance with the Policies entails a number of costs or burdens upon them which are neither "trivial" nor "insubstantial". They say that they live and work every day in the fear that, as a consequence of a patient's circumstances, they may face discipline by the CPSO for refusing to comply with the Policies or may have to leave the practice of medicine in Ontario. The Applicants' position regarding the costs or burdens of the Policies is described in greater detail in the proportionality analysis under section 1 of the *Charter*.

[99] The CPSO makes the following five arguments in support of its position that, in this case, the Individual Applicants' religious beliefs or conduct are not reasonably or actually threatened by the Policies notwithstanding these alleged costs or burdens to them.

[100] First, the CPSO says that the actions required of the Individual Applicants by the Policies are actions in their professional sphere within the context of the regulated practice of medicine. They say that the practice of medicine is a privilege that imposes on physicians an overriding duty and responsibility to their patients, which physicians know upon entering the profession.

[101] In my view, this issue is more appropriately addressed later in the proportionality analysis under section 1. The issue at this stage of the analysis is limited to the question of whether the costs or burdens of the Policies interfere with the ability of the Individual Applicants to apply their religious beliefs on a daily basis in the course of their practice of medicine on a basis that is more than "trivial or insubstantial". The issue of whether the costs or burdens of doing so is to be balanced by the context in which the Individual Applicants seek to apply their beliefs is a matter of proportionality.

[102] Second, the CPSO argues, in effect, that the Court should find that, as a legal matter for the purposes of the interpretation of rights under the *Charter*, the act of referral of a patient is not the equivalent of participation in the procedure sought by the patient. It refers to the decision in *Greater Glasgow Health Board (Appellant) v Doogan and another (Respondents) (Scotland)*, [2014] UKSC 68. I do not, however, find this case to be helpful in the present situation. The issue in *Doogan* was limited to the statutory construction of the phrase "to participate in any treatment authorized by this Act" and therefore addressed a statutory obligation without regard to any constitutional implications.

[103] Third, the CPSO says that a referral is neither an endorsement of the service for which the referral is provided nor a guarantee that it will be provided. Further, the CPSO says that, provided a physician referral is done in a respectful and non-judgmental manner, the objecting physician is free to convey to the patient that he or she objects to the requested procedure on the basis of conscience or religion. In short, the CPSO argues that indirect participation by providing a referral is too remote. This argument engages three separate issues.

[104] The CPSO suggests that referral is not a guarantee that the non-objecting physician or other medical professional will ultimately provide the requested service. This is, however, a factual matter that depends, to a significant extent, on the particular procedure at issue and the patient's circumstances. The CPSO's view of likely scenarios facing physicians may be correct for a great many, if not most, circumstances. However, I accept that there may also be cases involving a patient's request for services respecting medically-assisted death or abortion where the patient's circumstances are such that the patient unequivocally qualifies for such services and there is, therefore, a very high probability that the patient will receive the services upon referral. The fact that such circumstances may be limited in number does not mean that the infringement of religious freedom, when it occurs, will be "trivial or insubstantial" for the physicians involved who will be well aware of their patient's medical condition.

[105] In addition, the CPSO also submits that the Individual Applicants have failed to establish objectively that the Policies require them to violate their beliefs. The CPSO says that there are means of complying with the Policies that remove the concern that an "effective referral" will entail complicity in the procedure to which the referring physician objects.

[106] This submission relies on the availability of a number of alternative means of satisfying the effective referral requirements of the Policies that are set out in the Fact Sheet. As mentioned, the Fact Sheet lists five means of complying with the effective referral requirements of the Policies. The CPSO suggests that, on the evidence of the Individual Applicants or their experts, at least some of the Individual Applicants agree that at least one of the options listed therein would address their concerns.

[107] I accept that this is correct in respect of certain of the Individual Applicants and for many other religious physicians. However, for present purposes, the more important point is that the options in the Fact Sheet do not appear to address the concerns of all of the Individual Applicants. In particular, none of the options listed in the Fact Sheet would address the concerns of physicians who practice as sole practitioners, rather than as part of a practice group in a hospital, clinic or family practice. Accordingly, the adoption of one or more of these options by an objecting physician may reduce the absolute number of objecting doctors who would suffer a burden or cost in complying with the Policies. However, the availability of these options does not diminish the extent of the burden imposed on objecting physicians for whom these options are, for whatever reason, not a viable means of addressing their religious objections. Accordingly, while the availability of these options has significance for the proportionality analysis below, in my view it does not support the position of the CPSO that the cost or burden of the Policies is "trivial or insubstantial".

[108] Further, the notion that the Court should determine what constitutes "complicity" or "participation" in an act that a physician regards as immoral or sinful is inconsistent with the Court's role in matters involving religious belief, as was noted by Iacobucci J. in *Amselem* at para. 53:

> In my view, the State is in no position to be, nor should it become, the arbiter of religious dogma. Accordingly, courts should avoid judicially interpreting and thus determining, either explicitly or implicitly, the content of a subjective understanding of religious requirement, "obligation", precept, "commandment", custom or ritual. Secular judicial determinations of theological or religious disputes, or of contentious matters of religious doctrine, unjustifiably entangle the court in the affairs of religion.

[109] The CPSO's fourth argument on this issue is that, because the Policies are not binding or coercive documents, and because neither has a penalty built into it for non-compliance, there is an absence of coercion and constraint. It relies on the statement in *Big M Drug Mart* that freedom of religion is "characterized by the absence of coercion or constraint" to argue that the Individual Applicants' rights have thereby been respected.

[110] I do not consider that the absence of a specific penalty in the Policies for non-compliance with their provisions to be sufficient to establish that the infringement of the rights of freedom of religion of the Individual Applicants is "trivial or insubstantial". The Policies constitute an expression of the CPSO of the standard of professionalism expected for members of the profession in the conduct of their practice. Accordingly, while the circumstances of any particular case will inevitably govern the result in any particular disciplinary proceeding, the effective referral requirements of the Policies will represent an important point of departure for any such proceedings. The moral suasion associated with the Policies is therefore sufficient in my view to engage the provisions of section 2(a) of the *Charter*.

[111] Lastly, the CPSO argues that, because the Applicants have made it clear that they will not compromise their religious beliefs, the "chilling effect" on religion presented by the Policies is a subjective fear of discipline by the CPSO or of the possible need to change the nature or location of their practice of medicine. The CPSO says section 2(a) protects individuals from interference

with religious conduct and belief but not from experiencing subjective mental states that do not affect their conduct. In making this submission, the CPSO is actually addressing two very separate matters.

[112] Insofar as the Individual Applicants say that they believe it will be necessary for them change the nature or location of their practice of medicine, they are raising a cost or burden that is clearly objective rather than subjective. In my view, this is also a consideration to be addressed in the proportionality analysis below rather than in connection with an infringement under section 2(a).

[113] Insofar as the Individual Applicants argue that they experience mental states of anxiety as a result of conflicting loyalties, they are raising a subjective consequence of the imposition of the Policies. In my view, such a consequence can constitute a cost or burden for the purposes of the analysis under section 2(a) that is not "trivial or insubstantial". However, it is also related to the concern regarding the necessity of changing the nature or location of their practice of medicine, given that such action is a means of eliminating such consequences of the imposition of the Policies if the options contemplated by the Fact Sheet do not resolve the concerns of a physician. Accordingly, I also think that this consideration is more appropriately dealt with in the context of the proportionality analysis below.

[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.

Freedom of Conscience

[115] Freedom of conscience under section 2(a) was defined by Wilson J. in *R v. Morgentaler,* [1988] 1 S.C.R. 30 at p. 179 as separate and distinct from freedom of religion. The limited jurisprudence in this area suggests that freedom of conscience may be broader than freedom of religion: see *Roach v. Canada (Minister of State of Multiculturalism and Citizenship)*, [1994] 2 FC 406 at para. 25.

[116] The Applicants argue that, to the extent that the Court rejects their argument that the rights of freedom of religion of the Individual Applicants are infringed by the effective referral requirements of the Policies, the Court should find that their rights of freedom of conscience under section 2(a) have nevertheless been infringed. In view of the finding above, it is not necessary to address this issue and, accordingly, I decline to do so.

Section 15(1)

[117] The Applicants also argue that the Policies infringe their right to equality under section 15(1) of the *Charter*. I note, however, that the parties devoted little attention to this claim at the hearing of these Applications and generally relied upon the arguments set out in their respective facta. In particular, the Applicants focused their oral submissions on the operation of section 2(a) and section 1.

Applicable Law

[118] In *Kahkewistahaw First Nation v. Taypotat*, 2015 SCC 30, [2015] 2 S.C.R. 548 at para. 17, the Supreme Court reconfirmed that section 15 protects substantive equality. In that decision, at paras. 19 and 20, the Supreme Court articulated a two-fold analysis under section 15(1) as follows: (1) whether, on its face or in its impact, a law creates a distinction on the basis of an enumerated or analogous ground [in section 15(1)]; 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.

[119] I adopt the following statements of McLachlin C.J. in her concurring opinion in *Quebec (Procureur Général) v. A.*, 2013 SCC 5, [2013] 1 S.C.R. 61 at paras. 417-418 as a useful amplification of the requirements for establishing a claim under section 15(1):

> ...To constitute discrimination, the impugned law must have the purpose or effect "of perpetuating or promoting the view that the individual is less capable or worthy of recognition or value as a human being or as a member of Canadian society, equally deserving of concern, respect, and consideration": *Law v. Canada (Minister of Employment and Immigration)*, 1999 CanLII 675 (SCC), [1999] 1 S.C.R. 497, at para. 88(3)(C); see also *Andrews v. Law Society of British Columbia*, 1989 CanLII 2 (SCC), [1989] 1 S.C.R. 143, at p. 171.
>
> Most recently, this Court has articulated the approach in terms of two steps: (1) Does the law create a distinction based on an enumerated or analogous ground? (2) Does the distinction create a disadvantage by perpetuating prejudice or false stereotyping?: *Kapp*, at para. 17; *Withler*, at para. 30. While the promotion or the perpetuation of prejudice, on the one hand, and false stereotyping, on the other, are useful guides, what constitutes discrimination requires a contextual analysis, taking into account matters such as pre-existing disadvantage of the claimant group, the degree of correspondence between the differential treatment and the claimant group's reality, the ameliorative impact or purpose of the law, and the nature of the interests affected: *Withler*, at para. 38; *Kapp*, at para. 19.

Application of the Law to the Present Circumstances

[120] I will address each branch of the test in *Taypotat* in turn.

Do the Policies Create a Distinction on an Enumerated or Analogous Ground?

[121] The first branch of the test requires a claimant to establish that he or she has been denied a benefit that others are granted, or carries a burden that others do not, in each case by reason of a personal characteristic that falls within the enumerated or analogous grounds under section 15(1). In this case, the Individual Applicants submit that they carry a burden that other physicians do not by reason of their personal characteristic as practicing religious physicians. Accordingly, they submit that the Policies create a distinction on the basis of religion.

[122] The CPSO, Ontario and a number of the intervenors dispute whether the Policies create a distinction on the basis of religion for the purposes of section 15(1). However, in view of the determination below, it is not necessary to reach a conclusion on this issue and, accordingly, I decline to do so.

Do the Policies Impose Burdens in a Manner That Reinforces, Perpetuates or Exacerbates a Disadvantage of the Claimant Group?

[123] I am of the opinion that, even if the effective referral requirements of the Policies create a distinction between religious physicians who object on such grounds to the provision of certain medical services and all other physicians, the Applicants have not satisfied the second requirement of the test in respect of a claim under section 15(1) for the following reasons.

[124] The Applicants stress that the focus of an inquiry under section 15(1) is not an underlying motive or attitude, including whether or not a law perpetuates a prejudice or stereotype, but rather the presence or absence of a discriminatory impact. The Applicants say that, in this case, the Policies impose burdens or costs on religious physicians, discussed elsewhere in these Reasons, that are not imposed on non-religious physicians who do not object to the provision of medical services on religious or conscientious grounds.

[125] However, the mere existence of costs or burdens of a law or policy is not, without more, sufficient to satisfy the second part of the test in *Taypotat*. That decision states at para. 18 that section 15(1) addresses:

> ... distinctions that have the effect of perpetuating arbitrary disadvantage based on an individual's membership in an enumerated or analogous group: *Andrews*, at pp. 174-75; *Quebec v. A*, at para. 331. The s. 15(1) analysis is accordingly concerned with the social and economic context in which a claim of inequality arises, and with the effects of the challenged law or action on the claimant group: *Quebec v. A*, at para. 331.

[126] LeBel J. addressed the same point in *Quebec (Procureur Général) v. A*. at para. 179 when he stated:

> The central question is not whether one person receives less than another, but whether one person obtains less than another as a result of prejudice or stereotyping. This is the essence of the wrong or injustice that s. 15(1) is intended to prevent.

[127] The Applicants acknowledge that they are not members of an historically disadvantaged group and that the central purpose of section 15(1) has been to protect such groups, rather than members of historically advantaged groups. They say, however, that the Policies promote prejudice against religious physicians. The Applicants suggest that the effective referral requirements of the Policies suggest or imply that such physicians "are unable to practice modern medicine and care for their patients because of their backward and unreasonable religious beliefs about particular medical procedures".

[128] I acknowledge that the decision in *Trociuk v. British Columbia (AG)*, 2003 SCC 34, [2003] 1 S.C.R. 835 at para. 20 indicates that the absence of historical disadvantage does not exclude a finding of discrimination. However, I do not find any evidence in the record before the Court that supports the Applicants' allegations of the prejudice that they say results from the Policies. Moreover, a closer analysis of the three other factors, in addition to historical disadvantage, identified by Iacobucci J. in *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497 and referred to by McLachlin C.J. in her concurring decision in *Quebec (Procureur Général) v. A.*, support this conclusion for the following reasons.

[129] First, insofar as the distinction is expressed to be on the basis of religious grounds, the Policies represent an attempt to take into account the actual circumstances of religious physicians. An important feature of the effective referral requirements of the Policies is that they represent an effort to balance the rights of patients to access to health care, in particular the right to equitable access to care, with the rights of physicians whose religious convictions treat the provision of certain medical services as immoral or sinful and who are therefore not prepared to provide such services directly. The fact that this accommodation does not go far enough for the Applicants does not detract from this reality. The evidence establishes that these arrangements do respond to the concerns of many other physicians who raise religious or conscientious objections to the provision of such services.

[130] Second, for the reasons set out above and addressed further below in the proportionality analysis, the Policies have "an ameliorative purpose or effect for certain members of society", in particular, for patients who are members of vulnerable or disadvantaged groups in our society. The distinction drawn in the Policies is directed toward ensuring patient access to health care services and, in particular, to alleviating the possibility of inequitable access to health care services.

[131] Lastly, as discussed further in the proportionality analysis, the distinction in the Policies does not restrict access to a fundamental social institution or impede full membership in Canadian society. The burdens imposed on objecting physicians, for whom the options for compliance with the effective referral requirements of the Policies are not satisfactory, pertain ultimately to the nature of their practice of medicine. It is important in this context to note that there is no constitutionally protected right to practice medicine as discussed further below.

[132] The circumstances in the present case are substantially similar to the circumstances described by McLachlin C.J. in *Alberta v. Hutterian Brethreen of Wilson Colony*, 2009 SCC 37, [2009] 2 S.C.R. 567 at paras. 105-108. In the present case, as in *Hutterian Brethreen*, the Applicants' claim does not arise from any demeaning stereotype but from a neutral and rationally defensible policy choice. This does not constitute discrimination according to the principles articulated in *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143.

[133] In summary, in my view, the Applicants' reliance on the resulting imposition of costs or burdens on the Individual Applicants that they say are not borne by physicians who do not object to particular medical procedures on religious grounds evidences the reality that the Applicants' claim is not properly a claim of discrimination under section 15(1). Fundamentally, it is a claim to be free to practice medicine unfettered and in accordance with their religious practices, not a

claim to be free from religious discrimination. It is therefore a claim that their right of religious freedom has been infringed.

[134] Accordingly, the Applicants' claim that the effective referral requirements of the Policies contravene section 15(1) of the *Charter* is dismissed.

Is the Infringement of the Applicants' Right of Freedom of Religion Justified Under Section 1 of the *Charter*?

[135] The Applicants submit that the CPSO cannot justify the infringement of the Individual Applicants' rights under section 2(a) of the *Charter* in accordance with the test in *Oakes* because it cannot demonstrate: (1) that the Policies are prescribed by law; (2) that the Policies serve any pressing or substantial objective; or (3) that the Policies advance any such objective in a manner that is rational, minimally impairing and proportionate. I reject each of these submissions for the following reasons.

Are the Policies Prescribed by Law?

[136] The CPSO submits that the Policies are norms or standards of general application for the medical profession that are sufficiently precise, accessible and binding to constitute "laws" to which s. 1 of the *Charter* can apply. Accordingly, the CPSO says that the Policies constitute limits "prescribed by law" for the purposes of the *Oakes* analysis.

[137] This position is supported by the decision of the Supreme Court in *Greater Vancouver Transportation Authority v. Canadian Federation of Students – British Columbia Component*, 2009 SCC 31, [2009] 2 S.C.R. 295, which confirmed that the *Charter* may apply to the activities of a regulatory entity such as the CPSO to the extent that its activities can be said to be governmental in nature. In particular, in that decision at para. 65, the Supreme Court held that, 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'". I see no reason why this principle should not extend to policies of the CPSO given its statutory mandate. Accordingly, I find that the Policies constitute "laws" for the purposes of section 1 of the *Charter* based on these principles.

[138] It is my understanding that the Applicants accept this characterization of the Policies provided they were validly authorized. As discussed below, the Applicants argued that the effective referral requirements of the Policies were *ultra vires* the authority of the CPSO and, therefore, being invalid, cannot constitute "laws" for the purpose of the s. 1 analysis. I have, however, dismissed the *ultra vires* argument for the reasons set out above. The Policies fall within the CPSO's statutory mandate and are consistent with its duty to serve and protect the public interest. Accordingly, I am satisfied that the Policies establish limits prescribed by law that may be subject to the *Oakes* analysis.

Is the Objective of the Policies of Sufficient Importance?

[139] The first criteria under *Oakes* is that the objective of the Policies must be "of sufficient importance to warrant overriding a constitutionally protected right or freedom": see *R v. Big M*

Drug Mart Ltd. at para.69. Dickson C.J. added in the same para. that "[i]t is necessary, at a minimum that an objective relate to concerns which are pressing and substantial in a free and democratic society before it can be characterized as sufficiently important."

[140] The Applicants define the objective of the challenged provisions of the Policies to be ensuring access to health care. They say that the question for the Court is whether the objective of ensuring access to controversial procedures and pharmaceuticals is sufficiently important to warrant overriding the Individual Applicants' *Charter* rights under section 2(a). The Applicants argue on two grounds that this objective is not sufficiently important.

[141] First, as mentioned, the Applicants argue that the objectives of the CPSO do not include ensuring access to health care. This has already been addressed and dismissed. Second, the Applicants argue that there is no evidence to suggest that there was historically any problem with access to health care for procedures or pharmaceuticals to which physicians may object on religious or conscientious grounds. In addition, they say that there is no evidence to suggest that this is a problem in any other Canadian jurisdiction where physicians are not subject to an "effective referral" requirement which is substantially similar to the effective referral requirements of the Policies. In short, the Applicants argue that the Policies address a problem that does not exist and is based on speculative concerns.

[142] I find that the objective of the Policies is of sufficient importance to warrant overriding the Individual Applicants' rights of religious freedom. In this regard, the following considerations are relevant.

[143] First, it is necessary to be clear about the objectives of the effective referral requirements of the Policies.

[144] The CPSO describes the general purpose of the Policies as the articulation of physicians' professional and legal obligations to provide health services without discrimination. In particular, the effective referral requirements of the Policies set out the CPSO's expectations for physicians who limit the health services they provide because of their personal values and beliefs.

[145] The CPSO says that the goal of the effective referral requirements of the Policies, in particular, is 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. The CPSO says this is an important purpose, particularly the protection of all Ontario patients with an emphasis on ensuring that the most vulnerable are not exposed to harm. The CPSO says that a physician's professional and ethical obligations of non-abandonment, and of patient-centered care within the context of Ontario's public health care system, require a physician to have regard to the furtherance of these goals in the practice of medicine.

[146] I understand the essential purpose of the effective referral requirements of the Policies to be the facilitation of patient access to health care services, and in particular, the facilitation of equitable access to such services. There are a number of important elements to this purpose that warrant identification. As the CPSO notes, underlying this purpose 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.

[147] Second, I accept that there is no study or direct evidence that demonstrates that access to health care is, or was, a problem that was caused by physicians objecting on religious or conscientious grounds to the provision of referrals for their patients. However, I do not consider such evidence to be a necessary requirement in order to establish that the effective referral requirements of the Policies serve a "pressing and substantial" objective of facilitating access to health care.

[148] The issue of whether actual harm must be demonstrated to establish a "pressing and substantial" objective was addressed and rejected by the Supreme Court in *Harper v. Canada (Attorney-General)*, 2004 SCC 33, [2004] 1 S.C.R. 827 at para. 98:

> The respondent alleges that evidence of the actual pernicious effect of the lack of spending limits in past elections is necessary to establish that the objective is important and that the measures are proportional to the infringement of the rights of third parties. Surely, Parliament does not have to wait for the feared harm to occur before it can enact measures to prevent the possibility of the harm occurring or to remedy the harm, should it occur. As noted earlier, this Court has concluded on several occasions that a reasoned apprehension of harm is sufficient.

In the present case, there is a "reasoned apprehension of harm" discussed in greater detail below that is addressed by the effective referral requirements of the Policies.

[149] Third, the case law is clear that there is no requirement to establish competing *Charter* values in order to justify the Policies under section 1 of the *Charter*. A "pressing and substantial" governmental objective – in this case, access to health care and, in particular, equitable access to health care – is sufficient. Accordingly, even if the Applicants were correct that the Policies do not entail any conflict of patient rights under the *Charter* with the Individual Applicants' rights of freedom of religion, this is not a relevant consideration.

[150] Lastly, contrary to the position of the Applicants, 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. This evidence is discussed in the following section.

Are the Means Chosen Reasonable and Demonstrably Justified?

[151] The second requirement in *Oakes* is that the means chosen, in this case the impugned provisions of the Policies, be reasonable and demonstrably justified. This requires addressing three components of the proportionality test set out in *Oakes* at para. 70, which is directed at balancing the interests of society with those of individuals and groups:

> ..., once a sufficiently significant objective is recognized, then the party invoking s. 1 must show that the means chosen are reasonable and demonstrably justified. This involves "a form of proportionality test": *R. v. Big M Drug Mart Ltd., supra,* at p. 352. Although the nature of the proportionality test will vary depending on the circumstances, in each case courts will be required to balance the interests of society with those of individuals and groups. There are, in my view, three important components of a proportionality test. First, the measures adopted must be carefully designed to achieve the objective in question. They must not be arbitrary, unfair or based on irrational considerations. In short, they must be rationally connected to the objective. Second, the means, even if rationally connected to the objective in this first sense, should impair "as little as possible" the right or freedom in question: *R. v. Big M Drug Mart Ltd., supra,* at p. 352. Third, 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".

Rational Connection

[152] The first component of this test for proportionality is an assessment of whether the measures to achieve the objective are "rationally connected to the objective": *Oakes* at para. 74.

[153] In *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 SCR 199, the Supreme Court set out the test for a rational connection in the following manner:

> [The proponent] must show a causal connection between the infringement and the benefit sought on the basis of reason or logic. To put it another way, the [proponent] must show that the restriction on rights serves the intended purpose. This must be demonstrated on a balance of probabilities.

Accordingly, the CPSO must demonstrate that it is reasonable to suppose that the limits on the Individual Applicants' right of religious freedom will likely, on a balance of probabilities standard, further the goal of access to health care, and in particular, equitable access to health care, not that it will do so: see *Hutterian Brethren* at para. 48.

[154] 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.

[155] This is succinctly expressed in the evidence of Dr. Danielle Martin in her affidavit sworn October 14, 2016 at para. 19:

> The need for family physicians to provide patients with information and meaningful referrals is especially important in the Canadian system because many citizens do not have other access points through which to enter the system, or are

> unaware of what other access points exist. 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. ... Thus, in the Canadian context, both the geographic and community-based nature of our primary care catchment makes access to care particularly dependent on the consistency of service provided by doctors.

[156] The Applicants argue that the effective referral requirements of the Policies are not rationally connected to the objective of ensuring access to procedures or pharmaceuticals to which physicians may object because, in their view, the evidence does not establish that it will increase such access. They say that many of the CPSO's witnesses agreed that referrals are not necessary for such services and that, in many instances, a referral may actually impede access to health services by delaying a service.

[157] I have rejected the arguments of the Applicants for the following reasons.

[158] First, the evidence does not support the conclusions asserted by the Applicants. In particular, the Applicants have mischaracterized the evidence of one of the CPSO's experts that a written referral may actually impede access to health services by delaying a service. The witness was not addressing the effective referral requirements of the Policies, which require a timely referral without the requirement of a written referral.

[159] Second, and more importantly, as discussed further below, the fact that a patient is able to access certain services such as abortion and medically-assisted death directly, without the requirement of a written referral, does not ensure that a patient will in fact be able to access such services on a timely basis without the assistance of a physician. For example, patients 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.

[160] Third, the Applicants rely on the fact that other provincial requirements may not require an "effective referral" in respect of certain services, in particular medically-assisted death. The constitutionality of these other statutory schemes is not before the court in these proceedings. In any event, I am of the view that the existence of different requirements in other jurisdictions is not a basis for finding that the effective referral requirements of the Policies are not rationally connected to the objective of the Policies.

[161] Lastly, given the legal test for establishing a rational connection, the significance of the evidence upon which the Applicants rely is more appropriately addressed in the proportionality analysis below.

[162] Accordingly, I conclude that the effective referral requirements of the Policies are rationally connected to the goal of the Policies of ensuring access to health care services in Ontario, and, in particular, to the goal of ensuring equitable access to such medical services.

Minimal Impairment

[163] The second requirement of the proportionality test is that the means should impair "as little as possible the right or freedom in question": see *Big M Drug Mart* at para. 140.

[164] In this regard, the Supreme Court observed in *RJR-MacDonald* at para. 160, that the means selected must fall within a range of reasonable alternatives:

> As the second step in the proportionality analysis, the government must show that the measures at issue impair the right of free expression as little as reasonably possible in order to achieve the legislative objective. The impairment must be "minimal", that is, the law must be carefully tailored so that rights are impaired no more than necessary. The tailoring process seldom admits of perfection and the courts must accord some leeway to the legislator. If the law falls within a range of reasonable alternatives, the courts will not find it overbroad merely because they can conceive of an alternative which might better tailor objective to infringement: [citations omitted] On the other hand, if the government fails to explain why a significantly less intrusive and equally effective measure was not chosen, the law may fail.

The test for minimal impairment is encapsulated in the statement of McLachlin C.J. in *Hutterite Brethren* at para. 55 that "[t]he test at the minimal impairment stage is whether there is an alternative, less drastic means of achieving the objective in a real and substantial manner."

[165] The Applicants submit that the effective referral requirements of the Policies do not minimally impair the rights of the applicants under s. 2(a) of the *Charter* and that there are means which the CPSO could use that would not impair the Individual Applicants' *Charter* rights at all. These include (1) establishing "a general information line where the public can call for information" to which physicians who have a conscientious objection to particular procedures or pharmaceuticals could direct patients; and (2) enacting policies that would remove the requirement for referrals to physicians who provide "controversial services like abortion" so that patients could obtain such services directly. The Applicants suggest that less impairing ways of ensuring access to medically-assisted death include (1) requiring physicians to provide patients seeking such services with information on accessing such services and (2) establishing a coordinating service or registry to which physicians willing to provide such services could opt-in.

[166] In assessing application of the minimal impairment test in the present circumstances, the following considerations are relevant.

[167] First, the CPSO reviewed a number of alternative models and rejected them for the reasons set out in the affidavits dated October 18, 2016 of Andréa Fodi, a manager in the policy department of the CPSO. The excerpts below describe both the alternatives considered by the CPSO and the reasons for their rejection, as well as the principal circumstances in which, in my view, a legitimate issue of access to health care, including in particular equitable access to health care, would reasonably arise in the absence of the effective referral requirements of the Policies. The latter also inform the conclusions in the proportionality analysis below and, for this reason, I

have set out the relevant passages of the Fodi affidavits in their entirety. For present purposes, however, the reasons for rejection of the alternative models considered by the CPSO support the conclusion 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.

[168] In respect of the Human Rights Policy, the CPSO working group considered and rejected the "self-referral" model, an advisory model and a model involving a single requirement of referral to an agency for the following reasons:

> Another option the Working Group explored was requiring patients to assume responsibility for finding a non-objecting physician, for example, through a "self-referral" approach. The Working Group concluded this option was not acceptable given that the policy was intended to apply to a range of services provided by physicians across the province. Very few procedures can be accessed directly by the patient, without a referral from a physician. The self-referral model also did not account for the experiences of patients in smaller, non-urban settings, who may have difficulty identifying a non-objecting physician given the limited range of providers or options for accessing care. The Working Group was also concerned about the impact of requiring self-referral on the population generally, given the disproportionate burden it would impose on vulnerable and marginalized groups, including the homeless, mentally ill individuals and individuals dealing with addiction, and individuals with linguistic or cultural barriers. The Working Group concluded that the "self-referral" option unfairly and inappropriately imposed on patients the burden of managing a physician's conscientious objections.
>
> The Working Group further considered whether, instead of "requiring" an effective referral, it could simply "advise" or "recommend" that physicians make an effective referral, or whether it could require physicians to provide a referral only "when necessary". The Working Group rejected this option, reasoning that if permissive language such as "advise" or "recommend" were used in relation to an effective referral, objecting physicians would interpret the policy language as signalling that an effective referral was entirely optional, and the decision as to whether or not to provide an effective referral was at their own discretion. The Working Group was concerned that this permissive language would therefore result in objecting physicians not providing an effective referral, thereby frustrating the Working Group's objectives. The Working Group's assessment of this option was directly informed by the College's extensive experience both in policy development in general, and with implementation of the 2008 *Physicians and the Ontario Human Rights Code* policy in particular. In the College's experience, if policy expectations are not stated using mandatory language such as "must" or "require", some physicians will conclude that compliance is optional. Likewise, requiring referrals only "when necessary" left it up to the physician's sole discretion to decide whether a referral was necessary, and would create a risk that patients would not receive the required referral. Further, the Working Group

> felt that physicians are often not in the position to know whether a referral is necessary, in the circumstances of a particular patient, to ensure that the patient receives access to care. The Working Group was therefore concerned that requiring effective referrals only "when necessary" would unfairly impact patients, as whether a patient received an effective referral would depend not on their need for a referral, but on whether their physician chose to provide one....
>
> The Working Group concluded that providing an effective referral to an agency in addition to either a physician or health care provider would be acceptable. However, the Working Group felt it was important to include all three receptors to an effective referral (physician, health care provider and agency), as it reasoned that agencies do not exist to coordinate referrals for all health care services, and they do not provide services in all communities, particularly in rural or Northern Ontario. In the view of the Working Group, it was imperative that the College's policy response to physicians' assertion of a conscientious objection ensure that all Ontario patients would receive an effective referral and thereby access to health care services, and that no patients would be abandoned based solely on their place of residence or the type of care they required.

[169] In respect of the Maid Policy, the CPSO working group considered and rejected the "self-referral" model and a full "transfer of care" model for the following reasons:

> One alternative was that of a patient "self-referral" model. A self-referral model would require objecting physicians to provide patients with information or resources on how to find a non-objecting physician, but the responsibility for finding a non-objecting physician would ultimately fall to the patient. After considering the pros and cons, the Working Group rejected this option. The Working Group concluded that self-referral would place an undue burden on extremely vulnerable patients who may not have the capacity, knowledge or ability to seek out a non-objecting physician independently. This disadvantage was likely to be heightened in rural or remote communities, where there is a more limited range of health care providers or options for accessing care. Self-referral would also have a disproportionate impact on vulnerable and marginalized groups, including the homeless, mentally ill individuals and individuals dealing with addiction, and individuals with linguistic or cultural barriers. The Working Group noted that in *Carter*, the Court stated that in managing conscientious objections, physicians and patient rights would need to be reconciled. The Working Group concluded that the act of reconciling these rights would essentially require a compromise from both patients and physicians: patients must be prepared to accept being referred for [medically-assisted death] if the patient's physician conscientiously objects, and physicians must be prepared to take positive steps to facilitate patient access for this service. The Working Group concluded self-referral did not represent a compromise for both physicians and patients. Rather, it made patients entirely responsible for managing the physician's conscientious objection and would impose a disproportionate burden on vulnerable patients.

> Another alternative the Working Group considered was whether to permit physicians to effect a "transfer of care" as opposed to providing an effective referral. This option was proposed by some stakeholders, who indicated it may be more palatable to those who object to [medically-assisted death] for reasons of conscience or religion. The Working Group carefully considered this option. It concluded that the extent to which a "transfer of care" was an acceptable option would depend on how "transfer of care" was defined and implemented. If a transfer of care were construed broadly to mean that all care for the patient would be transferred to another provider, including care unrelated to [medically-assisted death], the transfer would be tantamount to ending the physician-patient relationship. The Working Group felt this was unacceptable for a number of reasons. This option would effectively penalize the patient for voicing an interest in pursuing a legally available, publicly funded health care service. Patients would feel obliged to choose between pursuing a treatment option or maintaining their existing relationship with their physician. The Working Group also considered that ending a physician-patient relationship in these circumstances would not be consistent with the College's policy on *Ending the Physician-Patient Relationship*, or with the professionalism principle that patient autonomy must be respected. Further, the Working Group felt that a transfer of care that is defined broadly to represent a termination of the physician-patient relationship was a disproportionate response to managing physician conscience and religious objections: it would removal all care from the physician's responsibility when the physician only objected to specific elements of care. ...
>
> The Working Group further considered that there was value in maintaining the effective referral requirement in the context of [medically-assisted death], from a principled perspective. It recognized that the analysis and considerations involved in managing and accommodating physicians' conscientious objections to [medically-assisted death] were comparable if not identical to those involved in managing and accommodating physicians' conscientious objections to other health care services or treatments. After extensive consultation, debate and consideration, Council had recently accepted that an effective referral requirement was justified and indeed required to manage physicians' conscientious objections in the context of the *Professional Obligations and Human Rights* policy. The Working Group believed that there was no qualitative difference between [medically-assisted death] and other health care services that would justify adopting a different position on conscientious objection in the context of [medically-assisted death]. Patients seeking [medically-assisted death] were not less entitled to physician support in being connected with a non-objecting physician provider, and physicians' professionalism obligations and duties to not abandon patients and to prioritize patient interests applied equally in the context of [medically-assisted death].

[170] Second, in 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.

[171] 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.

[172] Fourthly, the Applicants assert that the fact that certain other jurisdictions in Canada do not require physicians to take direct or indirect steps to assist patients where they have a religious or conscientious objection to a medical procedure is evidence that the requirements of the Policies are not minimally impairing. I do not agree for a number of reasons.

[173] The parties dispute the manner in which the comparable requirements of certain provinces and territories operate. Nevertheless, it is clear that a number of other Canadian and foreign jurisdictions have requirements that may use different language but in substance impose similar referral requirements as the Policies.

[174] In addition, the fact that some health profession regulators in Canada have developed policies that are arguably less restrictive of physicians' religious and conscientious freedom does not mean that the CPSO is bound to implement any of such policies. This was specifically addressed by Harvison Young J. in *Yazdanfar v. The College of Physicians and Surgeons*, 2013 ONSC 6420 at para. 133, in which the trial judge stated:

> Contrary to the appellant's submission, the fact that physicians in Alberta or Illinois are permitted to use testimonials is not evidence that Ontario's law must fail the minimal impairment test. It is merely evidence that different jurisdictions

> draw the line of acceptable conduct differently. The Supreme Court has held 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": *Irwin Toy Ltd. v. Québec (A.G.)*, 1989 CanLII 87 (SCC), [1989] 1 S.C.R. 927, at p. 999. See also *Quebec (A.G.) v. A, 2013 SCC 5* (CanLII), 354 D.L.R. (4th) 191, at para. 440, McLachlin C.J.C., concurring.

As noted in *RJR-MacDonald*, the test is whether the provision falls within the range of reasonable alternatives, which reflects, among other things, the requirement that courts afford some leeway to the legislator. Accordingly, I agree with the position of Ontario that the minimal impairment analysis should not be applied so strictly as to deprive the CPSO of its statutorily-mandated authority to make its own reasonable, considered, and informed decisions about complex policy issues regarding the professional obligations of physicians.

[175] The Applicants' approach is also inconsistent with the principles of federalism as McLachlin C.J. noted in her concurring opinion in *Quebec (Attorney General.) v. A*, para. 440:

> In addition, the minimum impairment test is informed by the values of federalism. "The uniformity of provincial laws that would be entailed by a stringent requirement of least drastic means is in conflict with the federal values of distinctiveness, diversity and experimentation": P. W. Hogg, *Constitutional Law of Canada* (5th ed. Supp. (loose-leaf)), vol. 2, p. 38-39; see also *R. v. Advance Cutting & Coring Ltd.*, 2001 SCC 70, [2001] 3 S.C.R. 209, at para. 275. The test must not be applied in a manner that amounts to identifying the Canadian province that has adopted the "preferable" approach to a social issue and requiring that all other provinces follow suit.

[176] Lastly, the Applicants' position on this issue is ultimately that, in the absence of documented studies demonstrating that the existing circumstances, which rely essentially on a self-referral model in the case of objecting physicians, result in restrictions on access to health care, the Court should find that the existing arrangements represent an alternative, less drastic means of achieving the objective of the Policies. I do not accept this argument for the reasons addressed above in this section and in addressing the first criterion under the test in *Oakes*.

[177] Based on the foregoing, I conclude that the 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*.

Proportionality

[178] The final requirement of the proportionality test 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'": see *Oakes* at

para. 70. The Applicants argue that, in the present case, the effects fall disproportionately on objecting physicians.

[179] McLachlin C.J. articulated the test for proportionality at para. 73 of *Hutterian Brethren* as follows:

> ... are the overall effects of the law on the claimants disproportionate to the government's objective? When one balances the harm done to the claimants' religious freedom against the benefits associated with the universal photo requirement for driver's licences, is the limit on the right proportionate in effect to the public benefit conferred by the limit?

Accordingly, the Court is required to identify and then weigh the salutary effects and the deleterious effects of the effective referral requirements of the Policies.

[180] I note that the standard of proof in regard to salutary benefits was also addressed by McLachlin C.J. in *Hutterian Brethren* at para. 85 in the following terms:

> As discussed earlier, a government enacting social legislation is not required to show that the law will in fact produce the forecast benefits. Legislatures can only be asked to impose measures that reason and the evidence suggest will be beneficial. If legislation designed to further the public good were required to await proof positive that the benefits would in fact be realized, few laws would be passed and the public interest would suffer.

Salutary Effects

[181] The CPSO asserts that the effective referral requirements of the Policies are important and necessary in ensuring equitable access to healthcare in Ontario in four respects. It says there is evidence that where physicians refuse to treat a patient, or refuse to refer a patient, because of their personal beliefs, thereby leaving a patient to "self-refer", a patient can be harmed by virtue of: (1) delayed access to the requested medical service; (2) a loss of eligibility for the desired service; (3) a denial of care altogether; or (4) a stigma or emotional distress associated with the physician's denial of the patient's request for medical services. I will address each in turn.

[182] First, at a minimum, the effect of delayed access is to increase the emotional distress suffered by a patient in circumstances, for example, where a patient seeks an abortion in respect of an unwanted pregnancy or services for medically-assisted death.

[183] Second, with respect to some medical services, such as emergency contraception or an abortion procedure, there is a limited period in which the medical intervention is available. Delay may mean that patients become ineligible to access the care they seek and require more complicated and riskier interventions such as surgical abortions.

[184] Third, leaving a patient to effect a self-referral can equate to a denial of care altogether in a variety of circumstances. The risk is particularly acute for vulnerable persons, including in particular individuals who are homeless, have linguistic or cultural barriers, have economic

constraints in terms of travel, have intellectual disabilities, or experience a lack of confidence after being told by their physician that the service they seek is morally repugnant. Such individuals may well lack the emotional and/or economic resources to find another physician on their own. The problem is exacerbated to the extent a patient is located in a more remote community. In addition, individuals with mental health or addiction issues may lack the capacity to seek alternative care independently. For all of these individuals, their physician's assistance in navigating the healthcare system can be crucial to, and a self-referral model will be a barrier to, their ability to access healthcare services.

[185] Lastly, a patient's experience of shame or stigma associated with a particular medical service may limit the patient's willingness to seek the service in the first place. A physician's refusal to assist the patient to obtain such services may well exacerbate such feelings to the point where the patient defers seeking such services independently, with adverse consequences, or loses the will altogether to seek such services independently. Similarly, young persons who seek a medical service contrary to the wishes of their parents, or without their knowledge, may be unwilling to proceed on their own if the trusted family physician refuses to provide assistance.

[186] In short, 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.

Deleterious Effects

[187] In assessing the deleterious effects of the effective referral requirements of the Policies, the bare assertion that the requirement curtails the religious practice of the Individual Applicants and other religious physicians does not, by itself, establish the seriousness of the limit for the purposes of the proportionality analysis. It is necessary to evaluate the manner and extent to which the requirement impacts such physicians.

[188] The Applicants describe the following four burdens or costs of the imposition of the Policies on physicians who object to the effective referral requirements of the Policies. First, the Applicants say that objecting physicians must choose between violating their conscientious beliefs and risking professional discipline. Second, they say that objecting physicians have an "ever-present fear" that they may be forced to choose between violating their faith and violating the Policies. Third, they say that such circumstances will cause objecting physicians to experience short-term emotional distress and anxiety and, potentially, more severe long-term mental health consequences if they comply with the Policies. Lastly, the Applicants say it will force objecting physicians to leave the particular field of medicine in which they currently practice, leave the province, or leave the practice of medicine altogether.

[189] With respect to the third burden set out above, the Applicants say that objecting physicians could experience a condition they refer to as "Moral Distress" or "Moral Injury". One of the Applicants' experts describes "Moral Distress" as a situation in which a healthcare provider knows what the ethical or moral course of action is, but is constrained from acting on it. The Applicants say that an objecting physician could suffer such psychological injury when placed in a situation in which the Policies require the physician to engage in conduct that the

physician finds to be morally reprehensible. They say that the effects of such a condition are, in the short term, a range of symptoms associated with anxiety and emotional distress and, in the longer term if left unaddressed, more serious physical conditions and depression.

[190] The extent to which "Moral Distress" is a recognized psychological condition is not clear from the record. I also note that an objecting physician has options available to him or her to avoid the moral conflict and the emotional stress and anxiety associated with such conflict. However, given the conclusions reached below, it is not necessary to make a determination regarding the significance of this alleged cost or burden of the Policies.

Balancing the Salutary and Deleterious Effects

[191] Having identified the deleterious effects that can result from the infringement of the Individual Applicants' freedom of religion, it is necessary to balance these deleterious effects against the salutary effects of the Policies in order to determine whether the overall impact of the effective referral requirements of the Policies is proportionate.

[192] Before doing so, I note that this assessment is being made in a social context in which the following three considerations are important.

[193] First, the Applicants argue that the only *Charter* issues engaged in these proceedings are the rights of freedom of religion of the Individual Applicants and other objecting religious physicians. They suggest that, on this basis, the protection of such rights under section 2(a) of the *Charter* should govern the proportionality analysis.

[194] However, the Policies are directed toward ensuring access to health care by patients who request medical procedures or pharmaceuticals to which religious physicians may object. Access to health care and, in particular, the right of patients to equitable access to health care services available under our publicly-funded health care system, are important goals in their own right.

[195] Further, in my view, the latter also engages a *Charter* right of patients. In making this statement, I do not suggest that the *Charter* confers a freestanding constitutional right to healthcare: see *Chaoulli* per Major J. at para. 104 which states that it does not. However, I do think that 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. Such a right is a natural corollary of the right of each individual under s. 7 to "life, liberty and security of the person". Further, as Wilson J. noted in *R. v. Morgentaler*, [1988] 1. S.C.R. 30, s. 7 is concerned with the fundamental concepts of human dignity, individual autonomy and privacy. The right of equitable access to healthcare gives effect to such concepts within the context of a single-payer, publicly funded health care system.

[196] Second, the Applicants do not have a common law right or a property right to practice medicine, much less a constitutionally protected right. Rather, a licence to practice medicine is granted by statute subject to regulation pursuant to the principles set out in the *RHPA* and the *Code*, among other statutes. These statutes grant the CPSO the authority to regulate physicians with a view to, among other things, protecting the public interest. Those who enjoy the benefits of a licence to practice a regulated profession must expect to be subject to regulatory

requirements that focus on the public interest, rather than the interests of the professionals themselves. In this case, physicians are assumed to accept this authority of the CPSO, including the authority of the CPSO to address the requirements of professionalism in the practice of medicine. Accordingly, physicians' *Charter* rights should be assessed against the expectation in entering the profession that such rights may be affected in the protection of the public interest.

[197] Third, as discussed above, physicians in Ontario practice in a single payor, publicly funded healthcare system which is structured on the basis of patient-centered care. Among other consequences of this reality, physicians are required to place the interests of their patients ahead of their own personal interests in the event of a conflict. This is fundamental for the trust that must exist in the doctor-patient relationship. In addition, physicians must respect patient autonomy by recognizing that a patient has the right to decide upon the treatment plan that best meets his or her health care needs and goals within his or her personal circumstances. Lastly, physicians are subject to a duty not to abandon a patient.

[198] Turning to the balancing exercise, in summary, the Applicants say the severe deleterious effects on their religious practice, equality, health and professional life imposed by the Policies outweigh any speculative benefits that they may achieve. To repeat, the Applicants say that, on the one hand, there is no evidence that permitting physicians to simply provide information to patients who would access services themselves would impede access to healthcare and that the CPSO's concerns that it would are speculative. The Applicants say that absent evidence of any benefit that would derive from the Policies, their right of freedom of religion should be respected.

[199] In weighing the effects of the effective referral requirements of the Policies, the following statements of McLachlin C.J. at paras. 92-95 of *Hutterian Brethren* are relevant in defining the standard to be applied:

> Canadian law reflects the fundamental proposition that the state cannot by law directly compel religious belief or practice. ... To compel religious practice by force of law deprives the individual of the fundamental right to choose his or her mode of religious experience, or lack thereof. Such laws will fail at the first stage of *Oakes* and proportionality will not need to be considered.
>
> Cases of direct compulsion are straightforward. However, it may be more difficult to measure the seriousness of a limit on freedom of religion where the limit arises not from a direct assault on the right to choose, but as the result of incidental and unintended effects of the law. In many such cases, the limit does not preclude choice as to religious belief or practice, but it does make it more costly.
>
> The incidental effects of a law passed for the general good on a particular religious practice may be so great that they effectively deprive the adherent of a meaningful choice: see *Edwards Books*. Or the government program to which the limit is attached may be compulsory, with the result that the adherent is left with a stark choice between violating his or her religious belief and disobeying the

> law: *Multani*. The absence of a meaningful choice in such cases renders the impact of the limit very serious.
>
> However, in many cases, the incidental effects of a law passed for the general good on a particular religious practice may be less serious. The limit may impose costs on the religious practitioner in terms of money, tradition or inconvenience. However, these costs may still leave the adherent with a meaningful choice concerning the religious practice at issue. The Charter guarantees freedom of religion, but does not indemnify practitioners against all costs incident to the practice of religion. Many religious practices entail costs which society reasonably expects the adherents to bear. The inability to access conditional benefits or privileges conferred by law may be among such costs. A limit on the right that exacts a cost but nevertheless leaves the adherent with a meaningful choice about the religious practice at issue will be less serious than a limit that effectively deprives the adherent of such choice.

[200] In the present case, the purpose of the Policies is not to interfere with religious practices. The limitation on the rights of the Individual Applicants is more accurately conceptualized as the result of incidental effects of policies that have as their goal access to health care. The issue for the Court is whether the effective referral requirements of the Policies effectively deprive the Individual Applicants and other religious physicians of a meaningful choice, or have the consequence that such parties are left with a stark choice between violating his or her religious belief and disobeying the Policies such that the impugned provisions effectively deprive the Individual Applicants of a meaningful choice.

[201] As discussed above, the goals of access to healthcare, and in particular equitable access to healthcare, are important social goals. These are not goals that should be lightly compromised or sacrificed. I do not accept the Applicants' position which is, in effect, that there is no basis for finding that a policy of permitting physicians to simply provide patients with information that they need to access services themselves would impede patient access to health services in the absence of evidence of actual circumstances in which this has occurred. In my view, the evidence in the record indicates that the goals of the Policies will be compromised or sacrificed in a variety of circumstances, more often than not involving vulnerable members of our society at the time of requesting services, in the absence of the effective referral requirements of the Policies.

[202] Against this important public benefit must be weighed the effect of the limitation on the Applicants' rights of freedom of religion. As discussed above, I proceed on the basis that the limitation does impose a cost or a burden on the Individual Applicants and other religious physicians.

[203] Ontario says that the impact of the Policies on the religious or conscientious rights of physicians is mitigated by the College's discretion regarding the consequences, if any, that would flow from any particular non-compliance of the Policies. Given the fact that non-compliance with the Policies is not expressly an act of professional misconduct under the *Code*, any instance of non-compliance would require a discretionary administrative adjudication

pursuant to the process contemplated thereunder which, itself, must satisfy the requirements of proportionality in accordance with the principles articulated in *Doré*.

[204] While this is correct, given the normative purpose of the Policies, I do not accord great weight to this consideration. In my view, the balancing exercise comes down to a weighing of the salutary benefits of the effective referral requirements of the Policies against the costs or burdens imposed upon the Individual Applicants and other religious physicians taking into consideration the options available to them to mitigate such costs or burdens.

[205] The evidence regarding these costs or burdens can be summarized as follows. For many religious physicians practicing medicine in Ontario, the concept of referral of a patient seeking medical procedures to which they object does not constitute "complicity" or "participation" in the provision of such medical services to which they object as sinful or immoral. There remain, however, some religious physicians who do regard the act of referral of patients as the equivalent of the provision of such medical services from the standpoint of their religious beliefs. A number of such physicians, including some of the Individual Applicants, can satisfactorily address their religious concerns by adopting one or more of the options contemplated by the Fact Sheet. In particular, physicians who practice in a hospital, a clinic or a family practice group may be able to address their concerns using one of the two options contemplated for such practices of medicine described above and there is no evidence that the cost of implementation of such options would be onerous. Accordingly, the impact of the effective referral requirements of the Policies is most acutely experienced by religious physicians who do not practice in a hospital, a clinic or a family practice group, or who do practice in such a setting but believe that the options presented in the Fact Sheet do not satisfactorily answer their concerns.

[206] I acknowledge that one or more of the Individual Applicants fall into this category together with other religious physicians not before the Court in their individual capacities. I am not in a position to assess the number of such physicians.

[207] I can, however, assess the costs or burdens on such physicians resulting from the Policies. It would appear that, for these physicians, the principal, if not the only, means of addressing their concerns would be a change in the nature of their practice if they intend to continue practicing medicine in Ontario. In short, they would have to focus their practice in a specialty or sub-specialty that would not present circumstances in which the Policies would contemplate an obligation of "effective referral" of patients in respect of medical services to which they object.

[208] As a related matter, the Applicants' argument based on the concern for possible psychological injury must be assessed in the context of the existence of the options available to a physician, even if not optimal. Given such options, the potential for a conflict between a physician's religious practice 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.

[209] I do not take these costs lightly. For the physicians involved, they would entail an impact on their professional lives. However, such burdens do not deprive objecting physicians of their ability to continue to carry on the practice of medicine in Ontario in accordance with their beliefs. The deleterious effects of the Policies, while not trivial, are less serious than an effective

exclusion from the practice of medicine. I also note that there is no evidence before the Court that such a response to the implementation of the Policies either has occurred or is likely to occur in any meaningful numbers.

[210] It is therefore necessary to balance the public benefit of ensuring access to health care, and in particular equitable access to health care, against these costs to objecting physicians. In the conduct of this balancing exercise, the impact of the Policies upon the Individual Applicants and other religious physicians must be assessed in the context of the environment in which physicians practice medicine in Ontario which reflects, in particular, the three considerations described above. In my view, given this context, to the extent there remains any conflict between patient rights and physician rights that cannot be reconciled within the Policies, the former must govern.

[211] Accordingly, balancing the salutary and deleterious effects of the Policies, I conclude that the impact of the effective referral requirements of the Policies on the religious practice of physicians who object to the provision of particular medical procedures or pharmaceuticals in the course of practicing medicine in Ontario is proportionate.

Conclusion on Justification

[212] I therefore conclude that the limit on objecting religious physicians imposed by the effective referral requirements of the Policies has been demonstrated to be justified under section 1 of the *Charter*. The goal of ensuring access to healthcare, in particular equitable access to healthcare, is pressing and substantial. The effective referral requirements of the Policies are rationally connected to the goal. The requirements impair the Individual Applicants' right of religious freedom as little as reasonably possible in order to achieve the goal. The alternatives proposed by the Applicants would compromise the goal of ensuring access to healthcare in many situations, often involving vulnerable members of our society at the time of requesting medical services. Finally, the requirements are proportionate in terms of effects: the positive effects associated with the effective referral requirements of the Policies are significant, while the impact on the Individual Applicants, while not trivial, does not extend to deprivation of the ability to practice medicine in Ontario although it may require an accommodation on their part.

Analysis and Conclusions Regarding the Constitutional Issues Raised in The Applications: The Emergency Provision of the Human Rights Policy

[213] In the HR Application, the Applicants also challenge the constitutional validity of the Emergency Provision of the Human Rights Policy. However, the Applicants did not address the Emergency Provision in their oral submissions and relied entirely on the arguments set out in their factum. I conclude that the HR Application should also be dismissed insofar as it alleges that the Emergency Provision is an infringement of the right of religious freedom of the Applicants and other religious physicians under section 2(a) of the *Charter*. The following sets out the basis of this conclusion.

Section 2(a)

[214] The Applicants say that the Emergency Provision could require physicians to perform an abortion in an "emergency" where failure to do so could "prevent imminent harm". As described above, the Individual Applicants regard participation in such procedures to be sinful and immoral. On this basis, they allege that the Emergency Provision constitutes an infringement of the right of religious freedom of the Individual Applicants under section 2(a) of the *Charter*.

[215] I assume for the purpose of this analysis that the Applicants have satisfied the two-part test in *Amselem*. The issue for the Court is whether the infringement of the rights of the Individual Applicants under section 2(a) is more than "trivial or insubstantial". In this case, I find that it does not constitute an infringement of the right of religious freedom of the Individual Applicants under section 2(a) that is more than trivial or insubstantial for the following reasons.

[216] While the Applicants have expressed concerns regarding the impact of the Emergency Provision in respect of several procedures, in fact, the issue is narrowed to their concern that they may be required to undertake an abortion procedure in an "emergency". The Maid Policy does not contain a comparable provision and it is my understanding that the CPSO has clarified that the Emergency Procedure does not apply to medically-assisted death or euthanasia. Further, the Individual Applicants have not raised any concerns with respect to the application of the Emergency Provision to any other procedures or medical services and it is hard to conceive of any others to which it would apply.

[217] Accordingly, the issue for the Court is whether the application of the Emergency Provision with respect to abortion is more than "trivial or insubstantial". This is essentially a fact-driven exercise rather than a matter of legal analysis given the evidence before the Court.

[218] In this case, all of the Individual Applicants agreed that they would not object to performing an abortion where it was necessary to save a pregnant woman's life. The representatives of the Institutional Applicants also agreed that most of their members would take the same position. In fact, there is no evidence before the Court that any physician would raise an objection in such circumstances. A number of the Individual Applicants also stated that, as a practical matter, they found it hard to imagine an emergency in which a pregnant woman would need an abortion to avoid imminent and serious but not life-threatening harm. Accordingly, there is 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, as the Applicants suggest.

[219] There is therefore no factual foundation establishing an infringement of the rights of the Individual Applicants or other religious physicians. There are two consequences to this conclusion. First, the Court must find that any infringement of rights of the Individual Applicants under section 2(a) of the *Charter* is "trivial or insubstantial". Second, in any event, the Court should not address any allegation of an infringement, given the factual vacuum, in accordance with the mandate of the Supreme Court in *MacKay v. Manitoba* [1989] 2 S.C.R. 357 at pp. 361-362. As in *MacKay*, it is not the purpose of the Emergency Provision that is said to infringe the *Charter* but its effects. If deleterious effects are not established, there can be *no*

Charter violation and the HR Application must fail with respect to the constitutionality of the Emergency Provision.

[220] Given this conclusion, it is unnecessary to address the application of section 15 of the *Charter* or the *Oakes* analysis in respect of the alleged infringement in regard to the Emergency Provision. I have done so, however, in case the conclusions of the Court are of relevance on any appeal.

Section 15(1)

[221] In my view, the Emergency Provision does not infringe upon the rights of the Individual Applicants under section 15(1) of the *Charter* for the same reasons as the Court concluded that the effective referral requirements of the Policies failed to infringe upon such rights. In this regard, the Applicants have not raised any distinction in principle between the application of section 15(1) to the Emergency Provision and its application in respect of the effective referral requirements of the Policies and I also see none.

Section 1

[222] The Applicants argue both that the Emergency Provision does not satisfy the requirements of "prescribed by law" for the purposes of section 1 of the *Charter* and that the infringement of the rights of the Individual Applicants under section 2(a) of the *Charter* is not justified under section 1.

Prescribed By Law

[223] The Applicants' argument that the Policies are *ultra vires* the authority of the CPSO also extended to the Emergency Provision. This argument has been rejected for the reasons set out above. In any event, the Applicants acknowledge that the object of the Emergency Provision also extends to the protection of patient safety, which object falls squarely within the authority of the CPSO.

[224] However, the Applicants make a further argument that is specific to the Emergency Provision. The Applicants say that the Emergency Provision is too vague to be a limitation that is "prescribed by law". They refer to *Vancouver* at paras. 50 and 64 for the proposition that a policy will not satisfy such requirement if it does not provide an "intelligible standard" for courts to use. In particular, the Applicants say that the absence of definitions of the terms "emergency", "imminent" and "harm" renders it impossible for physicians to know their obligations in any given situation. The Applicants say that, because in their view the Emergency Provision does not provide clear *ex ante* guidance to physicians, it does not constitute an "intelligible standard".

[225] I am not persuaded, however, on the basis of the record before the Court that the Emergency Provision fails to provide an "intelligible standard" to physicians. The Emergency Provision reflects a fundamental reality that, as a number of the Individual Applicants agreed, one of the responsibilities of a physician is the determination of whether or not an emergency exists and whether or not a patient is at risk of imminent harm. In my view, in the absence of anything more than bald assertions on the part of the Applicants, the Court should give some

deference to the CPSO regarding the level of detail required to provide meaningful and intelligent guidance to physicians in fulfilling their professional responsibilities. In my view, it is therefore reasonable to provide in the Emergency Provision that the responsibility for a determination of when an "emergency" exists should, in effect, rest with the physician.

The Oakes Analysis

[226] For the purposes of the *Oakes* analysis, I have proceeded on the basis that a principal purpose of the Emergency Provision is, as the Applicants acknowledge, the protection of life and of public safety.

[227] I do not think there can be any doubt that such object satisfies the requirement of sufficient importance. The Emergency Provision directly engages a patient's rights under section 7 of the *Charter*. The Applicants do not suggest otherwise.

[228] The Emergency Provision is also rationally connected to the object of the protection of life and public safety. It further satisfies the requirement of minimal impairment of the Individual Applicants' rights of religious freedom. In this regard, the Applicants do not offer any other means that are less intrusive or impairing of the right of religious freedom of religious physicians that fulfills the goal of the Emergency Provision. More generally, the Applicants do not suggest that these requirements of *Oakes* have not been satisfied.

[229] Lastly, in my view, the evidence in the record establishes that the salutary effects of the Emergency Provision – the protection of life and public safety – far outweigh any deleterious effect in the form of infringement of the rights of the Individual Applicants to practice medicine in accordance with their religious beliefs. As discussed above, the record does not establish any likelihood of an infringement of such rights that would be other than "trivial or insubstantial". In particular, there is no evidence that any of the Individual Applicants would feel compelled to withdraw from the area of medicine in which they currently practice by virtue of their obligations pursuant to the Emergency Provision.

Disposition of the Applications

[230] Based on the foregoing, I find that the Effective Referral Provisions of the Policies and the Emergency Referral Provision of the Human Rights Policy represent reasonable limits on religious freedom, demonstrably justified in a free and democratic society. The Applications are therefore dismissed in their entirety.

[231] Finally, for the reasons noted above, the issues in this proceeding have been addressed against a standard of correctness using the *Oakes* analysis in the consideration of whether the infringement of the rights of the Individual Applicants has been saved under s.1 of the *Charter*. I wish to note, however, that I would have reached the same result using the *Doré* framework proposed by the CPSO. As the CPSO acknowledged in argument, there is significant overlap between these two approaches that, in my view, compels a similar result under each approach.

Costs

[232] As the Court understands that the parties, including the intervenors, have reached an understanding regarding costs, it is not necessary to address the costs of this hearing.

Wilton-Siegel J.

I agree

Lococo J.

I agree

Matheson J.

Released: January 31, 2018

CITATION: The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario, 2018 ONSC 579
DIVISIONAL COURT FILE NO.: 499/16 / 500/16
DATE: 20180131

ONTARIO
SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

Wilton-Siegel, Lococo, Matheson JJ.

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

– and –

College of Physicians and Surgeons of Ontario

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

Intervenors

Wilton-Siegel J.

Released: January 31, 2018