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COURT	COURT OF QUEEN'S BENCH OF ALBERTA
JUDICIAL CENTRE	[redacted]
APPLICANT	ANNETTE LEWIS
RESPONDENTS	ALBERTA HEALTH SERVICES, ABC HOSPITAL, DR. A, DR. B, DR. C, DR. D, DR. E, and DR. F
DOCUMENT	**MEMORANDUM OF ARGUMENT OF THE APPLICANT ANNETTE LEWIS**

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I. INTRODUCTION

> 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.[1]

1. Statement of Facts

Ms. Lewis

1. The Applicant**,** Annette Lewis, is a 57-year-old woman who resides in Sexsmith, Alberta.[2] She has a terminal [redacted] disease called *idiopathic pulmonary fibrosis*.[3] Ms. Lewis has been on the waiting list for a double [redacted] transplant for the past two years and is currently at Status 2 on that list. Status 2 is for [redacted] transplant candidates who are in urgent need of a transplant. As of her last [redacted] capacity test in July 2021, her [redacted] capacity was below 35%. She requires the use of an oxygen machine 24 hours a day and has been informed by pulmonologists that her condition is terminal. Without a [redacted] transplant, she does not have long to live.

2. From August 2019 to March 2020, Ms. Lewis underwent extensive testing to assess her suitability for a [redacted] transplant with the [redacted] Transplant Program (**the "LTP"**) at the Respondent ABC Hospital. The LTP team is comprised of Drs. A to F (collectively **the "Respondent Doctors/Respondent Physicians"**).

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[1] *R. v. Big M Drug Mart Ltd.*, 1985 CanLII 69 (SCC), [1985] 1 SCR 295, per Chief Justice Dickson, at para. 95 **[TAB 1, Book Of Authorities ("BOA")]**

[2] Affidavit of Annette Lewis, Sworn November 19, 2021 ["Lewis Affidavit 1"], para 2.

[3] Lewis Affidavit 1, para 4.

3. In June of 2020, the LTP team confirmed that Ms. Lewis was in excellent health apart from her diseased [redacted] and was a good candidate for a [redacted] transplant.[4] As a result, she was placed on the transplant list and has been awaiting surgery for a new set of [redacted].

4. In March 2021, she was moved up to Status 2 on the transplant list because her [redacted] were deteriorating.[5] Ms. Lewis was directed to take certain medications in preparation for the transplant surgery, including re-taking all her childhood vaccines because her medical records could not be verified.[6] She did so.[7]

5. In March of 2021, Ms. Lewis met with the Respondent Dr. B, a pulmonologist on the LTP team, and he informed her that the LTP team required [redacted] transplant candidates to receive one of the recently developed Covid-19 vaccines as a condition of receiving the [redacted] transplant (the **"Requirement"**).[8]

6. Also, in March 2021, the Northern Alberta Organ and Tissue Donation Program of Alberta Health Services ("**AHS**") emailed Ms. Lewis and asked her to review a two-page document entitled "Covid-19 Vaccine information Solid Organ Transplant Candidates and Recipients" ("**AHS Organ Transplant Policy – March**")[9]; An updated version of that policy was emailed to Ms. Lewis on September 1, 2021 ("**AHS Organ Transplant Policy – September**")[10] (collectively referred as "**AHS Organ Transplant Policy**"). The AHS Organ Transplant Policy outlines AHS' policy on Covid-19 vaccines and solid organ transplant candidates and recipients and specifically states that the Covid-19 vaccines <u>are recommended, not required</u>, for transplant surgeries.

7. The Requirement imposed by the Respondent Doctors directly contradicted the AHS Organ Transplant Policy. The AHS Organ Transplant Policy did not say that the vaccines were required. In fact, the AHS Organ Transplant Policy provided instructions on when best to take the vaccines

[4] Lewis Affidavit 1, para 6.
[5] Lewis Affidavit 1, para 12.
[6] Lewis Affidavit 1, paras 9 and 10.
[7] Lewis Affidavit 1, para 11.
[8] Lewis Affidavit 1, para 13.
[9] Lewis Affidavit 1, para. 14, Exhibit B
[10] Lewis Affidavit 1, para. 24.

after the surgery and specifically stated: "transplantation should not be delayed because of COVID vaccine schedule."[11]

8. Ms. Lewis reviewed the AHS Organ Transplant Policy, the warnings from Health Canada on the Covid-19 vaccines and various scientific research and articles. She recognized that the Covid-19 vaccines are still in clinical trials. She felt threatened by the Respondent doctors to comply with the Requirement, although none of the Respondents fully explained to her all of the risks of taking the Covid-19 vaccines to someone in her condition.[12] Based on these factors, Ms. Lewis determined that she did not want to take the Covid-19 vaccines.[13]

9. Ms. Lewis repeatedly advised the members of the LTP that she could not take the Covid-19 vaccine and that she needed to stay on the [redacted] transplant list.[14] In response, the LTP team told Ms. Lewis they would remove her from the transplant recipient list if she did not receive the Covid-19 vaccine (the "**Decision**").[15] At the same time, the Respondent, Dr. A, informed Ms. Lewis she would die if she did not receive the surgery soon.[16]

10. The Decision and the Requirement for Ms. Lewis to take the Covid-19 vaccines have caused Ms. Lewis tremendous stress. Her evidence is that "the LTP [team] members have coerced me to take this vaccine. I am under extreme duress, knowing that my choice not to comply will result in the loss of my life. I cannot give informed consent under duress…I need this requirement removed so that I can get my [redacted] transplant. I do not want to die."[17]

11. The Decision and the Requirement exploit her fear of death and make her agreement a condition precedent to receiving life-saving surgery. The attempt to compel Ms. Lewis against her will to receive the Covid-19 vaccine or die is coercion.

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[11] Lewis Affidavit, para. 14, Exhibit B
[12] Lewis Affidavit 1, para. 35
[13] Lewis Affidavit 1, para 30.
[14] Lewis Affidavit 1, para. 18
[15] Lewis Affidavit 1, para 17.
[16] *Ibid.*
[17] Lewis Affidavit 1, para 34, 38

12. From March 2021 to sometime in the Fall of 2021, the Respondent Doctors were acting contrary to AHS' policy on Covid vaccination for transplant candidates. The Respondent doctors, however, were carrying out a government program of the government of Alberta in providing life-saving medical care to Albertans like Ms. Lewis. Consequently, the Requirement and the coercive actions of the Respondent Doctors violated Ms. Lewis' fundamental freedoms of conscience protected under section 2(a) of the *Charter*, her rights to life, liberty, and security of the person as protected by section 7 of the *Charter*, and her right to equal protection from discrimination provided under section 15 of the *Charter.*[18]

13. Both expressly and by implication, the Respondent Doctors have threatened to remove Ms. Lewis from the transplant recipient list.[19] Dr. A recently confirmed in her affidavit that she intends to move Ms. Lewis to Status 0 on the transplant waitlist if she is unsuccessful in this court action.[20] Should this occur, she will die.

14. The Respondent, Dr. B, contacted Ms. Lewis on November 15, 2021, to try to coerce her again to take the Covid-19 vaccine.[21] He noted in her medical record that he reviewed the importance of taking the vaccine prior to transplant and that "AHS is now mandating this for all transplant patients."[22]

15. Ms. Lewis admits that at times she "came close" to taking the Covid-19 because of her "wish to live." She is a "wife, mother, and grandmother" who wants to be a part of her family's lives.[23] But her "conscience always stopped [her] in the end."[24]

16. On November 19, 2021, Ms. Lewis filed an Originating Application against the Respondent Doctors, ABC Hospital, and AHS which are collectively referred to herein as the

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[18] *Canadian Charter of Rights and Freedoms,* ss 2 and 7, Part 1 of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11**. [TAB 33, BOA]**
[19] Lewis Affidavit 1, para 17.
[20] Affidavit of Dr. A, Sworn January 6, 2022, para. 58 ["Dr. A Affidavit"]
[21] Lewis Affidavit 1, para 28
[22] Dr. A Affidavit, Exhibit K, page 15
[23] Lewis Affidavit 2, para. 4
[24] Lewis Affidavit 2, para. 5

"Respondents." She seeks declaratory relief for violations of her constitutional rights and freedoms as set out in the Originating Application.

17. Ms. Lewis also filed a Notice of Application for injunctive relief to prevent her from being removed from the transplant list. On December 21, 2021, the Respondents agreed that pending the determination of this constitutional challenge, Ms. Lewis would not be denied a [redacted] transplant on the sole basis that she is not vaccinated for Covid-19.

18. This Memorandum of Argument is in support of her Application for relief under the *Charter* and the *Alberta Bill of Rights*.

19. Ms. Lewis extracted scientific and other evidence from the expert reports and cross-examinations that she intends to rely upon for the *Charter* sections 1 and 7 analysis at **Appendices A-H** to this Memorandum of Argument.

Dr. A

20. Dr. A is a pulmonologist in Alberta whose practice primarily involves [redacted] transplants within the LTP. AHS contracts her to provide services as a part of the LTP team. Dr. A is the only Respondent Physician to give evidence in this application.

21. Dr. A is one of the physicians who told Ms. Lewis directly that she would have to be vaccinated for Covid-19 before receiving a [redacted] transplant and threatened to remove her from the transplant list if she did not receive the Covid-19 vaccines.[25]

22. Dr. A stated in her affidavit that the LTP's ultimate goal "is to provide organs to patients in a manner than maximizes duration and quality of life for both the recipient and the organ."[26] She explained that being unvaccinated for Covid-19 is a contraindication to a [redacted] transplant. However, she is willing to permit unvaccinated patients with a "valid medical exemption" to be transplanted.[27]

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[25] Lewis Affidavit 1, at para. 17
[26] Dr. A Affidavit, at para. 23
[27] Dr. A Affidavit, para. 39

23. Dr. A admitted in cross-examination that unvaccinated candidates with a medical exemption would have the same risk of catching Covid, transmitting Covid, and dying of Covid as an unvaccinated candidate without a medical exemption.[28]

24. During cross-examination, she also admitted that there is now a medical treatment to help post-transplant patients if they become infected with Covid-19.[29]

25. Dr. A asserted in cross-examination that the Covid-19 vaccines for use in Canada had completed clinical trials.[30] This evidence completely contradicts the unchallenged expert evidence of Dr. Bonnie Mallard and the expert evidence of Dr. Byram Bridle.[31]

26. She also has not made any attempt to study natural immunity to Covid-19 or to consult with an immunologist about natural immunity and has not tested Ms. Lewis to see if she is naturally immune to Covid-19.[32]

27. Yet, Dr. A has decided that Ms. Lewis should be put to Status 0 on the waitlist, where she will eventually die without the [redacted] transplant.[33]

28. Some of the highlights of Dr. A's cross-examination evidence that Ms. Lewis intends to rely upon are found below:

a. All [redacted] transplant candidates waiting for a [redacted] transplant that has had Covid-19 caught it despite being vaccinated for Covid-19; she is not aware of [redacted] transplant unvaccinated [redacted] transplant candidates having had Covid-19;[34]

[28] Transcript of Dr. A, March 21, 2022 ["Dr. A Transcript"] p. 28, lines 22-25; p. 29, lines 1-2, 10-25; p. 30, lines 1-2; p. 30, lines 10-14
[29] Dr. A Transcript, p. 78, lines 8-11
[30] Dr. A Transcript, p. 33, lines 22-25
[31] Affidavit of Dr. Bonnie Mallard, Sworn February 18, 2022, Schedule "A", Expert Report Dated November 17, 2021 ["Mallard Report 1"] pp. 2-3; Affidavit of Dr. Bonnie Mallard, Sworn February 18, 2022, Schedule "A", Expert Report Dated February 18, 2022 ["Mallard Report 2"], page 4, para. 2; Transcript of Dr. Byram Bridle April 6, 2022 ["Bridle Transcript] p. 45, lines 13-25; p. 46, lines 1-2
[32] Dr. A Transcript, p. 16, lines 8-25; p. 17, lines 1-12
[33] Dr. A Affidavit, para. 58
[34] Dr. A Transcript, p. 27, lines 6-9.

b. A written Covid-19 vaccine policy does not exist;[35] and

c. She agrees that at her May 17, 2021 appointment with Ms. Lewis, there is no notation that she explained the risks of the Covid vaccine to her, even though there is a section in the notes called "Vaccine Hesitancy.[36]

29. Additional evidence from Dr. A's evidence Ms. Lewis intends to rely on is attached in **Appendix A** to this Memorandum of Argument.

Deanna Paulson

30. Ms. Paulson is the Director of Donation and Transplant Services at the ABC Hospital.[37]

31. Her evidence on behalf of AHS is that there are many more people waiting for an organ than there are donated organs and that the "professionals at Transplant Services are committed to act as appropriate stewards of the donor's gift, by ensuring that the donated organ goes to an individual most at need and most likely to have a successful post-transplant outcome."[38]

32. Ms. Paulson's evidence is that Ms. Lewis is a patient at "Transplant Services" and "she is on a rapid decline of health." She confirmed that "…if Ms. Lewis does not receive a transplant, she will die."[39]

33. Ms. Paulson confirmed that "Monoclonal antibody treatment is a treatment for active Covid-19 infection upon presentation of symptoms."[40]

34. Some of the highlights of Ms. Paulson's cross-examination are found below:

a. She agreed that the AHS solid organ transplant document from September 2021 states that the Covid vaccine is recommended but is not mandatory; and

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[35] Dr. A Transcript, p. 44, lines 14-17
[36] Dr. A Transcript, p. 66, lines 1-25; p. 67, lines 1-14.
[37] Affidavit of Deanna Paulson, sworn January 6, 2022 ["Paulson Affidavit"] para. 1
[38] Paulson Affidavit, para. 5
[39] Paulson Affidavit, paras. 2, 19
[40] Paulson Affidavit, para. 26

b. She agreed that the Canadian Transplant Society document does not speak to the long-term side effects of the Covid vaccines and doesn't discuss the AZ and Johnson and Johnson vaccines.[41]

35. Additional evidence from Ms. Paulson's cross-examination that Ms. Lewis intends to rely upon is found in **Appendix B** to this Memorandum of Argument.

2. The Science

36. The science at issue in this Application is novel, and it is very much contested. The parties are not arguing over the safety and efficacy of childhood vaccines which have been around for more than 30 years and for which there is plenty of long-term safety data. The science regarding the safety and efficacy of the Covid-19 vaccines is not settled. As will be discussed more fully below, the FDA just limited the use of the Johnson and Johnson Covid-19 vaccine in the United States due to persistent reports of blood clotting.[42] Health authorities, governments, doctors, and scientists are learning new things about these new vaccines on a regular basis, and there is no long-term safety data regarding these vaccines.

37. Ms. Lewis respectfully submits that this is not a case where the Respondents ought to be able to rely on public health's stated position that the Covid-19 vaccines are safe and effective, or that the court ought to take judicial notice of this claim. There is insufficient conclusive evidence, particularly as it relates to Ms. Lewis unique health matters, to apply general public health data in these specific circumstances.

A. The Applicant's Expert Witnesses

Dr. Bonnie Mallard

38. Dr. Bonnie Mallard has a Ph.D. in immunology and is an immunogenetics specialist at the University of Guelph who has taught Undergraduate Immunology and Graduate Advanced Topics in Immunology for over 30 years. Professor Mallard is the first Canadian to win the Governor

[41] Dr. A Transcript, p. 41, lines 13-18.
[42] Coronavirus (COVID-19) Update: FDA Limits Use of Janssen COVID-19 Vaccine to Certain Individuals https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-limits-use-janssen-covid-19-vaccine-certain-individuals **[TAB 37, BOA]**

General's Award for Innovation (2017) and the NSERC Synergy Award (2020). She received these awards for her work on genetic regulation of the immune system as a tool to enhance natural immunity. She has experience with xenotransplantation[43] and is consulted by clinicians in transplant programs with respect to her knowledge of immunological issues in this area.[44]

39. Dr. Mallard wrote two expert reports on this matter. Her evidence is clear and unequivocal: the Requirement is not beneficial, nor should it be a requisite for [redacted] transplant surgery. Her reports provide a compelling, well-cited, and organized review of the peer-reviewed scientific and medical literature and real-world data on the safety and effectiveness of the Covid-19 vaccines, natural immunity to Covid-19, and Covid-19 infection in vaccinated versus unvaccinated patients. Her professional opinion overwhelmingly validates Ms. Lewis' choice not to receive the injection.

40. Some of the highlights from Dr. Mallard's expert reports and cross-examination, which Ms. Lewis will be relying upon, are found below:

1. Vaccine manufacturers confirm individuals in Ms. Lewis's condition were excluded from safety trials and do not recommend the vaccine for anyone in the unexamined groups – Ms. Lewis ought to be automatically excluded from being vaccinated as there is no safety or efficacy data from the clinical trials for people with her condition;[45]
2. Prior to a [redacted] transplant, it is imperative not to induce inflammatory episodes, particularly in the [redacted];[46] and
3. Omicron has changed the landscape, and it's mild, and the vaccines are of low efficacy. There's no point using them against Omicron.[47]

[43] Xenotransplantation is the process of grafting or transplanting organs or tissues between members of different species. Dr. Bridle states in his cross-examination that xenotransplantation is in fact more complicated process then transplantation between same species; Bridle Transcript, p. 23, lines 11-24
[44] Transcript of Dr. Bonnie Mallard, March 16, 2022 ["Mallard Transcript] paras. 18-23
[45] Mallard Report 1, page 2, paras 1-2.
[46] Mallard Report 1, page 8, para 2.
[47] Mallard Transcript, p. 73, lines 7-11.

41. Additional evidence from Dr. Mallard's evidence Ms. Lewis intends to rely upon is found in **Appendix C** to this Memorandum of Argument.

Dr. Byram Bridle

42. Dr. Bridle is an Associate Professor of Viral Immunology in the Department of Pathobiology at the University of Guelph in Ontario. He obtained his Ph.D. in 2005. He is a Vaccinologist as he has a sub-specialty in the field of vaccinology. He researches vaccine development for the prevention of infectious diseases and to treat cancer in humans. He also trains research fellows in vaccinology. He has published three peer-reviewed papers focused on Covid-19.[48]

43. His doctoral-level training was in the field of transplantation immunology, emphasizing the study of immunological tolerance in the context of xenotransplantation.[49]

44. In 2020 and 2021, Dr. Bridle was recognized as an "outstanding reviewer" for the Canadian Institutes of Health Research for his "dedication to peer review." [50]

45. He is familiar with [redacted] immunology extensively because he does lots of work with the development of vaccines protecting against infectious diseases and respiratory infectious diseases. He develops immunotherapies for treating [redacted] cancer, so he has "deep expertise" in pulmonary immunology and transplant immunology.[51]

46. Dr. Bridle provided an expert report in reply to the expert report of Dr. Michael Houghton. He found that in general, Dr. Houghton did not use scientific sources to support his conclusions[52] and/or that the sources he cited were of poor quality and not peer-reviewed.[53] He wrote: "Scientific truths are not the result of utterances from highly qualified experts. Instead, they must be demonstrated with raw data accompanied by clear interpretation that show a deep understanding

[48] Affidavit of Dr. Byram Bridle, Sworn February 18, para. 5 ["Bridle Affidavit"]
[49] Bridle Transcript, p. 23, lines 11-24; Bridle Affidavit, para. 6
[50] Bridle Affidavit, Exhibit "A", Schedule "A", page 2
[51] Bridle Transcript, p. 22, lines 23-25, p. 23, lines 1-10
[52] Bridle Report, p. 2, para. 2
[53] Bridle Report, p. 6, para. 6; Bridle Report, p. 8, para. 11

and/or via references to peer reviewed papers."[54] On the other hand, Dr. Bridle was able to support the opinions in his report by citing multiple peer-reviewed sources, and he used charts and graphs citing provincial data.

47. Dr. Bridle's conclusions also support Ms. Lewis' position that a Covid-19 vaccine ought not to be mandated in order for her to receive life-saving double [redacted] transplant surgery. Some of the highlights of Dr. Bridle's evidence are found below:

1. The evidence that the COVID-19 vaccines blunt the severity of the disease is spurious at best. Since mid-December 2021, most of the people associated with Covid-19 in hospitals and ICUs were vaccinated;[55]
2. A basic cost-benefit analysis concludes that the best way to maximize the health and safety of the patient and the donated organ is to keep her unvaccinated. A lower risk of contracting Covid-19 means a lower risk of harm to the engrafted tissue;[56] and
3. The duration of Covid vaccine immunity is horrifically short. It is challenging to make a vaccine that would have such a short duration of immunity.[57]

48. Additional evidence from Dr. Bridle's evidence that Ms. Lewis intends to rely upon is found in **Appendix D** to this Memorandum of Argument.

Dr. Benjamin Turner

49. Dr. Turner is a general surgeon with fellowships in head and neck oncology and microvascular reconstruction. He graduated from medical school in 2011 and has nine years of clinical training.

50. Dr. Turner also has a Master's Degree in Health Care Ethics from Duquesne University in Pittsburgh, Pennsylvania, which he obtained in July 2019.

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[54] Bridle Report, p. 8, para. 11
[55] Bridle Report, p. 3, para. 3; p. 4, figures A and B.
[56] Bridle Report, p. 8, para. 10.
[57] Bridle Transcript, p. 42, lines 8-10, 13-15.

51. Dr. Turner wrote a report about the ethics of denying Ms. Lewis [redacted] transplant surgery on the basis of her refusal to receive the Covid-19 vaccines. An attempt to coerce Ms. Lewis toward vaccination is not compatible with patient autonomy, and denying Ms. Lewis a [redacted] transplant, when the alternative is death is not ethically justified, even considering that organs are scarce resources that justify heightened ethical consideration. Some of the highlights of Dr. Turner's evidence are found below:

a. Denying Ms. Lewis a [redacted] transplant for which she is otherwise a candidate, when the alternative is death, is an example of doing harm;[58] and

b. An attempt to coerce the patient toward vaccination by means of fear is not compatible with patient autonomy. The patient is faced with the alternatives of treatment she does not want and certain death in the medium term. If she permits herself to be vaccinated at this point, she will have undergone medical treatment under duress and, therefore, without free consent.[59]

52. Additional evidence from Dr. Turner's evidence that Ms. Lewis intends to rely upon is found in **Appendix E** to this Memorandum of Argument.

B. The Respondents' Expert Witnesses

Dr. Olivia Kates

53. Dr. Olivia Kates graduated from medical school in 2015. She is a physician trained in Internal Medicine and Infectious Diseases. She practices Transplant and Oncology Infectious Diseases at Johns Hopkins Hospital in Baltimore, Maryland. Dr. Kates has a Master's Degree in Bioethics and Humanities from the University of Washington in Seattle which she obtained in June 2021.

54. Dr. Kates' professional opinion is that it is ethical to deny [redacted] transplant candidates life-saving transplants if they refuse Covid-19 vaccination.[60]

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[58] Affidavit of Dr. Benjamin Turner, Sworn February 18, 2022, Exhibit A, Schedule A, Report Dated November 26, 2021, ["Turner Report 1"] page 3, para. 2.
[59] Turner Report 1, page 4, para. 3.
[60] Affidavit of Dr. Olivia Kates, Affirmed December 31, 2021, Schedule "A", ["Kates Report"] p. 1, para. 7

55. Some of the highlights of Dr. Kates' evidence are below:

1. It is possible to have a transplant without the Covid-19 vaccination;[61]
2. Special consideration should be given to racial groups, like Black Americans, because of "authentic personal and community histories of medical abuse."[62]
3. Informed consent must not be influenced by threats or promises;[63] and
4. Denying organs to patients in need has major ethical implications.[64]

56. Additional evidence from Dr. Kates' evidence Applicant intends to rely upon is found in **Appendix F** to this Memorandum of Argument.

Dr. Marcelo Cypel

57. Dr. Cypel is a thoracic surgeon and Surgical Director at the Ajmera Transplant Centre at the University Health Network in Toronto. He has been a medical doctor since 1999. He completed a Masters in Medical Science with a focus on [redacted] transplantation in 2008. Dr. Cypel provided his professional opinion on whether the LTP team met the standard of care in requiring Covid-19 vaccination pre-[redacted] transplantation. He supports the Requirement and the Decision.

58. Dr. Cypel admitted in cross-examination that he is not an immunologist, vaccinologist, or virologist and has not published any studies in the areas of vaccines or immunology.

59. In cross-examination, he was unaware that none of the Respondent doctors entered notes in Ms. Lewis's chart detailing a discussion of the risks of the Covid-19 vaccines.

60. Some of the highlights of Dr. Cypel's evidence that Ms. Lewis intends to rely upon are found below:

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[61] Transcript of Dr. Olivia Kates, March 21, 2022 ["Kates Transcript"] p. 47, lines 12-14.
[62] Kates Transcript, p. 72, lines 12-25; p. 73, lines 1-2.
[63] Kates Transcript, p. 94, lines 10-12.
[64] Kates Transcript, p. 96, lines 23-25.

a. He is aware that patients with severe and chronic respiratory diseases were excluded from the initial clinical trials for the Covid-19 vaccines;[65]

b. Agrees that when he says they are safe in his expert report, he is not referring to long-term safety because no one has data long-term;[66] and

c. He agreed that it would be good practice to educate a patient who expresses fear of the Covid-19 vaccines about the safety information from Health Canada, and it's a reassuring discussion to have. He agrees it is important that the discussion occurs with a patient who repeatedly expresses fears of the Covid vaccines.[67]

61. Additional evidence of Dr. Cypel that Ms. Lewis intends to rely upon is found in **Appendix G** to this Memorandum of Argument.

Dr. Michael Houghton

62. Dr. Houghton is a professor in the Faculty of Medicine and Dentistry at the University of Alberta. He directs the Li Ka Shing Applied Virology Institute. He discovered the hepatitis D viral genome in 1986 and the hepatitis C viral genome in 1989, for which he received a Nobel prize in Medicine in 2020.

63. Dr. Houghton has spent 32 years as a high-level employee for various pharmaceutical companies in England and the United States.

64. Dr. Houghton has published one peer-reviewed study on Covid-19. (In comparison, Dr. Bridle has published three.)

65. Dr. Houghton provided evidence as an expert witness for AHS on the safety and efficacy of the Covid-19 vaccines. His professional opinion is that the Covid-19 vaccines are safe and effective.

[65] Transcript of Dr. Marcelo Cypel, April 8, 2022 ["Cypel Transcript"] p. 16, lines 4-8.
[66] Cypel Transcript, p. 16, lines 9-13.
[67] Cypel Transcript, p. 49, lines 20-25; p. 50, lines 1-2, 22-25; p. 51, lines 1-2.

66. Ms. Lewis respectfully submits that Dr. Houghton was combative, arrogant, and rude when he was asked questions about his *curriculum vitae* during his cross-examination. He accused counsel of asking "ridiculous" and "pedantic" questions regarding his qualifications and experience and characterized what he thought the intent of those questions was as "pathetic." [68] He refused to answer an undertaking about why he received 10 million dollars a year over 30 years from pharmaceutical companies.[69] That refusal is currently the subject of a motion to compel undertakings that this Court has not yet heard.

67. Some of the highlights of Dr. Houghton's evidence that Ms. Lewis intends to rely upon are found below:

a. People who have received the Covid vaccines still get Omicron;[70]

b. He agreed that we have long-term safety data for many vaccines but none for vaccines introduced in the last few years;[71] and

c. He agreed that it would be "a reasonable thing to do" to test a patient who is waiting for a [redacted] transplant for natural immunity to Covid-19.[72]

68. Additional evidence of Dr. Houghton that Ms. Lewis intends to rely upon is found in **Appendix H** to this Memorandum of Argument.

[68] Transcript of Dr. Michael Houghton, April 1, 2022 ["Houghton Transcript"] p. 25, lines 23-25; p. 26, lines 1-17
[69] Houghton Response to Undertakings, Refused
[70] Houghton Transcript, p. 35, lines 15-21.
[71] Houghton Transcript, p. 94, lines 10-17.
[72] Houghton Transcript, p. 97, lines 12-17.

II. ISSUES

A. Have the Respondents discharged their onus to show that their experts' opinions are admissible and reliable?

No. Dr. Kates' and Dr. Houghton's expert evidence is biased and impartial and ought to be afforded minimal weight in this Application.

In the alternative,

Dr. Houghton's evidence on novel and contested science ought to be found unreliable as he has not supported it with the reliable underlying science and raw data.

B. Are the Respondents bound by the *Charter*?

Yes, they all are state actors whose actions in this matter are subject to *Charter* scrutiny.

C. What is the standard of review?

The Requirement affects the *Charter*-protected rights of all Canadians waiting for a [redacted] transplant in the LTP at the ABC Hospital. As a result, the standard of review of the Requirement is *correctness*.

In the alternative,

The Decision to specifically require Ms. Lewis to get vaccinated with Covid-19 vaccines prior to her [redacted] transplant surgery is reviewable under the standard of *reasonableness*.

D. Have the Respondents violated Ms. Lewis's section 2(a) *Charter* right of conscience?

Yes. The Requirement and the Decision to withhold lifesaving treatment to Ms. Lewis unless she is vaccinated for Covid-19 has violated her conscientiously held belief against taking the recently-developed Covid-19 vaccines.

E. Have the Respondents violated Ms. Lewis's section 7 *Charter* rights to life, liberty, and security of the person in a manner that is contrary to the principles of fundamental justice?

Yes. The Requirement threatens Ms. Lewis' life by preventing her from receiving life-saving surgery, limits her bodily autonomy and freedom of choice in her medical care, and has caused her immense psychological suffering. It is arbitrary, overbroad, and grossly disproportionate.

F. Have the Respondents violated Ms. Lewis's section 15 *Charter* right not to be discriminated against based on her medical status as a person who is not vaccinated for Covid-19?

Yes. The Requirement creates a distinction based on her medical status which puts her at a disadvantage compared to patients waiting for a [redacted] transplant who have been vaccinated for Covid-19.

G. If Ms. Lewis's *Charter* rights have been violated, are the violations justified under section 1 of the *Charter*?

No, the *Charter* violations are not prescribed by law, and are not reasonable or demonstrably justifiable in a free and democratic society.

H. Have the Respondents violated Ms. Lewis's rights under sections 1 and 2 of the *Alberta Bill of Rights*?

Yes.

III. ARGUMENT

1. The Weight to be Attributed to the Respondents' Expert Evidence

69. Ms. Lewis submits that there is a threshold issue that ought to be decided prior to argument on the *Charter* issues. She submits that the evidence of some of the Respondents' experts ought to be given less weight than the expert evidence of Ms. Lewis's experts.

A. The Requirement of Fair, Objective and Non-Partisan Evidence has not been met

70. In *White Burgess Langille Inman v. Abbott and Haliburton Company*,[73] the Supreme Court of Canada spoke extensively about the principles surrounding expert evidence. As stated in *White Burgess*, the Supreme Court of Canada expanded on the admissibility of the expert evidence test laid down in *R. v. Mohan*. The Court explained the two-part test for the admissibility of expert witness evidence:

> At the first step, the proponent of the evidence must establish the threshold requirements of admissibility. These are the four *Mohan* factors (relevance, necessity, absence of an exclusionary rule and a properly qualified expert), and in addition, in the case of an opinion based on novel or contested science or science used for a novel purpose, the reliability of the underlying science for that purpose. At the second discretionary gatekeeping step, the judge balances the potential risks and benefits of admitting the evidence in order to decide whether the potential benefits justify the risks.[74]

71. In order to meet the threshold requirement for expert evidence admissibility, the Court stated that experts have the duty to give "fair, objective and non-partisan opinion evidence." The Court explained that experts must be aware of this duty and willing to carry it out. If this requirement is not met, the evidence proposed should not be admitted. Once this threshold requirement is met, concerns about an expert witness's independence or impartiality should be

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[73] *White Burgess Langille Inman v. Abbott and Haliburton Co.,* 2015 SCC 23, White Burgess Langille Inman v. Abbott and Haliburton Co. - SCC Cases (lexum.com) ["*White Burgess*"] **[TAB 2, BOA]**

[74] *Ibid*. at para. 23-24

considered as part of the overall weighing of the costs and benefits of admitting the evidence. The Court explained:

> In my view, expert witnesses have a duty to the court to give fair, objective and non-partisan opinion evidence. They must be aware of this duty and able and willing to carry it out. If they do not meet this threshold requirement, their evidence should not be admitted. Once this threshold is met, however, concerns about an expert witness's independence or impartiality should be considered as part of the overall weighing of the costs and benefits of admitting the evidence. This common law approach is, of course, subject to statutory and related provisions which may establish different rules of admissibility.[75]

72. The Court further explains the duty owed to the court by expert witnesses, stating that impartiality, independence, and absence of bias underlie the duty owed to the court. The Court states that for an expert's opinion to be impartial, it must reflect an objective assessment of the questions at hand. For an expert's opinion to be independent, it must be the product of the expert's independent judgement, uninfluenced by who has retained him or her or outcome of the litigation. The expert's evidence must also be unbiased, in the sense that it does not unfairly favour one party's position over the other.

Dr. Kates

73. Dr. Kates testified that it is ethical not to transplant a candidate who is unvaccinated and who can be safely transplanted.[76] Yet, she also testified that "Black Americans" waiting for transplants ought to be exempt from the Covid-19 vaccine requirement.[77]

74. Ms. Lewis submits that Dr. Kates' promotion of differential treatment of transplant candidates based on their race is unethical in itself, unreliable, and evidences her poor judgment on ethical issues. There is no scientific basis to support exempting Black Americans from a vaccine

[75] *Ibid*. at para. 10
[76] Kates Transcript, p. 51, lines 13-15
[77] Kates Transcript, p. 72, lines 12-25; p. 73, lines 1-2; p. 73, lines 19-25; p. 74, lines 2-3; p. 74, lines 15-18

mandate if the goal is to reduce the likelihood of a negative outcome from Covid-19 for a transplanted person or reduce the likelihood of infection with Covid-19. There is no evidence that Black Americans are less likely to catch Covid-19 post-transplant or to have a better outcome post-transplant than someone of another race.

75. Dr. Kates also believes that "we all have a mandate, a calling, to be vaccinated ourselves and promote vaccination in others for the good of our communities." [78]

76. It is apparent that Dr. Kates has a clear bias toward vaccine mandates as she personally considers the mandates to be a "calling" and "duty." It is Ms. Lewis's position that her personal feelings about the vaccine mandates have prejudiced her expert opinion on whether the Requirement is ethical. Dr. Kates is not impartial or objective. She is, in essence, advocating a discriminatory vaccination policy that harms and excludes Caucasians, like Ms. Lewis, from life-saving organ transplants because of her racial biases.

77. Ms. Lewis submits that Dr. Kates' evidence ought to be found unreliable and given no weight or substantially reduced weight as compared to Dr. Turner's evidence. Dr. Turner's professional opinion was based on medical science and not tainted by racial prejudices regarding Covid-19 vaccine mandates.

Dr. Houghton

a. Lack of Impartiality

78. Ms. Lewis submits that the Court ought to consider that Dr. Houghton worked as a high-level employee for pharmaceutical companies for over 30 years, affecting his impartiality. He testified that he was paid $10 million per year for 30 years while employed by Novartis/Chiron pharmaceuticals. The specifics of that funding and what it was for are currently the subject of a motion to compel an answer to an undertaking, and Ms. Lewis reserves the right to make additional arguments on this point depending on the outcome of that motion and what further evidence is received in this regard.

[78] Kates Transcript, p. 104, lines 24-25; p. 105, lines 1-7

79. At a minimum, Ms. Lewis submits that there is a likelihood that Dr. Houghton has deep loyalty to the pharmaceutical industry, which paid him such hefty amounts of money over a 30-year period and for which he did not want to disclose under cross-examination. As a result, he is not able to give an impartial and objective opinion about the safety and efficacy of Covid-19 vaccine products.

b. Dr. Houghton's opinion fails to provide reliable underlying science

80. The Supreme Court of Canada held that in the case of an opinion based on novel or contested science, the reliability of the underlying science is an additional threshold requirement.[79]

81. The reliability of novel or contested scientific evidence is part of both relevance and necessity at the first step of the analysis. This is because, as set out by the Court of Appeal for Ontario in *R. v. K.A.*, scientific evidence "must meet a certain threshold of reliability in order to have sufficient probative value to meet the criterion of relevance." [80] Further, the Court of Appeal has noted, "it could hardly be said that the admission of unreliable evidence is *necessary* for a proper adjudication to be made by the trier of fact."[81]

82. The Supreme Court of Canada has also directly commented on novel or contested science.[82] In *R. v. J.-L.J.*, at para. 33, Binnie J. set out four factors to evaluate the reliability of such evidence and determine whether novel or contested science has an appropriate foundation to be admissible as evidence:

1. whether the theory or technique can be and has been tested;
2. whether the theory or technique has been subjected to peer review and publication;
3. the known or potential rate of error or the existence of standards; and
4. whether the theory or technique used has been generally accepted.[83]

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[79] *White Burgess* at para. 23.
[80] *R. v. K.A.*, (1999), 1999 CanLII 3793 (ON CA) at para. 84. **[TAB 3, BOA]**
[81] *R. v. K.A.*, (1999), 1999 CanLII 3793 (ON CA) at para. 84. [Emphasis added].
[82] See, for example, *R. v. Trochym*, 2007 SCC 6 (CanLII) at paras. 33-34. **[TAB 4, BOA]**
[83] *R. v. J.-L.J.*, 2000 SCC 51 (CanLII), [2000] 2 SCR 600 at paras. 33-35. **[TAB 5, BOA]**

83. Further, Binnie J. referred to language from *R. v. Mohan*[84] on the "special scrutiny" which is to be applied to "novel science":

> In *Mohan*, Sopinka J. emphasized that "novel science" is subject to "special scrutiny" at p. 25:
>
> > In summary, therefore, it appears from the foregoing that expert evidence which advances a novel scientific theory or technique is subjected to special scrutiny to determine whether it meets a basic threshold of reliability and whether it is essential in the sense that the trier of fact will be unable to come to a satisfactory conclusion without the assistance of the expert.[85]

84. It is Ms. Lewis's respectful submission that the legal test regarding the novel science of the safety and efficacy of the Covid-19 vaccines applies equally to the expert evidence of Dr. Houghton, as it does to that of Dr. Mallard and Dr. Bridle. All Respondent witnesses and expert witnesses agree that the Covid-19 vaccines are novel; therefore, it follows that the science supporting the Covid-19 vaccine is equally novel.

85. Of utmost importance, Dr. Houghton's two-and-a-half-page report lacks any raw data on the safety and efficacy of the Covid-19 vaccines. It is in stark contrast to the reports provided by Dr. Mallard and Dr. Bridle on the same topic.

86. His expert report also made conclusions about the efficacy of the Covid-19 vaccines and natural immunity based on CDC data from September 2021 and early November 2021 that pre-dated the Omicron variant.[86]

87. When asked in cross-examination to confirm that he did not cite peer-reviewed studies for more than one of his twelve conclusions, he provided the following justifications:

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[84] *R. v. Mohan*, 1994 CanLII 80 (SCC). **[TAB 6, BOA]**
[85] *R. v. J.-L.J.*, 2000 SCC 51 (CanLII) at para. 35. **[TAB 5, BOA]**
[86] Affidavit of Sir Michael Houghton, Affirmed January 21, 2022, Exhibit "B" ["Houghton Report"] p. 3, para. 11

- "If I were to put every single paper down on that subject, this affidavit would be a thousand pages"[87];
- "If I referred to all the peer-reviewed publications that I could have, all the statements from public health agencies around the world…this document would be 10,000 pages long"[88];
- "if I referenced all the peer-reviewed manuscripts that are published around these topics…I'll still be writing it, frankly"[89]; and,
- "It is such an obvious statement to any reasonable scientist that it almost doesn't need referencing. But once again, if I were to reference that statement, I would never end. I would still be referencing it today."[90]

88. The Court ought to consider Dr. Houghton's evasive and inconclusive answers when his evidence is considered. Dr. Houghton was presented as an expert and ought to be providing the court with credible and clear evidence to the Court. It is Ms. Lewis's submission that he did not do so.

89. In contrast, Dr. Mallard's first report cited 35 peer-reviewed studies and raw data, and her reply report cited 18 peer-reviewed studies and multiple sources of raw data from around the world. Dr. Bridle cited 70 peer-reviewed studies in his reply expert report and included raw data from Ontario and Alberta.[91]

90. Although Dr. Houghton was presented as AHS' expert on the safety and effectiveness of the Covid-19 vaccines, he answered "Possibly" when asked if he had seen the study on the safety and efficacy of the Moderna Covid-19 vaccine from the US National Library of Medicine which was shown to him during cross-examination.[92]

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[87] Houghton Transcript, p. 32, lines 19-21
[88] Houghton Transcript, p. 59, lines 3-7
[89] Houghton Transcript, p. 96, lines 8-13
[90] Houghton Transcript, p. 98, lines 19-24
[91] Bridle Report, pages 3-5, 10, 15-17
[92] Houghton Transcript, p. 48, lines 22-24

91. When Dr. Houghton was questioned on whether or not the clinical trials for the Covid-19 vaccines were finished, he stated, "I don't know."[93]

92. When the study of the safety and efficacy (clinical trial) of the Pfizer vaccine from the US National Library of Medicine was shown to him, he said, "I **think** that's because they are now testing Covid vaccines derived from the Omicron variant," and he "**believe[d]**" the testing was for Omicron, and he "**assume[d]**" that is what the document referred to.[94]

93. He also admitted he was unaware of Health Canada's warning labels on the Covid-19 vaccines for myocarditis, blood clots and Bell's Palsy.[95] He was also unaware of the 2022 WHO safety signal for hearing loss in relation to the Covid-19 vaccines.[96]

94. Dr. Houghton admitted he was unaware that Pfizer had to comply with a US court order[97] to release thousands of pages a month of its trial data. He stated he had not seen the Covid-19 vaccine Pfizer data which showed nine pages of adverse events of special interest.[98]

95. When Dr. Houghton was asked in cross-examination to confirm that his Nobel prize was not for any vaccine-related work, he was evasive and refused to give a straight answer. His evidence on cross-examination was that "[t]t took into account my …. [c]ontributions to developing curative drugs as well as vaccine candidates to hepatitis C…" When pressed to confirm that his Nobel prize was not for making a vaccine for Hepatitis C, he said that he did not know what the Nobel notation said and that Applicant's counsel would have to check it to see what it said. It was provided as an undertaking and nowhere in the Nobel notation for his prize did the word "vaccine" or anything to do with vaccines appear.[99]

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[93] Houghton Transcript, p.38, lines 18-21; p. 39, lines 2-4
[94] Houghton Transcript, p. 40, lines 5-19
[95] Houghton Transcript, p. 72, lines 14-18
[96] Houghton Transcript, p. 83, lines 15-20
[97] *Public Health and Medical Professionals for Transparency v Food and Drug Administration*, Case No.:21-CV-1058-P, United States District Court For The Northern District Of Texas Fort Worth Division **[TAB 7, BOA]**
[98] Houghton Transcript, p. 87, lines 9-11
[99] Houghton Answer to Undertaking, Nobel Prize Notation

96. It is clear that his award was for the discovery of the Hepatitis C virus and not for work on a vaccine. Therefore, the Court should give no weight to Dr. Houghton's Nobel Prize, which is unrelated to the issues at hand.

97. Ms. Lewis submits that for a purported "expert" in vaccinology, and on the safety and effectiveness of Covid-19 vaccines, in particular, Dr. Houghton's knowledge of the important and latest safety information is severely lacking. It appears that Dr. Houghton relied heavily on other organizations and public "media"[100] in forming his opinion as opposed to providing the Court with a well-researched professional opinion in line with his duty as an expert to the Court, particularly given the contested and novel nature of the science in this matter.

98. Ms. Lewis argues that Dr. Houghton was not confident in his assertions about the clinical trials of the safety and efficacy of the Covid-19 vaccines. He was unable to give definitive answers to questions about the clinical trials, and it appeared that he had not reviewed them before he drafted his expert report on the safety and efficacy of the Covid-19 vaccines. This is so even though the clinical trial data was cited in Dr. Mallard's expert report, which he had reviewed.[101] Dr. Houghton did not inform himself of whether the clinical trials were completed and has not kept up with the latest information released to the public about the safety of the Pfizer vaccine from Pfizer's own data.

99. Dr. Bridle and Dr. Mallard fulfilled their duty to the court and provided research and raw data to support their scientific conclusions.

100. As a result, Ms. Lewis submits that Dr. Houghton's expert opinion on the novel and contested science on the safety and efficacy of the Covid-19 vaccines ought to be given less weight compared to that of Dr. Mallard and Dr. Bridle.

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100 Houghton Transcript, p. 32, line 17, p. 36, line 4, p. 59, line 6, p. 67, line 4, p. 96, line 12 and p. 99, line 2.
[101] Mallard Report 1, pp. 2-3; Mallard Report 2, page 4, para. 2

2. The Respondents' Actions are Subject to *Charter* Scrutiny

101. Pursuant to section 52(1) of the *Constitution Act*, 1982 and as confirmed by the Supreme Court of Canada, "the Constitution of Canada is the supreme law of Canada." All legislation, regulations, orders, government decisions, and government action are subject to the Constitution, including all public health orders.[102]

AHS and ABC Hospital are bound by the Charter

102. Health services are delivered in Alberta pursuant to the *Alberta Health Act*[103] and *Alberta Health Care Insurance Act*[104] and their regulations, all in accordance with the *Canada Health Act*[105]. Pursuant to the *Canada Health Act* definitions, AHS is Canada's largest province-wide, fully integrated health system, responsible for delivering health services in Alberta and provides insured health services to Albertans.

103. The *Alberta Health Care Insurance Act* creates the framework for a publicly administered health services plan in Alberta pursuant to the definitions and Section 7 of the *Canada Health Act*. Pursuant to the *Alberta Health Care Insurance Plan*, [redacted] transplants are covered pursuant to Section 45.5, "Other Operations on Bronchus and [redacted]."

104. The Preamble of the *Alberta Health Act,* which sets out the principles that will guide the health care system in Alberta, includes but is not limited to the following:

> WHEREAS Albertans acknowledge:
>
> > that individuals, families, communities, health professionals and the Government of Alberta all share in supporting and enhancing the health and wellness organizations that deliver health services to Albertans...

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[102] *The Constitution Act, 1982,* Schedule B to *the Canada Act 1982 (UK), 1982, c 11*
103 *Alberta Health Act*, SA 2010, c A-19.5. **[TAB 34, BOA]**
[104] *Alberta Health Care Insurance Act*, RSA 2000, c A-20. **[TAB 35, BOA]**
[105] *Canada Health Act,* RSC 1985, c C-6. **[TAB 36, BOA]**

> WHEREAS policies, organization, operations and decisions about Alberta's health system should be guided and measured and sustained consistent with the following principles:
>
> > that Alberta is committed to the principles of the *Canada Health Act*…
> >
> > that accessibility to publicly funded health services is based on need, not on the ability to pay…
> >
> > that health decisions, financial stewardship and the allocation and use of resources are done in such a way that they are transparent to Albertans and ensure that Alberta's publicly funded health system is sustained for the future.[106]

105. In furthering the objectives set out in the *Canada Health Act*, *Alberta Services Act* and A*lberta Health Care Insurances Act* and their regulations, AHS and ABC Hospital deliver publicly funded, quality health services in line with one of the most comprehensive social programs in Canada.

106. Dr. A said in her affidavit that her practice is in [redacted] transplantation within the LTP at the ABC Hospital in Alberta, and "The LTP is run through Alberta Health Services."[107] She further stated that "Medical decisions for the program are made by the LTP Respirologists with input from the LTP surgeons and allied health as required."[108]

107. Furthermore, *Eldridge v. British Columbia (Attorney General)* confirms that a private entity that provides services under a provincial insurance act constitutes a government body for purposes of section 32 of the *Charter* and specifically states:

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[106] *Alberta Health Act,* SA 2010, c A-19.5 Preamble **[TAB 34, BOA]**
[107] Dr. A Affidavit, paras. 2, 3
[108] Dr. A Affidavit, at para. 5

> *McKinney* makes it clear, however, that the *Charter* applies to private entities in so far as they act in furtherance of a specific governmental program or policy. In these circumstances, while it is a private actor that actually implements the program, it is government that retains responsibility for it. The rationale for this principle is readily apparent. Just as governments are not permitted to escape *Charter* scrutiny by entering into commercial contracts or other "private" arrangements, they should not be allowed to evade their constitutional responsibilities by delegating the implementation of their policies and programs to private entities.[109]

108. AHS and ABC Hospital in providing medically necessary services delivering publicly funded quality health services, are carrying out a specific government objective and are the vehicles the legislature has chosen to deliver these programs. They are therefore subject to *Charter* scrutiny.

109. Furthermore, AHS and ABC Hospital cannot escape *Charter scrutiny* for the Respondent physicians' actions regardless of whether a formal, written Covid-19 vaccine policy for transplant services existed. Dr. A confirmed that AHS does not always have a formal policy and standard practice allows medical management decisions to be made by the practicing physicians:

> So when it comes to medical management, AHS has its frameworks, but they allow medical management decisions to be left up to the clinical team. At that time, I am uncertain whether AHS had a policy. But when we considered the Covid-19 vaccine, we considered it like other clinical decisions where we took the best available information, our concern for our patients and our efforts to have the best outcomes for our patients and to ensure medical optimization, and made our decisions based on those factors, our medical decisions. For many things, AHS will never have a policy.[110]

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[109] *Eldridge v. British Columbia (Attorney General)*, 1997 CanLII 327 (SCC), [1997] 3 SCR 624 para 43 ["*Eldridge*"] **[TAB 8, BOA]**
[110] Dr. A Transcript page 45, lines 2-14.

110. Further, Dr. B confirmed to Ms. Lewis at a telemedicine appointment on November 15, 2021, that AHS was mandating the Covid-19 vaccine for all transplant patients.[111] By that time, the Requirement was no longer imposed by the Respondent doctors alone, and AHS and the ABC Hospital were imposing it despite the fact that none of the Respondents had a written policy.

LTP Physicians Are Bound by the Charter

111. The Respondent doctors are state actors and are bound by the *Charter*.

112. As evidenced in *Eldridge* courts have consistently held that government cannot contract out of their *Charter* obligations. It is Ms. Lewis's submission that a physician, albeit an independent contractor, is subject to that same scrutiny.

113. While the Supreme Court of Canada in *Eldridge* did not specifically rule on the application of the *Charter* to the actions of independent contractors, or non-employee health care providers working in hospitals like the Respondent physicians, the Alberta Court of Appeal recently considered the nature of the activity itself. In *UAlberta Pro-Life v Governors of the University of Alberta*, the Alberta Court of Appeal found:

> …an entity may be found to attract *Charter* scrutiny with respect to a particular activity that can be ascribed to government. This demands an investigation not into the nature of the entity whose activity is impugned but rather into the nature of the activity itself. In such cases, in other words, one must scrutinize the quality of the act at issue, rather than the quality of the actor. If the act is truly "governmental" in nature -- for example, the implementation of a specific statutory scheme or a government program -- the entity performing it will be subject to review under the *Charter* only in respect of that act, and not its other, private activities. [emphasis added][112]

[111] Dr. A Affidavit, Exhibit K, page 15
[112] *UAlberta Pro-Life v Governors of the University of Alberta*, 2020 ABCA 1 at para 128. **[TAB 9, BOA]**

114. Ms. Lewis submits that because the Respondent physicians provide life-saving [redacted] transplants under provincial health insurance and health services legislation, such health care services are among the most significant social policies and programs provided by Canadian governments. The Respondent physicians in delivering medical services as part of the LTP at ABC Hospital are subject to the same *Charter* scrutiny in delivering those services.[113]

115. In delivering medical services to the public pursuant to government legislation providing for those services, physicians are subject to the *Charter* even as independent contractors, because like AHS and hospitals, physicians and other publicly funded health care providers can readily be characterized as acting "as agents for government in providing the specific medical services set out" in provincial health insurance legislation, under the general framework of the *Canada Health Act.*[114]

3. The Standard of Review

116. The Supreme Court of Canada in *Dore v Barreau du Quebec*[115] asserts that when the constitutionality of a law is in question, as opposed to an administrative decision, courts are to apply the section 1 *Oakes* test and specifically stated:

> It is clear from the decisions of the Tribunal and the reviewing courts in this case that there is some confusion about the appropriate framework to be applied in reviewing administrative decisions for compliance with *Charter* values. Some courts have used the same s. 1 *Oakes* analysis used for determining whether a law complies with the *Charter*; others have used a classic judicial review approach.[116]

117. The Supreme Court of Canada explained that the standard of review in *Dore* applies to administrative discretionary decisions which affect the rights of a particular individual, as distinct from laws of general application and clarified this distinction:

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[113] Dr. A Affidavit, para. 5
[114] *Eldridge*, at para 665. **[TAB 8, BOA]**
[115] *Doré v. Barreau du Québec*, 2012 SCC 12 (CanLII) **[TAB 10, BOA]**
[116] *Ibid* at para 40.

> As explained by Chief Justice McLachlin in *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37, [2009] 2 S.C.R. 567, **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** (see also Bernatchez). **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 (para. 53; see also *Suresh v. Canada (Minister of Citizenship and Immigration)*, 2002 SCC 1, [2002] 1 S.C.R. 3, at para. 39). **When a particular "law" is being assessed for *Charter* compliance, on the other hand, we are dealing with principles of general application**.[117]

118. In this case, the Requirement is a policy which has general application to all [redacted] transplant candidates in Alberta, not just Ms. Lewis. The applicable standard of review of the Requirement is *correctness*, and a section 1 analysis under *R. v. Oakes*.[118]

119. In the alternative, if this court finds that the administrative Decision made by the Respondents to impose the Requirement upon Ms. Lewis is being reviewed, the standard of review is *reasonableness*. In that instance, a section 1 analysis is undertaken, but it is different from the *Oakes* analysis. When an administrative decision implicates the *Charter* rights of an individual, the question is whether that decision reflects a proportionate balancing between the *Charter* rights with the objective of the measure.

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[117] *Dore* at para. 36 **[TAB 10, BOA]**

[118] *R. v. Oakes*, [1986] 1 SCR 103; See also: *The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2018 ONSC 579 (CanLII) at paras. 51-69 **[TAB 13, BOA]**

4. Ms. Lewis's *Charter* Rights Have Been Infringed

A. The Requirement Violates Ms. Lewis' Section 2(a) *Charter* Right of Conscience

120. Ms. Lewis states in her affidavits that having to take one of the recently-developed Covid-19 vaccines offends her conscience and that she ought to have the choice about what goes into her body without the threat of losing her life.[119] She states in her second affidavit:

> For my whole life, I have had a very strong belief that a person should have the free will to choose what goes into their body. Refusing this vaccine even at the cost of losing my life was the only choice I could ultimately make without violating my conscience. Being threatened, under duress, to take an experimental medical treatment or face the loss of ones life is a complete affront to my conscience and my belief in free till. While I was tempted to take it to save my life, in the end, I was and remain faithful to my conscience.[120]

121. In *R. v. Morgentaler*[121], the Supreme Court of Canada discussed the freedom of conscience, citing from its previous decision in *R. v. Big M Drug Mart*:

> What unites enunciated freedoms in the American First Amendment, in s. 2(*a*) of the *Charter* and in the provisions of other human rights documents in which they are associated is the notion of the centrality of individual conscience and the inappropriateness of governmental intervention to compel or to constrain its manifestation. In *Hunter v. Southam Inc.*, *supra*, the purpose of the *Charter* was identified, at p. 155, as "the unremitting protection of individual rights and liberties." It is easy to see the relationship between respect for individual conscience and the valuation of human dignity that motivates such unremitting protection.
>
> It should also be noted, however, that an emphasis on individual conscience and individual judgment also lies at the heart of our democratic

[119] Lewis Affidavit, at paras. 30, 36
[120] Lewis Affidavit 2, para. 6
[121] *R. v. Morgentaler*, 1988 90 (SCC), [1988] 1 SCR 30 **[TAB 14, BOA]**

> political tradition. **The ability of each citizen to make free and informed decisions is the absolute prerequisite for the legitimacy, acceptability, and efficacy of our system of self-government. It is because of the centrality of the rights associated with freedom of individual conscience both to basic beliefs about human worth and dignity** and to a free and democratic political system that American jurisprudence has emphasized the primacy or "firstness" of the First Amendment…
>
> Viewed in this context, the purpose of freedom of conscience and religion becomes clear. The values that underlie our political and philosophic traditions demand that **every individual be free to hold and to manifest whatever beliefs and opinions his or her conscience dictates**, provided *inter alia* only that such manifestations do not injure his or her neighbours or their parallel rights to hold and manifest beliefs and opinions of their own.
>
> It seems to me, therefore, that in a free and democratic society "freedom of conscience and religion" should be broadly construed to extend to conscientiously-held beliefs, whether grounded in religion or in a secular morality…
>
> Legislation which violates freedom of conscience in this manner cannot, in my view, be in accordance with the principles of fundamental justice within the meaning of s. 7.[122] [Emphasis added]

122. Dr. Barry Bussey, writing recently in *The Forgotten Fundamental Freedoms of the Charter*, published by LexisNexis, postulates freedom of conscience as "the foundational rights that leads to most, if not all, other human rights."[123] He states:

> Although freedom of conscience is frequently subsumed by religion, the two concepts are not the same. Indeed, though often intertwined with religious motivations, conscience represents an even deeper, inner principle

[122] *Ibid*, at para. 257
[123] Barry W. Bussey, "Blazing the Path: Freedom of Conscience as the Prototypical Right," *The Forgotten Fundamental Freedoms of the Charter* (Toronto: Lexis Nexis, 2020) at 145. **[TAB 38, BOA]**

> which is accessible to all, regardless of their faith or lack of faith. It is, at heart, the individual's undertaking of the truth and his responsibility to that truth. This profound and uncompromising allegiance, which supersedes any other commitment, demands accommodation.[124]

123. Professor Brian Bird, writing in the same volume, describes the legal analysis for freedom of conscience as analogous to freedom of religion, stating the test as follows: "does the claimant hold a sincere moral commitment with which the state has interfered in a manner that is more than trivial?"[125] Professor Bird asserts that "[m]atters of conscience are also often fundamental to identity," linked to integrity and identity.[126] He states:

> Conscience points to moral judgments, and living in alignment with these judgments (or not) affects our integrity and identity. Living conscientiously sustains and develops integrity and identity while living unconscientiously leads to the opposite result. A person who violates her moral judgments—and therefore injures her integrity or identity—suffers harm.[127]

124. Although not a religious belief, Ms. Lewis' longstanding and firm belief in individual bodily autonomy is equally entitled to our *Charter*'s protection. The unethical attempts of the Respondent physicians to coerce Ms. Lewis into taking the recently developed Covid-19 vaccine have affronted Ms. Lewis' conscience to such an extent that despite facing the loss of her life, she has remained faithful to her conscience.[128]

B. The Requirement Violates Ms. Lewis' Section 7 *Charter* Rights

125. The Requirement also violates Ms. Lewis' right to life, liberty, and security of the person under section 7 of the *Charter*. The section 7 protection provides that:

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[124] *Ibid* at 146.
[125] Brian Bird, "The Reasons for Freedom of Conscience," *The Forgotten Fundamental Freedoms of the Charter* (Toronto: Lexis Nexis, 2020) at 118. **[TAB 39, BOA]**
[126] *Ibid* at 112.
[127] *Ibid*.
[128] Lewis Affidavit 1, para 30; Lewis Affidavit 2, paras. 5-6.

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

126. These principles guard against laws, government decisions, or state action that is overbroad, arbitrary, or grossly disproportionate.

127. The liberty interest protects the right of individuals to bodily autonomy, free bodily movement, core lifestyle choices, and fundamental relationships. The security of the person interest protects the right of individuals to be free from state action that threatens physical harm to their bodies or a "serious and profound effect on a person's psychological integrity."[129] Liberty and security of the person are engaged when informed consent is at issue in respect of government action.

Life – the right to live

128. The Requirement is an ultimatum that places Ms. Lewis in an unbearable situation. Withholding life-saving treatment and utilizing the threat of imminent death to coerce her to capitulate to the Requirement is the ultimate duress. The exploitation of her vulnerability in such an egregious manner may have no precedent in Canadian medical history. As Ms. Lewis sets out, it is profoundly disturbing that the government's provision of a known and life-saving medical intervention is contingent upon the receipt of a novel and experimental medical intervention.[130]

129. The Supreme Court of Canada in *Chaoulli v Quebec*[131] has held that state action giving rise to an increased risk of death has been held to engage the section 7 right to life. While there is not a constitutional right to health care, the government is not entitled to remove health care from those otherwise entitled to receive it in a manner that violates their *Charter* rights and freedoms.

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[129] *New Brunswick (Minister of Health and Community Services) v G(J),* [1999] 3 SCR 46, 1999 653 (SCC) at para 60 [*New Brunswick*]. **[TAB 15, BOA]**
[130] Lewis Affidavit 1, para 33.
[131] *Chaoulli v. Quebec (Attorney General),* 2005 SCC 35 [2005] 1 SCR 791 [*Chaoulli*]. **[TAB 16, BOA]**

130. Concurring with the decision of Justice Deschamps, Chief Justice McLachlin and Justice Major wrote:

> The primary objective of the *Canada Health Act*, R.S.C. 1985, c. C-6, is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial **or other barriers**" (s. 3). By **imposing exclusivity** and then failing to provide public health care of a reasonable standard **within a reasonable time**, the government creates circumstances that trigger the application of s. 7 of the *Charter.*[132]
> [bold emphasis added]

131. It is Ms. Lewis's position there has been a clear violation of her section 7 right to life, coupled with an obvious disregard for her life. Imposing the Requirement on Ms. Lewis in her vulnerable and defenseless state is reprehensible. If she does not comply with the Requirement she will not survive – it is, without exaggeration, a death sentence.

Right to Liberty

132. Liberty includes freedom from physical restraint but also applies when a law prevents a person from making "fundamental personal choices."[133] In *Carter v. Canada*, the Supreme Court of Canada found that a law which prohibited aiding or abetting a person to commit suicide deprived the plaintiff of liberty in a manner not in accordance with the principles of fundamental justice. It found that the law denied her the right to make a fundamental personal choice free from state interference:

> **An individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy.** The law allows people in this situation to request palliative sedation, refuse artificial nutrition and hydration, or request the removal of life-sustaining medical equipment, but denies them the right to request a physician's assistance in dying. This interferes with their ability to make decisions

[132] *Chaoulli* at para 105.
[133] *Blencoe v. British Columbia*, [2000] 2 S.C.R. 307 [*Blencoe*] **[TAB 17, BOA]**

> concerning their bodily integrity and medical care and thus trenches on liberty.[134] [Emphasis added].

133. Dr. Benjamin Turner states in his expert report that a primary principle of medical ethics is respect for patient autonomy. He wrote: "Agents are said to be autonomous when they direct themselves toward their own chosen ends… Attempts to influence a patient's decisions with threats or promises demonstrate a lack of respect for autonomy; they are intended to make the patient choose something other than his own preferred means or ends."[135]

134. The Requirement has deprived Ms. Lewis of liberty as it has restricted her ability to make a fundamental personal choice free from state interference. The Respondents have threatened her with death if she does not comply and a promise of a chance to experience a longer life if she does comply. The Requirement has made her life dependent upon her complying with a government-dictated choice which violates her conscience and leaves her highly fearful for her physical welfare.

Right to security of the person

135. Security of the person is generally given a broad interpretation and has both a physical and psychological aspect. The Supreme Court of Canada held that it encompasses "a notion of personal autonomy involving... control over one's bodily integrity free from state interference."[136] It further held that security of the person is engaged by state interference with an individual's physical or psychological integrity, including any state action that causes physical or serious psychological suffering.[137]

136. There is no question that the Requirement has caused Ms. Lewis significant psychological suffering and distress.[138] The Requirement is inherently coercive, removing Ms. Lewis' notion of personal autonomy and her ability to decide independently. A choice made under the circumstance of death cannot be said to be free or voluntary. It violates her freedom of conscience. It is the very

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[134] *Carter v Canada (Attorney General),* 2015 SCC 5, [2015] 1 SCR 331 at para 64 [*Carter*]. **[TAB 18, BOA]**
[135] Turner Report 1, pages 2-3
[136] *Rodriguez v British Columbia (Attorney General),* [1993] 3 SCR 519, at pp. 587-88 (para 136) per Sopinka J. **[TAB 19, BOA]**
[137] *New Brunswick*, at para 58; *Chaoulli* at paras. 43, 191 and 200 **[TAB 15, BOA]**
[138] Lewis Affidavit 2, paras. 4-6

embodiment of duress. Accordingly, it offends longstanding medical ethics principles codified in the Canadian Medical Association (**"CMA"**) Code of Ethics and Professionalism.[139]

137. In an email Ms. Lewis wrote to the LTP team on November 18, 2021, she wrote:

> …On a day-to-day basis, I go through so much turmoil in my mind it is driving me to such depression because of the fact that I am being forced into these vaccines which I do not want at all. Due to the fact I hardly get any proper rest now because it is constantly on my mind that the transplant team says the only way, I can get my transplant now is to get the Covid 19 vaccines. If I get the Covid 19 vaccines I believe a lot of harm will come to my body as well if I don't get the Covid 19 vaccines I will surely meet death soon. So, either way I am given a death sentence and that is playing very hard on my mind and am under so much stress, all over an experimental vaccine…[140]

138. There are similarities between Ms. Lewis' case and the *R. v. Morgentaler* case. In that case, the *Criminal Code* section which prohibited abortion was found to violate pregnant women's section 7 rights to choose what they did with their bodies, despite the fact that the Court acknowledged that the intention of the section was to protect the life of the unborn baby and the safety of the mother. A woman's right to choose prevailed over the right of her unborn fetus to live. In this case, the Respondents argue for the right to determine for Ms. Lewis what experimental medical treatment goes into her body as a condition to their willingness to try to save her life with transplant surgery. If she does not succumb to *their* choice, she will not survive.

139. In its discussion on security of the person, the Supreme Court of Canada in *Morgentaler* wrote:

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[139] Affidavit of Dr. Benjamin Turner, Sworn February 18, 2022, Exhibit "A", Schedule "C", TAB 5
[140] Dr. A Affidavit, Exhibit L, page 1

> At the most basic, physical, and emotional level, every pregnant woman is told by the section that she cannot submit to a generally safe medical procedure that might be of clear benefit to her unless she meets criteria entirely unrelated to her own priorities and aspirations. **Not only does the removal of decision-making power threaten women in a physical sense; the indecision of knowing whether an abortion will be granted inflicts emotional stress**. Section 251 clearly interferes with a woman's bodily integrity in both a physical and emotional sense. Forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person. Section 251, therefore, is required by the *Charter* to comport with the principles of fundamental justice.[141] (emphasis added)

140. Like the abortion committees did to pregnant women in *Morgentaler*, the Respondents have removed the decision-making power from Ms. Lewis. Not knowing whether she is on the transplant list or whether the Requirement will be lifted when she is quite literally fighting for her life has caused her severe emotional stress. The Requirement interferes with her bodily integrity in a physical and emotional sense. Pressuring her with the threat to her life to take an experimental drug that she doesn't want is a profound interference with her body and a violation of security of the person.

141. She states: "I am under incredible stress over the fact that these doctors are demanding I take this vaccine in order for me to get my life-saving surgery. I am having trouble sleeping, and I am filled with mental anguish knowing that I will die without this surgery."[142]

142. She also states: "This decision whether or not to take this experimental Covid-19 vaccine has been agonizing for me and has caused me incredible stress and sorrow. I went back and forth with this decision because I do not want to die. I came close to getting a vaccine that I did not want

[141] *Morgentaler,* pages 56-57 **[TAB 14, BOA]**
[142] Lewis Affidavit 1, para 28.

to take and felt under tremendous duress because of my wish to live. However, my conscience always stopped me from taking it in the end."[143]

143. While she waits, Ms. Lewis:

a) is dependent on supplied oxygen to breathe;
b) has 35% [redacted] capacity remaining;
c) has extremely limited mobility; and
d) is aware of her terminal condition with months to live.

144. The resultant psychological strain on Ms. Lewis due to the Respondent's coercive actions must be considered in light of her already painful and very difficult circumstances.[144] Additional psychological stress placed on a person in such a condition not only rises well above the scale of the ordinary but is also cruel.

Informed Consent – Liberty and Security of the Person

145. Informed consent is an established part of the section 7 *Charter* protections in Canadian jurisprudence. In *Carter*, the Supreme Court of Canada determined:

> The law has long protected patient autonomy in medical decision-making. In *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 S.C.R. 181, a majority of this Court, per Abella J. (the dissent not disagreeing on this point), endorsed the "tenacious relevance in our legal system of the principle that competent individuals are — and should be — free to make decisions about their bodily integrity" (para. 39). This right to "decide one's own fate" entitles adults to direct the course of their own medical care (para. 40): **it is this principle that underlies the concept of "informed consent" and is protected by s. 7's guarantee of liberty and security of the person**

[143] Lewis Affidavit 2, paras. 4-5
[144] *Blencoe* at para 56. **[TAB 17, BOA]**

> (para. 100; see also *R. v. Parker* (2000), 2000 CanLII 5762 (ON CA), 49 O.R. (3d) 481 (C.A.)).[145]

146. As will be established below, the Requirement breaches [redacted] transplant candidates' rights to liberty and security of the person because it precludes candidates from providing their informed consent. As Dr. Turner states in his expert report:

> An attempt to coerce the patient toward vaccination by means of fear is not compatible with patient autonomy. The patient is faced with the alternatives of a treatment she does not want and certain death in the medium term. **If she permits herself to be vaccinated at this point, she will have undergone medical treatment under duress, and therefore without free consent**.[146]

147. Dr. Kates also agreed on cross-examination that threats or promises must not influence informed consent.[147]

148. Consent requirements are part of the common law and have evolved through judicial decisions. The courts have insisted that consent is valid only if the patient has been fully informed of the risks and benefits of the proposed procedure. In a leading case, the court held that:

> Without a consent, either written or oral, no surgery may be performed. This is not a mere formality; it is an important individual right to have control over one's own body, even where medical treatment is involved. It is the patient, not the doctor, who decides whether surgery will be performed, where it will be done, when it will be done by whom it will be done.[148]

149. The patient must be given sufficient information to weigh the risks and benefits for consent to be informed. In *Reibl v. Hughes*, the Supreme Court of Canada held that the test is whether "the reasonable person in the patient's position, knowing of the risks, have

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[145] *Carter*, at para. 67 **[TAB 18, BOA]**
[146] Turner Report 1, page 4, para. 3
[147] Kates Transcript, p. 94, lines 10-12
[148] *Reibl v. Hughes*, 1980 CanLII 23 (SCC). **[TAB 20, BOA]**

consented to the treatment." According to the New Brunswick Court of Appeal, a doctor's duty to inform a patient of a risk that was "uncommon," "extraordinary," but known to "occur occasionally" was a breach of his duty to inform his patient before treatment.[149]

150. Dr. Mallard also wrote about informed consent in her expert report. She attached the AHS document "Consent to Treatment/Procedures" which explains that patients must be informed of the potential risks and benefits of proposed treatment, and the patient shall have the opportunity, without undue influence, to accept or refuse a treatment, and that decision shall not prejudice their access to ongoing or future health care.[150]

151. Dr. Cypel agreed in his cross-examination that doctors need to provide patients information about the risks and benefits of medical treatment in order for them to provide informed consent and that explaining risks is especially important when the patient expresses repeated fears of the treatment.[151] He agreed it would be good medical practice to discuss the Health Canada warnings with Ms. Lewis.[152] There is no written evidence that this was ever done, and Ms. Lewis's unchallenged evidence is that it was not.[153] Dr. A admitted in cross-examination, it is her usual practice to make notes of her interactions with patients.[154]

152. Ms. Lewis' unchallenged evidence is that the Respondent Doctors never fully explained all the risks and benefits of the Covid-19 vaccine to her, including the specific known Health Canada warning labels on the Covid-19 vaccines for the conditions of myocarditis, Bell's Palsy, thrombocytopenia, and venous thrombocytopenia.[155] It is also Ms. Lewis' evidence that she brought up concerns about the safety and efficacy of the Covid-19 vaccines with various members of the LTP team. And while Ms. Gilda Frizzell made notes about an alleged discussion of risks and benefits between Dr. A and Ms. Lewis in May 2021, Dr. A made no such notes after any of Ms. Lewis' many appointments and neither did any of the other Respondent Doctors.

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[149] *Kitchen v. McMullen*, 1989 CanLII 218 (NB CA), at para. 22. **[TAB 21, BOA]**
[150] Mallard Report 1, pp. 17-18.
[151] Cypel Transcript, p. 49, lines 20-25; p. 50, lines 1-2, 22-25; p. 51, lines 1-2.
[152] Cypel Transcript, p. 49, lines 20-25; p. 50, lines 1-2, 22-25; p. 51, lines 1-2.
[153] Lewis Affidavit 1, para. 35.
[154] Dr. A Transcript, p. 65, lines 8-15
[155] Lewis Affidavit 1, para. 35.

153. Dr. Cypel further agreed that it is good practice for physicians to have more than one discussion about risks if new risks of a recommended treatment become known after the first discussion on risks occurred.[156] The only written reference in the medical notes from Ms. Lewis' file to a discussion about the risks of the Covid-19 vaccines was from May 2021,[157] before the Health Canada warnings about myocarditis, Bell's Palsy, and venous thrombocythemia were published. They were given warning labels on April 26, 2021 (Thrombosis – Johnson & Johnson), June 30, 2021 (myocarditis), August 6, 2021 (Bell's Palsy), and November 9, 2021 (venous thromboembolism – Johnson & Johnson, Astra Zeneca).[158]

154. Ms. Lewis submits that it is improper and bad medical practice for the Respondent Doctors not to have specifically discussed the risk and benefit of the Covid-19 vaccines, as it relates to Ms. Lewis specifically, particularly given that she expressed significant concern and fear about taking the Covid-19 vaccines. There are no notations in the Respondent Doctors' notes about any discussions regarding these safety warnings with her.

155. It was not possible for Ms. Lewis to provide informed consent to the Covid-19 vaccines because the risks were never fully explained to her by Respondent Doctors. Her evidence on this point was unchallenged by the Respondents. Further, and as noted by Dr. Turner, she cannot provide informed consent because she would have been doing so under coercion and duress to save her own life, against her conscience and bodily autonomy.[159]

C. Section 7's Inherent limits – The Principles of Fundamental Justice

156. Limitations of the section 7 interests are only lawful so long as the infringements caused by government action or a law are in accordance with the principles of fundamental justice.[160]

157. According to the Supreme Court of Canada, the principles of fundamental justice "are about the basic values underpinning our constitutional order."[161] It has recognized a number of

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[156] Cypel Transcript, p. 45, lines 19-25; p. 46, line 1
[157] Dr. A Affidavit, Exhibit D, page 124
[158] Lewis Affidavit 1, Exhibits M and N
[159] Turner Report 1, page 4, para. 3
[160] *Canada (Attorney General) v Bedford*, 2013 SCC 72, [2013] 3 SCR 1101 at paras 74-78 [*Bedford*]
[161] *Bedford* at para 96. **[TAB 22, BOA]**

principles of fundamental justice, but three have "emerged as central… laws that impinge on life, liberty or security of the person must not be arbitrary, overbroad, or have consequences that are grossly disproportionate to their object."[162]

158. Therefore, a law will be contrary to the principles of fundamental justice if the infringement of or interference with the section 7 rights is arbitrary, overbroad, or grossly disproportionate.

Arbitrariness

159. Arbitrariness involves:

> …whether there is a direct connection between the purpose of the law and the impugned effect on the individual, in the sense that the effect on the individual bears some relation to the law's purpose. There must be a rational connection between the object of the measure that causes the s. 7 deprivation, and the limits it imposes on life, liberty, or security of the person. A law that imposes limits on these interests in a way that bears no connection to its objective arbitrarily impinges on those interests.[163]

160. A law is arbitrary when there is no rational connection between the limit on the right and the object of the law. An arbitrary law is one that limits rights but is not capable of fulfilling or in any way furthering the objectives of that law.[164]

161. The Requirement is arbitrary and cannot fulfill the objective of protecting Ms. Lewis from Covid-19 for these reasons:

i. The Covid-19 vaccines are ineffective in preventing infection and transmission and protecting against Covid-19 infection,[165] the very reason the Requirement and the Decision are purported to be imposed;

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[162] *Carter v Canada (Attorney General),* 2015 SCC 5, [2015] 1 SCR 331 at para 72 [*Carter*] **[TAB 18, BOA]**
[163] *Bedford* at para 111. **[TAB 22, BOA]**
[164] *Carter*, *supra*, at para. 85; *Bedford*, *ibid*.
[165] Mallard Transcript p. 35, lines 5-11; p. 48, line 3; p. 58, lines 18-23; Bridle Transcript, p. 38, lines 1-5; p. 42, lines 8-10, 13-15; p. 42, lines 23-25; p. 43, lines 1-5; Bridle Report, p. 2, para, 2; p. 3, para. 1; Affidavit of Dr. Benjamin Turner, Sworn February 18, 2022, Exhibit "A", Expert Report dated February 18, 2022 ["Turner Report 2"], page 18, para. 1

ii. Alberta's own public health data shows that vaccinating a patient awaiting a [redacted] transplant would increase her risk of contracting Covid-19.[166] Mandating the vaccines would increase Ms. Lewis's risk of contracting Covid-19 and would put her transplanted [redacted] tissue at enhanced risk of harm;[167]

iii. Dr. A's evidence was that all transplant candidates who had Covid-19 were vaccinated, and she did not know of any unvaccinated transplant candidates who had Covid-19;

iv. The Requirement and the Decision fail to take into consideration natural immunity to Covid-19, a consideration even the Respondents' experts agreed was important;[168] and

v. During the Covid-19 pandemic, but before the Covid-19 vaccines were available, the Respondents did not put a stop to [redacted] transplants.[169]

Overbreadth

162. As for overbreadth, if an impugned law or government measure which limits section 7 rights "goes too far and interferes with some conduct that bears no connection to its objective," it will be overbroad.[170]

163. The Requirement is overbroad as it may affect [redacted] transplant candidates who have recovered from Covid-19 and who do not need the Covid-19 vaccine because their natural immunity may protect them from infection and a serious outcome from Covid-19. Dr. Mallard's and Dr. Bridle's evidence is that natural immunity is superior and longer-lasting than the immunity conferred by the Covid-19 vaccines.[171]

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[166] Bridle Report, p. 7, para. 8
[167] Bridle Report, p. 7, para. 8
[168] Mallard Transcript p. 59; lines 5-6, 11-16; Mallard Report 1, p. 14-15; Bridle Report, p. 8, para. 9; Kates Transcript, p. 57, lines 14-17; Houghton Transcript, p. 97, lines 12-17
[169] Dr. A Affidavit, para. 32
[170] *Bedford* at para 101. **[TAB 22, BOA]**
[171] Mallard Report 1, pages 14-16; Mallard Transcript p. 59; lines 5-6, 11-16; Bridle Report, p. 8, para. 9

164. As Dr. Houghton admitted in his expert report and on cross-examination, the protection from the Covid-19 vaccines is temporary. He also admitted that recovery from Covid-19 "produces some immunity"[172] and that patients should be tested for natural immunity.[173]

165. The Requirement could have been structured so that all [redacted] transplant candidates are tested to see if they have antibodies to Covid-19 in their blood and to what degree an immunologist says they are immune to Covid-19. The Requirement currently completely ignores natural immunity, and therefore, it is overbroad – punishing [redacted] transplant patients who do not need the vaccine with certain death.

Gross Disproportionality

166. Regarding gross disproportionality, the Supreme Court of Canada has stated, "if the impact of the restriction on the individual's life, liberty or security of the person is grossly disproportionate to the object of the measure," the restriction will not be found to accord with the principles of fundamental justice.[174] The Court further found:

> The inquiry into gross disproportionality compares the law's purpose, "taken at face value", with its negative effects on the rights of the claimant, and asks if this impact is completely out of sync with the object of the law.[175]

167. According to Dr. A, the objective of the Requirement is to: (1) minimize the risk of adverse outcomes from Covid-19 post-transplant *and* (2) minimize the risk associated with contracting Covid-19 while waiting to be transplanted.[176] This objective seeks to preserve the health of a patient in the care of the LTP team and to take actions which, in their opinion, will protect her from harm.

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[172] Houghton Transcript, p. 29, lines 7-16; Houghton Report, p. 3, para. 11
173 Houghton Transcript, p. 97, lines 12-17.
[174] *Carter*, at para 89. **[TAB 18, BOA]**
[175] *Carter*, at para 89. **[TAB 18, BOA]**
[176] Dr. A Affidavit, para. 31

168. The impact of the Requirement on Ms. Lewis, which violates her right of conscience, freedom of choice and control over her bodily autonomy, is the loss of her life, which is diametrically opposed to the Respondents' medical duty and objective. As noted, the Respondents' objective is to prevent the loss of their patients' lives. Therefore, the Requirement is grossly disproportionate.

D. The Requirement Violates Ms. Lewis' Section 15 Charter Rights

169. Section 15 of the *Charter* states:

> Equality Rights
>
> 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.
>
> (2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

170. The overarching principle of section 15 of the *Charter* is the provision of equal protection from discrimination on both enumerated and analogous grounds.

171. Ms. Lewis submits that being "unvaccinated against Covid-19" ought to be considered an analogous ground of discrimination under section 15 of the *Charter*.

172. The Supreme Court of Canada, in *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497, determined that the list of analogous grounds is not closed.[177] Ms. Lewis submits that with the numerous governmental policies across Canada making Covid-19 vaccination requirements for work, social settings, and travel and thereby imposing widespread

[177] *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497, at para. 88 **[TAB 23, BOA]**

disadvantage and social discrimination, adding this "medical status" as an analogous ground is highly appropriate and proper.

173. The Supreme Court of Canada in *Fraser v Canada (Attorney General)*[178] ("*Fraser*") held that the claimant must first demonstrate that the effect of an impugned law or policy creates a distinction based on an enumerated or analogous ground, in the sense that the law or policy disproportionately impacts members of a protected group.[179] The Supreme Court of Canda determined that even policies that are seemingly neutral in their application may have "built-in headwinds" for members of protected groups[180] and stressed that the principle of substantive equality is the "animating norm" of section 15, which contextually recognizes that "identical or facially neutral treatment may 'frequently produce serious inequality."[181]

174. Ms. Lewis submits that the effect of the Requirement disproportionately impacts members of a group of people who are unvaccinated for Covid-19. She is asking this Court to add "medical status" to the list of analogous grounds. "Medical status" under these circumstances would refer to the personal characteristics of an individual who lacks the presence of a pharmaceutical product within her body but could also include other circumstances in other future cases. As noted above, such an addition to the list of analogous grounds is timely. Assuming the court agrees and finds that "medical status" is an appropriate addition to the list of analogous grounds under section 15 of the *Charter*, Ms. Lewis submits that the Requirement disproportionately impacts her on the basis of her medical status as a person unvaccinated for Covid-19. The effect of the Requirement on her and other Canadians like her would be the denial of her eligibility for life-saving medical treatment, as compared to those Canadians who have been vaccinated for Covid-19 who would be eligible to receive that life-saving treatment.

175. At the second stage of the section 15 test, the claimant must demonstrate that the challenged law or policy has the effect of reinforcing, perpetuating, or exacerbating her disadvantage.[182] The existence of systemic or historical disadvantages (including social prejudices or stereotyping) may

[178] *Fraser v Canada (Attorney General)*, 2020 SCC 28 [Fraser]. **[TAB 24, BOA]**
[179] *Fraser*, at para. 52.
[180] *Fraser*, at para. 53
[181] *Fraser*, at paras. 42, 47
[182] *Fraser*, at para. 76

be relevant in making this determination, but these are not necessary factors; the section 15 inquiry focuses on discriminatory impacts and effects, not discriminatory attitudes or intentions.[183] The Supreme Court of Canada in *Fraser* removed the requirement that such disadvantage is arbitrary, holding that it is ultimately the government's onus under section 1 to demonstrate that policies which limit section 15 are not arbitrary.[184]

176. The Supreme Court of Canada in *Fraser* stated: "There is no "rigid template" of factors relevant to [the second step] inquiry," and that, "The goal is to examine the impact of the harm caused to the affected group" and that this harm "may include "[e]conomic exclusion or disadvantage, [s]ocial exclusion . . . [p]sychological harms . . . [p]hysical harms . . . [or] [p]olitical exclusion."[185]

177. The impact of the Requirement on Ms. Lewis includes psychological and physical harm. She has been threatened with the loss of her life if she does not comply with the Requirement. The coercion and duress resulting from the Requirement has caused her immense stress and despair, and this discriminatory Requirement will lead to her death if she does not comply.

178. The basis of her ineligibility for a [redacted] transplant is her "medical status" of being a person unvaccinated for Covid-19, and it does not matter that others with a different medical status (i.e. people unvaccinated for Covid-19 but who have a "valid medical exemption") are eligible for a [redacted] transplant. Where the law has "a disproportionate impact on members of a protected group ... the first stage of the s. 15 test will be met,"[186] and "disproportionate impact can be established if members of protected groups are denied benefits … more frequently than others."[187] "Heterogeneity" within the claimant group "does not defeat a claim of discrimination."[188] That is, it is not a defence for the Respondents that the discriminatory effect is experienced by only some [redacted] transplant candidates who are unvaccinated for Covid-19 rather than all [redacted] transplant candidates who are unvaccinated for Covid-19.

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[183] *Fraser*, at para. 329.
[184] *Fraser*, at para. 144
[185] *Fraser*, at para. 76.
[186] *Fraser*, at para. 52
[187] *Fraser*, at para. 55
[188] *Fraser*, at para. 75. see also paras. 51, 72-73

179. Ms. Lewis does not have to prove a governmental intention to discriminate,[189] nor to "independently prove that the protected characteristic "caused" the disproportionate impact."[190] Nor is a discriminatory impact excused under s. 15 "simply because it was relevant to a legitimate state objective … Similarly, there is no burden on a claimant to prove that the distinction is arbitrary to prove a *prima facie* breach of s. 15(1)."[191] The focus in section 15 is on distinction and differential impact only. All of the Respondents' justificatory arguments about the purpose for the impugned provisions must be addressed in the section 1 analysis.

180. Moreover, any suggestion that Ms. Lewis could have avoided the discrimination by choosing to be vaccinated despite her intense fear of the Covid-19 vaccine, worries about its safety, and the affront to her conscience, is no defence.[192] Rather, "[t]he very act of forcing some people to make such a choice violates human dignity, and is therefore inherently discriminatory."[193]

181. The Requirement fails to respond to the actual needs of persons whose conscience prevents them from receiving the Covid-19 vaccine. It instead imposes a burden on her in a manner that has the effect of reinforcing, perpetuating, or exacerbating her disadvantage.

5. Analytical Framework for the Justification of the Respondents' *Charter* infringing Policy

A. Justification for the Requirement

182. The *Charter* 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. Should the court agree that Ms. Lewis's *Charter* rights have been breached, the onus shifts to the Respondents to justify those breaches under section 1 of the *Charter*. Specifically, this case will be determined on the basis of whether the Respondents prove that the Requirement is "prescribed by law as can be demonstrably justified in a free and democratic society."

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[189] *Fraser*, at para. 35
[190] *Fraser*, at para. 70
[191] *Fraser,* at paras. 79, 80
[192] *Fraser*, at paras. 86-92
[193] *Fraser*, at para. 87, quoting *Lavoie v. Canada*, [2002] 1 S.C.R. 769.

183. The case of *Greater Vancouver Transportation Authority* explains what constitutes the meaning of "prescribed by law", and thus whether the Requirement is able to be justified by the government under section 1. For a limit to be prescribed by law: (1) the government entity in question must have been authorized to enact the policy; (2) the policy in question must set out binding rules of general application; (3) the policy must be sufficiently precise so as to enable people to regulate their conduct by it, and so as to provide guidance to those who apply the law; (4) the policy must be sufficiently accessible to give notice to the public of the rules to which they are subject.[194]

184. In this case, (1) AHS authorized the Respondent Physicians to enact the Requirement, and then instituted its own. The Respondents' Requirement (the Respondent Physicians and now AHS') is unwritten, and fails to fulfill criteria (2)-(4). Ms. Lewis submits that the Requirement lacks the clarity necessary to be "prescribed by law" and fails the *Oakes* test on this basis.

185. In the alternative, the Requirement fails the *Oakes* test for the reasons set out below.

The Oakes Test

a. The Onus of Proof Lies on the Respondents

186. Under section 1 of the *Charter*, the rights and freedoms set out therein can only be "demonstrably justified in a free and democratic society."[195] This "clearly indicates that the onus of justification is on the party" who has limited the *Charter* rights engaged. Consequently, the onus, in this case, is on the Respondents to prove, on a balance of probabilities, that the *Charter* infringements resulting from the Requirement are justified in accordance with the *Oakes* test.

187. "[D]emonstrably justified" connotes a strong evidentiary foundation: the Respondents must demonstrate through "cogent and persuasive evidence" the "consequences of imposing or not imposing" the Requirement upon [redacted] transplant candidates, like Ms. Lewis, who have chosen

[194] *Greater Vancouver Transportation Authority v. Canadian Federation of Students*, 2009 SCC 31, https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/7796/index.do **[TAB 25, BOA]**
[195] *Oakes* at pp 136-37, at para 66 **[TAB 13, BOA]**

not to receive the Covid-19 vaccine. Whether the Requirement is necessary to achieve the Respondents' objective must be determined by evidence.[196]

b. The Two Branches of the Test

188. As per *Oakes*, the Respondents must show that:

1. The objective of the Requirement is pressing and substantial.
2. The Requirement is reasonable and demonstrably justified.
    i. The Requirement must be carefully designed to achieve the objective in question. It must not be arbitrary, unfair, or based on irrational considerations. It must be rationally connected to the objective.
    ii. The Requirement must impair the Applicant's *Charter* rights as little as possible.
    i. There must be a proportionality between the effects of the Requirement on individuals and groups in society, and its objective. The more severe the deleterious effects, the more important the objective must be.

First Branch – Pressing and Substantial

189. Dr. A states that the ultimate goal of the LTP is to provide organs to patients in a manner that maximizes duration and quality of life for both the recipient and the organ.[197] Ms. Lewis agrees that this is a laudable goal.

190. According to Dr. A, the objective of the Requirement, however, is to: (1) minimize the risk of adverse outcomes from Covid-19 post-transplant, *and* (2) minimize the risk associated with contracting Covid-19 while waiting to be transplanted.[198]

191. Ms. Lewis states that the Respondents have not met the first branch of the test. It is not pressing and substantial to demand that all [redacted] transplant candidates receive a Covid-19 vaccine for a disease which has significantly lessened in severity over time. The Omicron variant is far milder than Delta and other previous variants,[199] there are medications to assist [redacted] transplant

[196] *Oakes* at page 138, at para 68; *R v Spratt*, 2008 BCCA 340 at para 30
[197] Dr. A Affidavit, para. 23
[198] Dr. A Affidavit, para. 31
[199] Mallard Transcript p. 61; line 25; p. 62, lines 1-7; p. 73, lines 7-11; Bridle Report, p. 8, para. 9

patients should they get Covid-19 post-transplant,[200] and many more people have natural immunity to Covid-19 than they did at the outset of the pandemic. Further, the Province of Alberta has lifted all Covid-19 restrictions and most vaccine mandates signalling the return to normal in Alberta and to living with the virus.

Second Branch – Not Reasonable or Demonstrably Justified

192. Ms. Lewis submits that the Requirement is not reasonable or demonstrably justified, and that it fails all three parts of the second branch of the *Oakes* test.

a. There is No Rational Connection Between the Requirement's Objectives and the Requirement

193. As confirmed by McLachlin CJ in *Hutterian Brethren*, section 1 requires the Respondents to "to show a rational connection between the infringement and the benefit sought on the basis of reason or logic."[201]

194. As per *Oakes*, the Requirement must not be "unfair," "arbitrary," or "based on irrational considerations."[202]

195. Ms. Lewis submits that there is no rational connection between the Respondents' objective and the Requirement for multiple reasons.

The Omicron Variant is Mild

196. During his cross-examination, Dr. Bridle testified that the infection fatality rate of Covid-19 was about 0.15%, in the ballpark of a bad flu season.[203] He specifically stated in his expert report that Omicron is the least dangerous form of SARS-CoV-2.[204] He was not challenged on that assertion.

197. Both Dr. Mallard's and Dr. Bridle's evidence is that Omicron is "mild."[205]

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[200] Dr. A Transcript, p. 78, lines 8-11
[201] *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37, [2009] 2 S.C.R. 567 at para. 48 ["*Hutterian Brethren*"] **[TAB 12, BOA]**
[202] *Oakes*, at para. 70
[203] Bridle Transcript, p. 20, lines 7-11
[204] Bridle Report, p. 8, para. 9
[205] Mallard Transcript p. 61; line 25; p. 62, lines 1-7; p. 73, lines 7-11; Bridle Report, p. 8, para. 9

198. It would be unfair to require [redacted] transplant candidates to get a Covid-19 vaccine for a "mild" condition when they express conscientious and other objections based on the exercise of their right of bodily autonomy and when they face discrimination based on their medical status.

The Covid-19 Vaccines Are Ineffective in Preventing Infection and Transmission and Protecting Against Omicron

199. Dr. Mallard's evidence on cross-examination revealed that the greatest proportion of cases of Omicron are in the vaccinated, and the vaccines do not prevent transmission.[206] She characterized the Covid-19 vaccines as "poor … at very best",[207] and that their effectiveness wanes exceedingly quickly – perhaps after 180 days.[208]

200. Dr. Bridle testified that the historically mandated vaccines confer sterilizing immunity or near sterilizing immunity. They protect the person from disease and prevent transmission of the disease. The Covid-19 vaccines do not.[209] Dr. Bridle referred to the duration of the Covid-19 vaccines' immunity as "horrifically short." He stated that it would be challenging to make a vaccine with such a short duration of immunity.[210] He also stated that by comparison, childhood vaccines produce good quality duration of immunity and long-term protection.[211]

201. Dr. Bridle's unchallenged expert report showed that Alberta Public Health's data reveal that with Omicron, the sub-group least likely to get Covid-19 was the unvaccinated.[212]

202. Dr. Turner's expert report stated: "The UK Health Security Agency reports efficacy against death of only 59% at 25 or more weeks after the second dose. Waning effectiveness is the rationale for giving supplemental doses, and the same document reports 95% effectiveness after a third dose. But as Kates says, these same patients are likely to mount a suboptimal immune response to post-transplant doses. The long-term effectiveness of vaccination in Ms. Lewis' case is likely to be less than in the general population."[213]

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[206] Mallard Transcript p. 35, lines 5-11
[207] Mallard Transcript p. 48, line 3
[208] Mallard Transcript p. 58, lines 18-23
[209] Bridle Transcript, p. 38, lines 1-5
[210] Bridle Transcript, p. 42, lines 8-10, 13-15
[211] Bridle Transcript, p. 42, lines 23-25; p. 43, lines 1-5
[212] Bridle Report, p. 2, para, 2; p. 3, para. 1
[213] Turner Report 2, page 18, para. 1

203. Dr. Houghton admitted during cross-examination that the Covid-19 vaccines' effectiveness is transient.[214]

204. Dr. A testified on cross-examination that all [redacted] transplant candidates waiting for a [redacted] transplant that have had Covid-19 caught it despite being vaccinated, and that she is not aware of unvaccinated [redacted] transplant candidates who have had Covid-19. [215]

205. Both Ms. Lewis's experts and Respondents' experts agree that the Covid-19 vaccines' effectiveness is short-lived. The current Requirement does not require boosters, therefore mandating a vaccine that everyone agrees is ineffective in the long-term when Ms. Lewis is unaware of when a compatible set of [redacted] will come in is an irrational consideration.

The Requirement Fails to Recognize Natural Immunity to Covid-19

206. Dr. Mallard's evidence is that natural immunity is being ignored and it is equal to or superior to the immunity from the Covid-19 vaccines.[216] [217] Dr. Mallard was never cross-examined on her conclusions in her expert report about natural immunity.

207. Dr. Bridle, a viral immunologist, concluded in his expert report that pre-existing natural immunity's associated antibodies are longer-lasting than those induced by the Covid-19 vaccines.[218]

208. Dr. A admitted in cross-examination that she did not test Ms. Lewis to see if she had antibodies to Covid-19 in her blood.[219] She also admitted she is not an immunologist and there is no immunologist on the LTP team.[220] She further admitted that she may not consult with an immunologist to determine whether or not Ms. Lewis ought to be tested for natural immunity to

[214] Houghton Transcript, p. 29, lines 7-16; p. 97, lines 22-24; Houghton Report, p. 3, para. 11
[215] Dr. A Transcript, p. 27, lines 6-9
[216] Mallard Transcript, p. 59; lines 5-6, 11-16
[217] Mallard Report 1, p. 14-15
[218] Bridle Report, p. 8, para. 9
[219] Dr. A Transcript, p. 16, lines 8-25; p. 17, lines 1-12
[220] Dr. A Transcript, p. 10, lines 6-10; p. 11, lines 2-6; p. 26, lines 14-22

Covid-19.[221] She admitted that Ms. Lewis may have had Covid in the past and that it may have been asymptomatic.[222]

209. Dr. Kates admitted in cross examination that "it is reasonable to raise that question" regarding whether Ms. Lewis had natural immunity.[223] So did Dr. Houghton.[224] In regard to testing Ms. Lewis to see if she is naturally immune to Covid-19 he answered, "I would say that would be a reasonable thing to do."[225] His belief was that natural immunity is transient, but so is the protection afforded by the Covid vaccines.[226]

210. It is unfair, arbitrary, and irrational for the Respondents to ignore natural immunity and consider that the only way to be protected from Covid-19 is through recently-developed vaccines.

211. Because the Requirement fails to consider natural immunity or provide an exemption for those who have some naturally acquired level of protection from Covid-19, it is unfair and not rationally connected to its objective.

The LTP Team Will Transplant [redacted] Transplant Candidates who are Unvaccinated for Covid-19 if They Have a Medical Exemption

212. Some of the factors that Dr. A and the LTP team have determined to support the Requirement include:

- The significant morbidity and mortality risk that Covid-19 presents to unvaccinated and highly immunosuppressed [redacted] transplant recipients;
- The LTP's responsibility to donors and donor families to use donated [redacted] in a manner that provides the best possible outcome for the graft;
- The risk that an unvaccinated transplant recipient would pose to other [redacted] transplant recipients during routine post-op care;

[221] Dr. A Transcript, p. 26, lines 1-22
[222] Dr. A Transcript, p. 23, lines 8-20
[223] Kates Transcript, p. 57, lines 14-17
[224] Houghton Transcript, p. 97, lines 11-17
[225] Houghton Transcript, p. 97, lines 12-17
[226] Houghton Transcript, p. 29, lines 8-16

- The scarcity of [redacted] donors in the context of other vaccinated candidates who could also benefit from a given donor organ;

- The now published and demonstrated benefit of Covid-19 vaccination before transplant v after transplant.[227]

213. Dr. A stresses the importance of these factors yet is willing to transplant an unvaccinated [redacted] transplant candidate with a medical exemption, despite testifying that such a patient:

- Could infect others at the hospital with Covid-19 to the same extent as an unvaccinated candidate without a medical exemption (such as Ms. Lewis);

- Is just as likely to pass away from Covid-19 after a transplant as an unvaccinated candidate without a medical exemption (such as Ms. Lewis);

- Is just as likely to catch Covid-19 as an unvaccinated candidate without a medical exemption (such as Ms. Lewis)[228]

214. Further, should it be true that the Covid-19 vaccine is necessary for [redacted] transplant candidates in order for the LTP to be responsible to donor families and maximize the benefit of scarce organs (and Ms. Lewis denies that this is true), those goals are not achieved by transplanting an unvaccinated candidate with a medical exemption. It is unfair and arbitrary for the LTP team to make an exception for *some* unvaccinated transplant candidates (those medically exempted), but not others (Ms. Lewis) when the effects of the exemption contradict the goals of the LTP in imposing the Requirement.

215. On this point Dr. Turner's report stated that "…even if no such an exemption had ever been granted, the mere possibility of such an exemption allowing a patient to qualify and be listed for transplant confirms that non-vaccination is not an absolute contraindication to transplant. The only difference between Ms. Lewis and someone with a medical exemption is a moral one…But moral

[227] Dr. A Affidavit, at para. 39
[228] Dr. A Transcript, p. 28, lines 22-25; p. 29, lines 1-2, 10-25; p. 30, lines 1-2; p. 30, lines 10-14

criteria are not included in AHS's evaluation for transplant candidacy, or in generally accepted criteria of other institutions and associations, nor ought they to be".[229]

216. Dr. Kates supports a medical exemption to the Requirement as being "ethically justifiable" and that "…individuals with a medical contraindication to vaccination stand to be directly harmed by vaccination, and I think that burden is excessive to impose."[230] At the same time, she suggests giving "Black American" transplant candidates exemptions to vaccine policies.[231],[232]

217. The fact that medically exempt [redacted] transplant candidates do not have to comply with the Requirement while other non-medically exempt unvaccinated [redacted] transplant candidates do is unfair and irrational. The Respondents fail this part of the test as there is no rational connection between the Requirement and its objective.

b. The Requirement Does Not Minimally Impair the Charter Rights It Infringes

218. Under section 1 of the *Charter*, minimal impairment means that the impugned measure is unjustified if it does not "impair the protected right as little as reasonably possible", meaning that the measure "must be carefully tailored so that rights are impaired no more than necessary." A failure to "explain why a significantly less intrusive and equally effective measure was not chosen" may be fatal to the impugned measure. [233]

219. The Supreme Court of Canada, writing on the minimal impairment stage of the section 1 test in *Hutterian Brethren*, stated:

> **In considering whether the government's objective could be achieved by other less drastic means, the court need not be satisfied that the alternative would satisfy the objective to *exactly* the same extent or degree as the impugned measure.** In other words, the court should not accept an unrealistically exacting or precise formulation of the government's objective which would effectively immunize the law from scrutiny at the minimal impairment stage. The requirement for an "equally effective" alternative measure in the passage from

[229] Turner Report 2, p. 2
[230] Kates Transcript, p. 50, lines 17-25; p. 51, lines 1-15
[231] Kates Transcript, p. 74, lines 15-18
[232] Kates Transcript, p. 73, lines 19-25; p. 74, lines 2-3
[233] *Oakes*, at p. 139 (para. 70); *Hutterian Brethren*, at para. 54.

> *RJR-MacDonald*, quoted above, should not be taken to an impractical extreme. It includes alternative measures that give sufficient protection, in all the circumstances, to the government's goal: *Charkaoui v Canada (Citizenship and Immigration)*, 2007 SCC 9 [2007] 1 S.C.R. 350. While the government is entitled to deference in formulating its objective, that deference is not blind or absolute. The test at the minimum impairment stage is whether there is alternative, less drastic means of achieving the objective in a real and substantial manner.[234]

Safety Protocols Could Be Offered Instead of Covid-19 Vaccination

220. The Respondents have not explained why they could not offer unvaccinated [redacted] transplant candidates the same safety protocols that they are willing to have in place when they transplant a medically exempt unvaccinated [redacted] transplant candidate, who poses the same risk to other patients in the hospital and case catch, transmit and die from Covid just as easily as non-medically exempt unvaccinated [redacted] transplant candidates can.

221. Dr. Mallard's evidence is that Ms. Lewis could avoid large crowds and take Vitamin D to help protect her from Covid-19.[235] Dr. Bridle also cited multiple studies that showed the benefits of Vitamin D in helping to prevent infection and boost the immune system.[236] Dr. Houghton only provided one study to show that Vitamin D was not effective, and admitted that the study authors found that if someone was truly Vitamin D deficient, Vitamin D supplementation could help prevent infection.[237]

Medications Could Be Offered to Treat Unvaccinated Post-Transplant Patients

222. Dr. A testified during her cross-examination that there are other medications that are available for immunosuppressed patients to help them when they get infected.[238] Ms. Paulson confirmed that monoclonal antibodies is a treatment for active Covid-19 infection upon presentation of symptoms.[239] Clearly, the situation is not hopeless for transplanted patients when

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[234] *Hutterian Brethren*, at para. 55 (emphasis added) **[TAB 12, BOA]**
[235] Mallard Report 1, p. 11, para. 2
[236] Bridle Report, p. 11, paras, 13-15; page 12, paras. 16-19; page 13, paras. 20-21
[237] Houghton Report, p. 2, para. 7; Houghton Transcript, p. 70, line 20; p. 71, lines 14-18
[238] Dr. A Transcript, p. 78, lines 8-11
[239] Paulson Affidavit, para. 26

they get Covid-19 if there are recognized medications available to treat them. The LTP could offer this treatment to Ms. Lewis post-transplant should she get infected with Covid-19.

The Respondents Could Provide an Exemption to Naturally Immune [redacted] Transplant Candidates

223. The Respondents have not explained why they are not testing [redacted] transplant candidates to see if they are naturally immune to Covid-19 and allowing proof of natural immunity (as opposed to Covid-19 vaccination only) for eligibility for a [redacted] transplant. Dr. A admitted during cross examination that she never reached out to an immunologist to discuss the possibility of having [redacted] transplant patients who are waiting for a transplant tested for antibodies to Covid-19.[240]

224. As noted, both Dr. Mallard's and Dr. Bridle's unchallenged evidence is that natural immunity is just as good as or superior to the immunity conferred by the Covid-19 vaccines.[241]

225. Dr. Houghton and Dr. Kates testified that it would be reasonable to learn if Ms. Lewis was naturally immune to Covid-19.[242]

226. Studying the level of natural immunity to Covid-19 in [redacted] transplant candidates' bodies before imposing the Requirement would be an alternative that would provide a reasonable alternative that would more minimally impair *Charter* rights. If they have antibodies to Covid-19, the LTP could consult with an immunologist to determine what level their antibodies are. The Requirement could include natural immunity which would reduce its harmful impact, and those with natural immunity could still get a transplant.

227. The Requirement thus cannot be said to impair Ms. Lewis's *Charter* rights as minimally as possible to achieve the objective of preventing transmission of and a negative outcome from COVID-19. Consequently, it is disproportionate and unjustified on this basis as well.

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[240] Dr. A Transcript, p. 16, lines 8-25; p. 17, lines 1-12
[241] Mallard Transcript p. 59; lines 5-6, 11-16; Mallard Report 1, p. 14-15; Bridle Report, p. 8, para. 9
[242] Kates Transcript, p. 57, lines 14-17; Houghton Transcript, p. 97, lines 11-17; Houghton Transcript, p. 97, lines 12-17

c. The Deleterious Effects of the Requirement Outweigh any Salutary Effect

228. The Requirement has egregiously severe and unprecedented deleterious effects on the *Charter* rights it infringes, without yielding a significant benefit established by the evidence.

229. To be justified, the salutary effects of a measure which infringes *Charter* rights must outweigh their deleterious effect on the rights at issue. In other words, the Court must weigh the impact "on protected rights against the beneficial effect of the [measure] in terms of the public good."[243]

Deleterious Effects

a. Death

230. The effect of the Requirement is that it literally forces [redacted] transplant candidates who are terminally ill, like Ms. Lewis, to choose between compliance or death. There is no middle ground.

b. Psychological Distress

231. Because the Requirement acts as a gateway between life and death, [redacted] transplant candidates who cannot comply or feel coerced into compliance experience tremendous psychological suffering at having their chance at life taken away. Ms. Lewis' affidavits detail the level of duress the Requirement has caused her.

232. Dr. Mallard explains in her expert report:

> Stress is well known to alter immune system performance. Chronic stress in particular is associated with immuno-depression. Mandated vaccination of the Applicant as a requirement to receive her transplant has already caused undo stress. This stress could be substantially alleviated by respecting her decision not to be vaccinated, allowing her own immune system to return to a more homeostatic level.[244]

233. Neither Ms. Lewis or Dr. Mallard were challenged on cross examination on these issues and significant impacts.

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[243] *Oakes*, at p. 140, para. 71; *Carter*, at para. 122 **[TAB 13, BOA]**
[244] Mallard Report 1, page 15

c. The Requirement Forces [redacted] Transplant Candidates to Take Part in an Experiment if they want to Survive

234. Dr. Bonnie Mallard's unchallenged expert evidence in both expert reports is that the Covid-19 vaccines that are available in Canada are still in clinical trials and will be in clinical trials until 2023.[245] She concluded that anyone who takes a Covid-19 vaccine while it is still in clinical trials is participating in a "population-level experiment."[246] None of the Respondents' responding reports challenged her on that, nor was she cross-examined on that point.

235. Dr. Bridle also testified in cross examination that the Covid-19 vaccines are experimental due to the fact that they are still in clinical trials until 2023,[247] and Dr. Turner's evidence on cross examination was that these vaccines as experimental.[248]

236. No human being ought to be threatened with loss of her life if they do not consent to an experimental medical treatment.

d. Safety of the Covid-19 Vaccines Cannot Be Established

237. The LTP requires [redacted] transplant candidates to be up to date on their childhood vaccinations, such as the DTP, MMR, polio vaccines, etc. Those vaccines have existed for over 30 years, and long-term safety data is available for those vaccines. Ms. Lewis willingly received all the required childhood vaccinations again, as she was directed to do by the LTP team.

238. It is agreed amongst both Ms. Lewis's and Respondents' expert witnesses and Dr. A in her cross-examination evidence that there are no long-term safety data for the Covid-19 vaccines, unlike the childhood vaccinations.[249] All experts and Dr. A also agree that it is unknown what safety concerns may arise in the next 5-10 years for someone who takes a Covid-19 vaccine today.[250]

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[245] Mallard Report 2, page 4, para. 2; Mallard Transcript p. 66; lines 10-25, p. 67, lines 1-7
[246] Mallard Report 1, page 16, para. 2
[247] Bridle Transcript, p. 45, lines 13-25; p. 46, lines 1-2
[248] Turner Transcript, p. 48, lines 4-19
[249] Cypel Transcript, p. 16, lines 9-13; p. 17, lines 5-25; p. 18, lines 1-2
[250] Cypel Transcript, p. 55, lines 22-25; p. 56, line 1; Houghton Transcript, p. 94, lines 1-6; Houghton Transcript, p. 94, lines 10-17;

239. Further, Dr. Mallard's unchallenged expert opinion is that Ms. Lewis Ms. Lewis ought to be excluded from receiving the Covid-19 vaccine because people with her medical condition were specifically excluded from the clinical trials which studied the safety and efficacy of the (Pfizer and Moderna) Covid-19 vaccines.[251] Dr. A, Dr. Cypel, and Dr. Houghton also agreed that [redacted] transplant candidates were excluded from the clinical trials and that conclusions about the safety and efficacy of the Covid-19 vaccines based on the clinical trials do not apply to Ms. Lewis.[252]

240. Dr. Mallard's evidence is that in the US and Europe, Covid-19 vaccines have generated more adverse event reports in the last nine months than all other 70 vaccines over the past 30 years combined.[253] Her evidence is that the vaccines are highly inflammatory, especially to the [redacted],[254] and can seriously hurt someone who has already recovered from Covid-19.[255]

241. Dr. Bridle came to the same conclusions.[256] For the same reasons he recommends not vaccinating someone whose immune status to Covid-19 is unknown.[257] None of this evidence was challenged by the Respondents or any of their witnesses.

242. Dr. Mallard also wrote about the Pfizer biodistribution study submitted to the Japanese government that showed that inflammatory lipid nanoparticles are capable of travelling to the [redacted],[258] and that prior to a [redacted] transplant it is imperative not to induce inflammatory episodes, particularly in the [redacted].[259] The Respondents never challenged this evidence either.

243. Dr. Mallard wrote that the VAERS data gives an "alarm signal", and that is how myocarditis and blood clots from the Covid-19 vaccines were uncovered.[260] She found that VAERS reports a huge increase in adverse events since the mass vaccination with the Covid-19 vaccines, which is greater than adverse events reported compared to all events prior to 1990.[261] On

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[251] Mallard Report page 2, paras 1-2
[252] Dr. A Transcript, p. 34, lines 16-25; p. 35, lines 1-8, Dr. A Transcript, p. 36, lines 4-11, Cypel Transcript, p. 16, lines 4-8, Houghton Transcript, p. 44, lines 15-25, and Houghton Transcript, p. 45, lines 1-5,
[253] Mallard Report 1, page 4, para. 3.
[254] Mallard Report page 7, para 2.
[255] *Ibid*.
[256] Bridle Report, p. 8, para. 9 and Bridle Report, p. 20, para. 35.
[257] Bridle Report, p. 15, para. 27
[258] Mallard Report page 8, para 2.
[259] Mallard Report page 8, para. 2
[260] Mallard Transcript, p. 70, lines 1-8.
[261] Mallard Transcript p. 66; lines 10-25, p. 67, lines 1-7.

cross examination she explained that the latest Pfizer information showed 1200 deaths, and the swine flu vaccine was stopped after 50 deaths.[262] Finally she referenced the Pfizer Report 5.3.6 which showed that out of 42,000 case reports of adverse events, 8,000 involved the [redacted].[263]

244. Dr. Bridle's expert report demonstrated that Alberta's own public health data shows that vaccinating a patient awaiting a [redacted] transplant would increase her risk of contracting Covid-19.[264] He concluded that mandating the vaccines would increase Ms. Lewis's risk of contracting Covid-19 and would put her transplanted [redacted] tissue at enhanced risk of harm.[265] He was not challenged on these conclusions on cross examination.

245. Dr. Bridle states in his report that Pfizer's fact sheet data suggests that the risk of serious adverse events may have been four times higher in the vaccinated group than the unvaccinated group in the short-term.[266] He was not challenged on this assertion in cross examination.

246. Dr. Bridle wrote that the European Medicines Agency lists important medical events following Covid-19 vaccination including [redacted] blood clots, anaphylactic reaction, deep vein thrombosis, pneumonia, thrombocytopenia, brain blood clots or brain bleeding, hallucinations, cerebral stroke, and myocarditis and pericarditis. Dr. Bridle states that all of these conditions are serious. [267] He was not challenged on this expert evidence.

247. Like Dr. Mallard, he found that Pfizer's biodistribution study which was submitted to the Japanese government showed that the Covid-19 vaccine's lipid nanoparticles which carry the mRNA encoding for the spike protein from SARS-CoV-2 travel to the [redacted].[268] He cited the precautionary principle and recommended that research should be done to rule out the concern that this mechanism of action could harm the [redacted], possibly inciting pathological autoimmune reactions in pulmonary tissues.[269] He was not challenged on this expert evidence.

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[262] Mallard Transcript, p. 66, lines 10-18.
[263] Mallard Transcript, p. 74, lines 3-10.
[264] Bridle Report, p. 7, para. 8.
[265] Bridle Report, p. 7, para. 8.
[266] Bridle Report, p. 14, para. 22.
[267] Bridle Report, p. 14, para. 23.
[268] Bridle Report, p. 14, para. 23.
[269] Bridle Report, p. 15, para. 25.

248. Dr. Houghton's evidence on cross examination was that his expert report said "**usually** Covid mRNA vaccines do not appear to damage the [redacted] of recipients waiting for a [redacted] transplant" because vaccines can have side effects and he didn't want to rule out the possibility that someone could suffer [redacted] damage from a Covid vaccine.[270]

249. Dr. Bridle's unchallenged analysis of Alberta Public Health data shows that the Covid-19 vaccines proved to be 10 times more dangerous (caused 10 times more adverse events) than the annual flu vaccine.[271] And the array and seriousness of adverse events was greater for those who received a Covid vaccine than those who received a flu vaccine.[272]

250. Dr. Bridle's unchallenged conclusion is that there is no sound scientific basis to require mandatory Covid-19 vaccination for anyone, especially a patient like Ms. Lewis. If she got the Covid vaccine her risk of potential harm and harm to the donated [redacted] would increase.[273]

251. Both Dr. Mallard and Dr. Bridle testified that the Canadian vaccine adverse event reporting system is passive and voluntary and is notorious for underreporting vaccine related adverse events.[274] They were not challenged on that evidence.

252. Dr. Cypel agrees that when he says the Covid-19 vaccines are safe in his expert report, he is not referring to long-term safety because no one has data long-term.[275] He also agrees that he does not know what will happen to any of the transplant patients who received the Covid-19 vaccine five or 10 years after they were vaccinated.[276] He further agrees that the other childhood vaccines which are required for transplant candidates in his [redacted] transplant program have been around for many years and long-term safety data is available for those other vaccines.[277]

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[270] Houghton Transcript, p. 62, lines 11-25.
[271] Bridle Report, p. 16, para. 28.
[272] Bridle Report, p. 17, Figure 6.
[273] Bridle Report, p. 20, para. 35.
[274] Bridle Report, p. 16, para. 28.
[275] Cypel Transcript, p. 16, lines 9-13.
[276] Cypel Transcript, p. 16, lines 24-25; p. 17, lines 1-4.
[277] Cypel Transcript, p. 17, lines 5-25; p. 18, lines 1-2

253. Dr. Cypel was shown a document called Pfizer Request for Priority Review, Covid-19 Vaccine May 2021, section on Safety at page 8. It was just released by Pfizer to the public on April 1, 2022. It said: "Clinical laboratory evaluations showed a transient decrease in lymphocytes that was observed in all age and dose groups after dose 1 which resolved in approximately one week."[278]

254. Dr. Cypel agreed that lymphocytes are white blood cells. He agreed that the document is saying that after dose 1, for one week, Pfizer's data shows that people who took the Pfizer vaccine had a decrease in white blood cells.[279]

255. Dr. Cypel agreed that if someone's white blood cell count was reduced to below 1,000, that person could generally be more susceptible to an infection. He agreed that there would be some instances where he would be concerned if there was a lower white blood cell count in someone waiting for a [redacted] transplant.[280] He agreed that he did not know from that document to what extent or how severe the drop in white blood cell count was.[281]

256. Although Dr. Houghton was unaware that there were Health Canada warning labels for the Covid-19 vaccines,[282] he acknowledged that the adenovirus (Astra Zeneca and Johnson and Johnson) Covid-19 vaccines are known to cause blood clots.[283] He also admitted that the Covid-19 vaccines have caused myocarditis and sudden death from myocarditis.[284]

257. The World Health Organization published a report in February 2022 called WHO Pharmaceuticals Newsletter.[285] Dr. Houghton agreed on cross examination that the WHO reported hearing loss and tinnitus as being associated with Covid vaccination.[286]

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[278] Cypel Transcript, p. 40, lines 18-25; p. 41, lines 1-20
[279] Cypel Transcript, p. 41, lines 22-25; p. 42, line 1.
[280] Cypel Transcript, p. 40, lines 5-17.
[281] Cypel Transcipt, p. 43, lines 1-9.
[282] Houghton Transcript, p. 72, lines 14-18.
[283] Houghton Transcript, p. 90, lines 15-17.
[284] Houghton Transcript, p. 91, lines 9-11; note: the transcript says "seven deaths" and it should say "sudden deaths".
[285] Houghton Transcript, Exhibit 1.
[286] Houghton Transcript, page 85, lines 13-16.

258. Dr. Houghton agreed that we do not know the long-term risks that the Covid-19 vaccines may pose to the people who took them, and agreed that we have long-term safety data for many vaccines.[287]

259. Dr. A admitted that the statement in her affidavit that Covid-19 vaccinations have been shown to be safe is not in relation to [redacted] transplant recipients.

260. The positions taken by public health on the safety of Covid-19 vaccines have evolved and continue to evolve as more people are vaccinated and as time passes. Dr. A agreed on cross examination that the Canadian government first recommended that Canadians take whichever vaccine was available, and subsequently changed its the advice on the AZ vaccine changed due to blood clotting concerns.[288] She also agreed that Ontario changed its recommendation for young males about the Moderna vaccine due to the higher incidence of myocarditis.[289]

261. Dr. A admitted during cross examination that sometimes the dangers of a new medication are not immediately apparent but are sometimes discovered over the passage of time.[290] She also admitted knowing that there is a nine-page long list of adverse events of special interest for the Pfizer Covid-19 vaccine, (however she did not plan to review it).[291]

262. Dr. B tried to convince Ms. Lewis to take the Johnson and Johnson vaccine in his meeting with her on November 15, 2021.[292] This is a vaccine that Dr. Houghton does not recommend because of known issues with blood clots.[293] Just a few months later, the US Food and Drug Administration limited its use due to an "updated analysis, evaluation, and investigation of reported cases" of blood clots. A May 5, 2022 news release on its website states:

> **After conducting an updated analysis**, evaluation and investigation of reported cases, the FDA has determined that the risk of thrombosis with thrombocytopenia

[287] Houghton Transcript, p. 83, lines 13-16.
[288] Dr. A Transcript, p. 60, lines 4-8.
[289] Dr. A Transcript, p. 60, lines 19-25; p. 61, lines 1-6
[290] Dr. A Transcript, p. 61, lines 3-6
[291] Dr. A Transcript, p. 80, lines 18-25; p. 81, lines 1-4
[292] Dr. A Affidavit, Exhibit K, p. 15
[293] Houghton Transcript, page 90, lines 15-17

> syndrome (TTS), a syndrome of rare and potentially **life-threatening blood clots** in combination with **low levels of blood platelets** with onset of symptoms approximately one to two weeks following administration of the Janssen COVID-19 Vaccine, **warrants limiting the authorized use of the vaccine**.[294]

263. Ms. Lewis demonstrated serious red flags related to the Covid-19 vaccines and specifically the negative effect the lipid nanoparticles and spike protein can have on the [redacted]. There are also recognized issues with blood clots and myocarditis, Bell's Palsy and possible hearing loss. All witnesses admit that there is no long-term safety data for these vaccines, unlike the other vaccines that the Respondents require prior to transplantation.

264. Ms. Lewis submits that despite general guidance by the Respondents for transplant patients to get vaccinated claiming safety and efficacy, even they lack the confidence to formalize a written policy.

265. The Covid-19 vaccines are incredibly novel medical treatments by any standard. While the experts may have different views regarding the short-term risks and benefits, none of the experts were able to opine on the long-term impacts because of their novelty. The deleterious effects to [redacted] transplant candidates from taking these vaccines could be significant. Where there is risk, there has to be choice.

266. Ms. Lewis submits that it is not reasonable and warranted for the Respondents to require [redacted] transplant candidates to take a novel medical treatment that has serious known and unknown long-term side effects in order for her to have access to life-saving surgery, especially since she may never get Covid, she may already have had Covid, Omicron is mild, and the vaccines don't prevent transmission of Covid. The Respondents should put a halt on the Requirement and at the very least wait until the clinical trials are finished before denying their patients access to life-saving surgery.

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[294] Coronavirus (COVID-19) Update: FDA Limits Use of Janssen COVID-19 Vaccine to Certain https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-limits-use-janssen-covid-19-vaccine-certain-individuals **[TAB 37, BOA]**

Minimal Salutary Effects

267. As noted above, the objective of the Requirement is to: (1) minimize the risk of adverse outcomes from Covid-19 post-transplant, and (2) minimize the risk associated with contracting Covid-19 while waiting to be transplanted.[295]

268. Ms. Lewis submits that the evidence shows that the Covid-19 vaccines do not minimize her risk of getting Covid-19. If anything, and especially with Omicron, they seem to increase her chance of getting Covid-19. Dr. A's own evidence on cross examination was that to her knowledge all of the [redacted] transplant candidates that got Covid-19 were vaccinated, and none of the unvaccinated [redacted] transplant candidates got Covid-19.[296]

269. Dr. Bridle's unchallenged expert evidence was that the Covid-19 vaccines blunt the severity of the disease is spurious at best[297] and since mid-December 2021, most Covid-19 patients in hospitals and ICUs were vaccinated.[298]

270. The bottom line is that the evidence shows that the Covid-19 vaccines do not fulfill the objectives claimed by the Respondents in justifying the Requirement as they do not stop transmission of Covid-19 and may not even reduce it's the severity of injection. In sum, the salutary benefits are minimal and do not outweigh the deleterious effects.

B. Justification for the *Decision*

The Dore Analysis

271. In the alternative, if the court finds that the proper framework is the *Dore* analysis, Ms. Lewis argues that the Respondents' decision to enforce the Requirement in regard to her specifically - the Decision - is unreasonable.

272. Where, as here, an infringement of Ms. Lewis's *Charter* rights has been shown, the Respondents (government and agents of government) bear the onus of proof under the *Doré*

[295] Dr. A Affidavit, para. 31
[296] Dr. A Transcript, p. 27, lines 6-9
[297] Bridle Report, p. 3, para. 3; p. 4, figures A and B
[298] Bridle Report, p. 3, para. 3; p. 4, figures A and B

framework[299] to demonstrably justify the Respondents' Decision to impose the Requirement on the basis that it proportionately balances Ms. Lewis' *Charter* rights with the Respondents' policy objectives.

273. As acknowledged last year in *Beaudoin*,[300] the Supreme Court of Canada has been clear that the *Doré* framework "works the same justificatory muscles" as the *Oakes* test. Under *Doré*, as under *Oakes*, the Requirement can be upheld only if the Respondents establish, with evidence, that they minimally impair Ms. Lewis's sections 2, 7, and 15 *Charter* rights, and that the harm which they inflict on Ms. Lewis's constitutional rights is proportionate to the Requirement's public benefit.

No Consideration of Charter rights in issue

274. A failure to actually consider the *Charter* rights of Ms. Lewis is fatal to the Respondents' *Doré* argument.[301] There must be evidence of such consideration in the record from the time the Decision was actually made.[302] In this instance, "the record" would include information in Dr. A's and Deanna Paulson's affidavits ("the **Record**").

275. There is no evidence in the Record whatsoever that the Respondents gave any consideration to Ms. Lewis's *Charter* rights. There is no evidence of any acknowledgement that the Requirement or Decision impacted Ms. Lewis's *Charter* rights of life, liberty (freedom to choose what medical treatment to receive) and security of the person (right to informed consent and not to be threatened with removal from the transplant list – i.e. death – for lack of compliance); further, there was no consideration as to how her conscience or equality rights are being impacted by the Requirement, and how to balance those rights with the stated objective to prevent transmission of Covid-19 and reduce the chance of a negative outcome from Covid-19.

276. The word *Charter* is non-existent in the Record. Any discussion of a balancing of rights and freedoms is similarly non-existent in the Record.

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[299] *UAlberta Pro-Life v Governors of the University of Alberta*, 2020 ABCA 1, at paras. 161-162. **[TAB 9, BOA]**
[300] *Beaudoin v British Columbia*, 2021 BCSC 512, at para. 217. **[TAB 27, BOA]**
[301] *Lethbridge and District Pro-Life Association v Lethbridge (City)*, 2020 ABQB 654, at paras. 108- 112. **[TAB 38, BOA]**
[302] *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65, at paras. 83-87. **[TAB 39, BOA]**

277. There was no consideration in the Record of why testing Ms. Lewis for Covid-19 antibodies to see if she's naturally immune would not be a viable option to at least explore considering her significant fear of the Covid-19 vaccine, or why whatever precautionary measures the Respondents were willing to take for unvaccinated [redacted] transplant candidates with a medical exemption would not also be available to Ms. Lewis.

278. There is no evidence in the Record showing that the LTP team ever turned their minds to the impact of their Decision to enforce the Requirement upon the *Charter* protections it engaged. There was no evidence that the Respondents engaged in the required balancing process involving the consideration Ms. Lewis' *Charter* rights and their objectives. For that reason alone, the Decision ought to be found unreasonable and an unjustifiable violation of her *Charter* rights.[303]

279. This is consistent with the Supreme Court's *Vavilov* decision, which notes that "it is not open to a reviewing court to disregard the flawed basis for a decision and substitute its own justification for the outcome":

> Where, even if the reasons given by an administrative decision maker for a decision are read with sensitivity to the institutional setting and in light of the record, they contain a fundamental gap or reveal that the decision is based on an unreasonable chain of analysis, it is not ordinarily appropriate for the reviewing court to fashion its own reasons in order to buttress the administrative decision. Even if the outcome of the decision could be reasonable under different circumstances, it is not open to a reviewing court to disregard the flawed basis for a decision and substitute its own justification for the outcome: *Delta Air Lines*, at paras. 26-28. To allow a reviewing court to do so would be to allow an administrative decision maker to abdicate its responsibility to justify to the affected party, in a manner that is transparent and intelligible, the basis on which it arrived at a particular conclusion. This would also amount to adopting an approach to reasonableness review focused

[303] See: *Zaki v. University of Manitoba*, 2021 MBQB 178 (CanLII), at para. 170, where the Manitoba Court of Queen's Bench found the University of Manitoba's decision to expel a student was unreasonable partly because the Record failed to show that the university considered the student's *Charter* rights in its decision making process. **[TAB 30, BOA]**

> solely on the outcome of a decision, to the exclusion of the rationale for that decision.[304]

The Decision was not a proportionate balance of Charter protections

280. As set out above in the *Oakes* analysis, neither the Requirement nor the Decision applying it to Ms. Lewis are a proportionate violation of her *Charter* rights and freedoms.

6. The Respondents Have Violated Ms. Lewis' Rights Under the *Bill of Rights*

281. In the alternative, Ms. Lewis argues that the Respondents have violated her rights under section 1 of the Alberta Bill of Rights, specifically:

> It is hereby recognized and declared that in Alberta there exist without discrimination by reason of race, national origin, colour, religion, sexual orientation, sex, gender identity or gender expression, the following human rights and fundamental freedoms, namely:

1. (a) the right of the individual to liberty, security of the person and enjoyment of property, and the right not to be deprived thereof except by due process of law;
2. (b) the right of the individual to equality before the law and the protection of the law;

282. Ms. Lewis submits that for the reasons articulated in the discussion of section 7 of the *Charter* above, the Respondents have violated her rights of liberty and security of the person.

283. She further submits that for the reasons articulated in discussion of section 15 of the *Charter* above, the Respondent has violated her right to equality before the law.

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[304] *Vavilov*, at para. 96. **[TAB 29, BOA]**

III. CONCLUSION

284. Ms. Lewis respectfully submits that this Court ought to find that the Requirement or the Decision is an unjustifiable infringement of her sections 2(a), 7, and 15 *Charter* rights, and/or a violation of her section 1(a) and (b) rights under the *Alberta Bill of Rights*.

ALL OF WHICH IS RESPECTFULLY SUBMITTED THIS 17th day of May 2022

Allison Kindle Pejovic

Eva Chipiuk

Counsel for the Applicant, Annette Lewis

APPENDIX A – Highlights of Dr. A' Cross Examination Evidence

Dr. A

Cross Examination

- She is a contractor with AHS;[1]
- She is not an immunologist, vaccinologist, or a virologist;
- There are no vaccinologists in the [redacted] transplant program;[2]
- The Applicant has idiopathic pulmonary fibrosis which will lead to disability and death over time;[3] it is a respiratory disease and a chronic pulmonary disease;[4]
- She agrees the Applicant is not a healthy person;[5]
- She agrees that Ms. Lewis has diligently taken the medication she requires in order to get her transplant, and has followed all instructions in order to prepare her for a [redacted] transplant;[6]
- Dr. A ordered rounds and rounds of blood tests in preparation for Ms. Lewis' potential transplant;[7]
- Dr. A agreed that she has never tested the Applicant to see if she has antibodies to COVID-19. She is aware that such blood testing exists. She said she would have to defer to an immunologist to confirm her understanding that it is challenging to totally understand how much true effect positive serology will have and how long it will last. She admitted she has never reached out to an immunologist to discuss the possibility of having [redacted] transplant patients who are waiting for a transplant tested for antibodies to Covid-19.[8]
- She agreed that it was possible that Ms. Lewis could have had Covid already, and also possible that she could have had an asymptomatic infection.[9]

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[1] Dr. A Transcript, p. 9, lines 14-15
[2] Dr. A Transcript, p. 10, lines 11-13
[3] Dr. A Transcript, p. 12, lines 3-11
[4] Dr. A Transcript, p. 12, lines 12-17
[5] Dr. A Transcript, p. 13, lines 10-18
[6] Dr. A Transcript, p. 13, lines 23-25; p. 14, lines 1-4
[7] Dr. A Transcript, p. 15, lines 20-25
[8] Dr. A Transcript, p. 16, lines 8-25; p. 17, lines 1-12
[9] Dr. A Transcript, p. 23, lines 8-20

- ***All [redacted] transplant candidates waiting for a [redacted] transplant that have had Covid-19 caught it despite being vaccinated for Covid-19***; ***she is not aware of [redacted] transplant unvaccinated [redacted] transplant candidates having had Covid-19***;[10]
- Agreed there are medical exemptions to the Covid-19 vaccine in the [redacted] transplant program and she would consider transplanting an unvaccinated candidate with a medical exemption. She agreed that unvaccinated patient could catch Covid-19 post-transplant, die of Covid-19 post-transplant, would in general be as likely as an unvaccinated person without a medical exemption to die from Covid-19 post-transplant, and could transmit Covid-19 to others in hospital post-transplant.[11]
- The other vaccines that are required to be taken pre-transplant have been around for many years and their clinical trials are finished. There is plenty of long-term safety data for these older vaccines.[12]
- Her evidence is that the main clinical trials phase 3 have been completed for the Covid vaccines that are available in Canada.[13]
- She is aware that the Pfizer clinical trials which were used to assess the safety and effectiveness of the vaccines only tested them on healthy individuals.[14]
- She is aware that Pfizer specifically excluded people from their safety and efficacy study who would be receiving immunosuppressive therapy in the next 6 months.[15]
- She agreed that Ms. Lewis' type of patient population was not actively studied in the original Pfizer trial.[16]
- She agreed that Moderna also excluded people like Ms. Lewis in their clinical trial on safety and efficacy of the Covid vaccine.[17]
- She agreed that the Covid-19 vaccines do not prevent the [redacted] transplant patient from catching Covid-19.[18]
- She agreed that the number of double vaccinated people in Alberta getting Covid

[10] Dr. A Transcript, p. 27, lines 6-9
[11] Dr. A Transcript, p. 28, lines 22-25; p. 29, lines 1-2, 10-25; p. 30, lines 1-2; p. 30, lines 10-14
[12] Dr. A Transcript, p. 32, lines 17-25; p. 33, lines 1-3
[13] Dr. A Transcript, p. 33, lines 22-25
[14] Dr. A Transcript, p. 34, lines 16-25
[15] Dr. A Transcript, p. 34, lines 16-25; p. 35, lines 1-8
[16] Dr. A Transcript, p. 35, lines 15-22
[17] Dr. A Transcript, p. 36, lines 4-11
[18] Dr. A Transcript, p. 37, lines 13-17

increased significantly in mid-December 2021;[19]

- It is the [redacted] transplant program's policy that patients who are awaiting a [redacted] transplant must be vaccinated for Covid-19 prior to getting their transplant;[20]
- A written Covid-19 vaccine policy does not exist.[21]
- She agrees that when Ms. Lewis was originally informed of the Covid-19 vaccine policy, AHS's written recommendations did not include a requirement that transplant recipients be vaccinated for Covid-19 prior to their surgery. AHS still does not have a written policy to require Covid-19 vaccinations prior to transplant surgery.[22]
- She agrees that there is no vaccine in Canada that is specifically designed to protect against the Omicron variant.[23]
- She said that her statement in her affidavit at para 36 about "Covid-19 vaccinations being shown to be safe and effective in reducing serious Covid-19 infections" has nothing to do with [redacted] transplant recipients.
- She agrees that the American Society of Transplantation did not say that Covid vaccines should be "required" prior to a [redacted] transplant.
- She agrees that the Canadian government first recommended people to take whichever vaccine was available, and then the advice on the AZ vaccines changed due to concerns with blood clotting.[24]
- She agrees that Ontario changed its recommendation for young males about the Moderna vaccine due to the higher incidence of myocarditis.[25]
- She agrees that sometimes the dangers of a new medication are not immediately apparent but are sometimes discovered over the passage of time.[26]
- She agrees that after each interaction with a patient, it is her usual practice as a doctor to make detailed notes of that interaction.[27]
- She agrees that Ms. Lewis has expressed more than once she is scared of the Covid-19

[19] Dr. A Transcript, p. 43, lines 13-17
[20] Dr. A Transcript, p. 43, lines 20-24
[21] Dr. A Transcript, p. 44, lines 14-17
[22] Dr. A Transcript, p. 46, lines 2-18
[23] Dr. A Transcript, p. 47, lines 23-25; p. 48, lines 1-2
[24] Dr. A Transcript, p. 60, lines 4-8
[25] Dr. A Transcript, p. 60, lines 19-25; p. 61, lines 1-6
[26] Dr. A Transcript, p. 61, lines 3-6
[27] Dr. A Transcript, p. 65, lines 8-15

vaccine. She agrees that it is important to take good notes with all interactions with patients.[28]

- She agrees that at her May 17, 2021 appointment with the Applicant, there is no notation that she explained the risks of the Covid vaccine to her, even though there is a section in the notes called "Vaccine Hesitancy".[29]
- At the June 21, 2022 appointment, although she says she recollects talking about side effects she did not write it down.[30]
- She states that getting the Covid vaccine is one way of being a "good citizen".[31]
- She agrees that there's not mention in the notes of Dr. B's meeting with the Applicant on November 15, 2021 that he discussed the risks and benefits of the vaccines.[32]
- She agrees that there are relevant risks or side effects that come up in between our discussions (with patients) and she should talk to patients about them. She agrees there's nothing in the notes about going through the Health Canada warnings about the vaccines with Ms. Lewis.[33]
- When asked about when the [redacted] transplant team evaluates whether the pandemic is over or nearly over, she said "we never discuss about pandemic timing."[34]
- ***She stated, "There are also now other medications that are available for immunosuppressed patients to help them when they get infected***." [35]
- She has heard in the media that there is a nine-page long list of adverse events of special interest for the Pfizer Covid vaccine. She does not plan to review it.[36]

[28] Dr. A Transcript, p. 65, lines 20-25
[29] Dr. A Transcript, p. 66, lines 1-25; p. 67, lines 1-14
[30] Dr. A Transcript, p. 68, lines 1-21
[31] Dr. A Transcript, p. 70, lines 24-25
[32] Dr. A Transcript, p. 72, lines 19-23
[33] Dr. A Transcript, p. 74, lines 18-21; p. 75, lines 4-15
[34] Dr. A Transcript, p. 77, lines 20-23
[35] Dr. A Transcript, p. 78, lines 8-11
[36] Dr. A Transcript, p. 80, lines 18-25; p. 81, lines 1-4

APPENDIX B – Highlights of Deanna Paulson's Cross Examination Evidence

Deanna Paulson

Cross Examination

- She agreed that the AHS solid organ transplant document from September 2021 states that the Covid vaccine is recommended but is not mandatory.[37]
- She agreed that the Canadian Transplant Society document does not speak to long-term side effects of the Covid vaccines and it doesn't discuss the AZ and Johnson and Johnson vaccines.[38]
- She admitted that the donation and transplant services at the ABC HOSPITAL Health Services has not considered what effect shame and scapegoating patients has on the mental health of patients.[39]
- The team of professionals who decide who gets a donated organ does not include an infectious disease professional.[40]
- In March 2021 there was no AHS policy that required [redacted] transplant candidates to get the Covid-19 vaccine. There still is no final written policy, but it is drafted.[41]

[37] Dr. A Transcript, p. 37, lines 14-17
[38] Dr. A Transcript, p. 41, lines 13-18
[39] Paulson Transcript, p. 54, lines 20-24
[40] Paulson Transcript, p. 59, lines 23-25
[41] Paulson Transcript, p. 61, lines 2-25

APPENDIX C – Highlights of Dr. Mallard's Evidence

Dr. Bonnie Mallard

Written Reports

- The Covid-19 vaccines are still in clinical trials and will be in clinical trials until 2023;[42] Pfizer's clinical trial ends May 15, 2023.[43] (****unchallenged on cross-examination**)
- Because the Covid-19 vaccines are still in clinical trials, anyone who takes a Covid-19 vaccine prior to the completion of those clinical trials is participating in a population-level experiment;[44] (****unchallenged on cross-examination**)
- Vaccine manufacturers confirm individuals in the Applicant's condition were excluded from safety trials and do not recommend the vaccine for anyone in the unexamined groups – the Applicant ought to be automatically excluded from being vaccinated as there is no safety or efficacy data from the clinical trials for people with her condition;[45] (****unchallenged on cross-examination**)
- In the United States and Europe, Covid-19 vaccines have generated more adverse reports in the last 9 months than all other 70 vaccines over the past 30 years combined;[46] (****unchallenged on cross-examination**)
- 50 deaths reported after inoculations with the swine flu vaccine in 1976 were sufficient to halt that vaccine's use. A cut off must be provided in order to objectively determine when the vaccine should be halted and if it is greater than 50 how is that number is determined. So far no death cut off has been determined for the Covid-19 vaccine;[47] (****unchallenged on cross-examination**)
- The Canadian Immunization Surveillance Program is unreliable as it only allows physicians to report adverse events which is problematic as it takes between 20-40 minutes per patient to submit the form, also the physician's personal assessment of a

[42] Mallard Report 1, pp. 2-3
[43] Mallard Report 2, page 4, para. 2
[44] Mallard Report 1, page 16, para. 2
[45] Mallard Report page 2, paras 1-2.
[46] Mallard Report 1, page 4, para. 3.
[47] Mallard Report 1, page 6, para. 1.

vaccine injury may also be vetoed by the local medical officer of Health and/or those at Health Canada monitoring the system;[48] (****unchallenged on cross-examination**)

- It is likely that the misconception of comparatively lower adverse events in Canada is due to the under-reporting in the Canadian system.[49] (****unchallenged on cross-examination**)
- Data indicates a lack of clear (vaccine) benefit;[50]
- A new peer-reviewed study shows that even for the elderly, there is a 5X greater chance of death from the vaccine than death from Covid-19;[51]
- The vaccines are highly inflammatory. The mRNA in the lipid nanoparticles in the mRNA vaccines encodes for the viral spike protein and the lipid nanoparticles travel throughout the body and the spike protein which is inflammatory will be expressed on cells and tissues in the body. If a person has already made antibodies to the spike protein from previous Covid-19 exposure when injected with the vaccine, the tissues can self-destruct;[52] (****unchallenged on cross-examination**)
- Prior to [redacted] transplant it is imperative not to induce inflammatory episodes particularly in the [redacted];[53] (****unchallenged on cross-examination**)
- Pfizer biodistribution report provided to Japanese regulatory authorities showed that inflammatory lipid nanoparticles are capable of travelling to the [redacted] and other organs;[54] (****unchallenged on cross-examination**)
- Traditional vaccines do not migrate throughout the body but stay in the muscle and draining lymph nodes and the cells of the immune system travel throughout the body and provide protection;[55] (****unchallenged on cross-examination**)
- It is scientifically confirmed highly Covid-19 vaccinated nations are those with the highest rates of Covid-19;[56] (****unchallenged on cross-examination**)
- The literature now points to evidence of autoimmunity associated with the Covid-19

[48] Mallard Report 1, page 6, para. 2.
[49] Mallard Report 2, page 3, para. 1
[50] Mallard Report page 5, para 1.
[51] Mallard Report page 3, para 1.
[52] Mallard Report page 7, para 2.
[53] Mallard Report page 8, para 2.
[54] Mallard Report page 8, para. 2.
[55] Mallard Report page 8, para. 2.
[56] Mallard Report page 13, para 2.

vaccines;[57] (****unchallenged on cross-examination**)

- Increasing scientific studies show that the spike protein by itself is bioactive and toxic to tissues. These genetic Covid-19 vaccines' mRNA provides the recipe for cells to make their own spike protein. The exact amount of spike protein each person receives is unknown;[58] (****unchallenged on cross-examination**)
- Vaccine trials have been subject to recent scrutiny regarding adequacy;[59] (****unchallenged on cross-examination**);
- The Pfizer insert specifically sets out that immunocompromised individuals may have a diminished immune response;[60] and,
- The Applicant can actively participate to protect herself from infection by avoiding crowds and increasing her vitamin D intake. (****unchallenged on cross-examination**)
- The new data from Pfizer's combined Phase 1/2/3 clinical trial that began in April 2020 is only now being released to the public. The first report showed an unexpectedly high number of serious adverse events from various countries involved, including close to 10,000 involving the respiratory system. Out of 42,086 adverse events reported, 1223 were fatal (2.9%) 11,361 had not yet recovered (27%), 520 had ongoing sequelae (1.2%), and 9400 were unknown. This previously undisclosed information underlies the safety of the new vaccine products. It alters the cost/benefit analysis of potential vaccine mandates.[61] (****unchallenged on cross-examination**)
- There remains years of research to conduct to determine the safety and efficacy of the current Covid-19 vaccines and any further variations introduced before administering them to Ms. Lewis.[62]
- The current vaccines do not provide sufficient protection to warrant mandatory vaccination – especially when the vaccinated population is making up the greatest proportion of cases per 100,000.[63]
- Previous attempts at generating gene-based vaccines have resulted in various forms of

[57] Mallard Report 1, page 9, para. 1.
[58] Mallard Report 1, page 9, para. 2.
[59] Mallard Report 1, page 13, para 2.
[60] Mallard Report 1, page 18, para 9.
[61] Mallard Report 2, page 3, paras. 2-4
[62] Mallard Report 2, page 4, para. 3
[63] Mallard Report 2, page 6, para. 2

vaccine-induced disease enhancement. She demands study to determine the cause resulting in the vaccinated population having the greatest number of cases.[64]

- Despite Dr. Houghton's claim that the "rapid progress in developing Covid vaccines using new RNA and adenoviral-based technologies" are responsible for providing "substantial protection" to those in the world's population who have been inoculated with them, it is demonstrably the opposite. She shows data from Israel, Alberta Scotland, and the UK.[65]
- Weekly updates to the VAERS system indicate that vaccine injuries have reached a historic record with 1 million reports and 23,149 deaths overall.[66]

Cross Examination

- The Applicant ought to be tested for natural immunity;[67]
- The greatest proportion of cases of Omicron are in the vaccinated, the vaccines are not preventing transmission;[68] in Israel it's the triple vaccinated, as an immunologist she sees negative repercussions of getting the Covid-19 vaccines. Graphs from Ontario and Alberta show that something is not as it should be. Vaccines should provide protective immune response.[69]
- It's a poor vaccine at very best.[70]
- Covid-19 vaccines' effectiveness wanes over time, and the time is exceedingly quickly. Some of the recent estimates are no effectiveness after 180 days.[71]
- Vaccinated people carry the highest viral load.
- Natural immunity is being ignored and it is equal to or superior;[72]
- The statistic that 20-30% of fully vaccinated patients who get Covid-19 post[redacted]-

[64] Mallard Report 2, page 8, paras 1-2
[65] Mallard Report 2, pages 8-11
[66] Mallard Report 2, page 22, para. 2
[67] Mallard Transcript p. 19, lines 15-16
[68] Mallard Transcript p. 35, lines 5-11
[69] Mallard Transcript p. 45, lines 21-25; p. 46, lines 1-2
[70] Mallard Transcript p. 48, line 3
[71] Mallard Transcript p. 58, lines 18-23
[72] Mallard Transcript p. 59; lines 5-6, 11-16

transplant pass away is pre-Omicron. Omicron is much milder.[73]

- What is concerning is that VAERS reports a huge increase in adverse events which is greater than adverse events reported compared to all events prior to 1990. It warrants further investigation, particularly now that Pfizer through the *Freedom of Information Act*, document 5.3.6 has been released. We are learning new information, and this is the reason for caution – we don't have all information in terms of the vaccines they are still in Phase 3 clinical trials. We are getting information from Pfizer monthly which is substantiating what we see in VAERS. The latest information from Pfizer showed 1200 deaths and we stopped the swine flu vaccines with 50 deaths.[74]
- When you see a hockey stick type graph like this[75] it is time to pause until we see the Pfizer data. The *New England Journal of Medicine* published a document accusing Pfizer of fraud, and that puts a caution on the use of the Pfizer vaccine until it is clarified;[76]
- VAERS lets us compare the adverse events signal of the Covid-19 vaccines to other vaccines over time. It is quite distinct in terms of these vaccines, maybe not surprising because they use different genetic technology which has never been used previously in a human vaccine;[77]
- When these vaccines are put through at warp speed and haven't completed Phase 3 clinical trials, it warrants some care before they are mandated, particularly since Omicron is so mild. Why vaccinate with something that has a high-risk signal and where we are getting data from the vaccine manufacturers that are shedding new light on this as we speak?[78]
- In response to whether VAERS data is misleading: It gives a signal. This is how myocarditis and thrombocytopenia were uncovered, that is the job of the signal. It is to give you an alarm signal.[79]
- The 1200 deaths is much higher than anything we have seen before. We are obligated

[73] Mallard Transcript p. 61; line 25; p. 62, lines 1-7
[74] Mallard Transcript p. 66; lines 10-25, p. 67, lines 1-7
[75] Mallard Report 2, p. 23
[76] Mallard Transcript, p. 67, lines 15-17, 20-24
[77] Mallard Transcript, p. 68, lines 6-12
[78] Mallard Transcript, p. 68, lines 23-25; p. 69, lines 1-8
[79] Mallard Transcript, p. 70, lines 1-8

to understand why that is. That is VAERS' function – it is a system to show signals. It has been used very effectively since 1990.

- Information has to be taken together. As an immunologist she sees red flags on vaccine effectiveness and adverse events.[80]
- Omicron has changed the landscape and it's mild and the vaccines are of low efficacy. There's no point using them against Omicron.[81]
- The latest Pfizer report, the 5.3.6 document, out of 42,000 case reports, 8,000 involved the [redacted][82]
- She disputes the Canadian Society of Transplantation [redacted] section and the American Society of Transplantation's statement that the vaccines are safe and effective. She sees an alarm signal in VAERS and the latest documents from Pfizer. The transplant society recommendation was made before Omicron. There is little point going back to look at old variants when we are currently dealing with Omicron. It is mild and we need to rethink the risk and recalculate the risk-benefit analysis.[83]
- She is not against vaccinations. They are one of the most effective strategies when used properly to help mitigate disease, and ***she has been involved in a design of a vaccine for a disease in pigs***. She is not an "anti-vaxxer".[84]

[80] Mallard Transcript, p. 72, lines 17-25; p. 73, lines 1-2
[81] Mallard Transcript, p. 73, lines 7-11
[82] Mallard Transcript, p. 74, lines 3-10
[83] Mallard Transcript, p. 75, lines 18-25; p. 76, lines 7-11
[84] Mallard Transcript, p. 85, lines 8-17

APPENDIX D – Highlights of Dr. Bridle's Evidence

Dr. Byram Bridle

Written Report

- Alberta Public Health data shows that in December 2021 and January 2022 when COVID-19 cases shattered records, the sub-group with the lowest risk of contracting COVID-19 was the unvaccinated group. Covid-19 vaccines should not be recommended for anyone in Alberta due to the province's own 'real world data' showing that they increase the risk of getting Covid-19.[85] (***unchallenged on cross-examination***)
- The evidence that the COVID-19 vaccines blunt the severity of the disease is spurious at best. Since mid-December 2021, most of the people associated with COVID-19 in hospitals and ICUs were vaccinated.[86] (***unchallenged on cross-examination***)
- Dr. Houghton provided no evidence that the current Covid-19 vaccines are safe and effective for transplant patients, especially in the context of the Omicron variant.[87] (***unchallenged on cross-examination***)
- Alberta's public health data shows that inoculating a patient awaiting a [redacted] transplant at the present time would actually increase their risk of contracting Covid-19. As an expert vaccinologist who spent several years conducting transplantation research, mandating the Covid-19 vaccines to the Applicant would increase her risk of contracting Covid-19 and would put her transplanted [redacted] tissue at enhanced risk of harm.[88] (***unchallenged on cross-examination***)
- As to the argument that patients awaiting a [redacted] transplant ought to receive the Covid-19 vaccine before they are transplanted, the antibodies induced by the Covid-19 vaccines are short-lived and irrelevant. Pre-existing natural immunity's associated antibodies are longer-lasting than those induced by the Covid-19 vaccines.[89]

[85] Bridle Report, p. 2, para, 2; p. 3, para. 1
[86] Bridle Report, p. 3, para. 3; p. 4, figures A and B
[87] Bridle Report, p. 7, para. 7
[88] Bridle Report, p. 7, para. 8
[89] Bridle Report, p. 8, para. 9

(****unchallenged on cross-examination***)

- The Omicron variant is the least dangerous form of SARS-CoV-2.[90] (****unchallenged on cross-examination***)
- A basic cost-benefit analysis concludes that the best way to maximize the health and safety of the patient and the donated organ is to keep her unvaccinated. A lower risk of contracting Covid-19 means a lower risk of harm to the engrafted tissue.[91] (****unchallenged on cross-examination***)
- Pfizer's fact sheet data suggests that the risk of serious adverse events may have been four times higher in the vaccinated group than the unvaccinated group in the short-term.[92] (****unchallenged on cross-examination***)
- The European Medicines Agency has compiled a list of important medical events following Covid-19 vaccination which are always to be classified as serious: blood clot in the [redacted], anaphylactic reaction, deep vein thrombosis, pneumonia, thrombocytopenia, blood clots or bleeding in the brain, hallucinations, cerebral stroke, myo- and peri- carditis.[93] (****unchallenged on cross-examination***)
- Pfizer's vaccine data package submitted to the Japanese government provided evidence of broad systemic distribution of their vaccine lipid nanoparticles that carry the mRNA encoding for the spike protein from SARS-CoV-2. The nanoparticles go to the [redacted] The precautionary principle would dictate that research should be done to rule in or out the concern that this mechanism of action could harm [redacted], possibly inciting pathological autoimmune reactions in pulmonary tissues.[94] (****unchallenged on cross-examination***)
- There is scientific evidence that the risk of serious adverse events caused by Covid-19 vaccines is enhanced if administered to people with pre-existing immunity against SARS-CoV-2. This aspect precludes mandating a vaccine to someone whose immunity status is unknown.[95] (****unchallenged on cross-examination***)

[90] Bridle Report, p. 8, para. 9
[91] Bridle Report, p. 8, para. 10
[92] Bridle Report, p. 14, para. 22
[93] Bridle Report, p. 14, para. 23
[94] Bridle Report, p. 15, para. 25
[95] Bridle Report, p. 15, para. 27

- Canada does not have an active surveillance system for monitoring vaccine safety. We rely on a passive voluntary surveillance system which is notorious for under-reporting vaccine related adverse events.[96] (****unchallenged on cross-examination**)
- An analysis of Alberta Public Health's own recent data shows that the Covid-19 vaccines proves to be 10 times more dangerous (caused 10 times more adverse events) than the annual flu vaccine.[97] And the array and seriousness of adverse events was greater for those who received a Covid vaccine than those who received a flu vaccine.[98] (****unchallenged on cross-examination**)
- Covid-19 is not a pandemic of the unvaccinated, and it is not particularly deadly.[99] (****unchallenged on cross-examination**)
- There is no sound scientific basis to require mandatory Covid-19 vaccination for anyone, especially a patient like the Applicant. If she got the Covid vaccine her risk of potential harm and harm to the donated [redacted] would increase.[100] (****unchallenged on cross-examination**)

Cross Examination

- The infection fatality rate of Covid-19 was about 0.15%, in the ballpark of a bad flu season.[101]
- His Ph.D. focused on transplantation immunology. He is familiar with [redacted] immunology extensively because he does lots of work with development of vaccines protecting against infectious diseases, respiratory infectious diseases. He develops immunotherapies for treating [redacted] cancer so he has deep expertise in pulmonary immunology and transplant immunology.[102]
- As of September 1, 2021, the definition of a vaccine was changed to allow for the Covid-19 vaccines. It removed the concept of immunity and now includes anything

[96] Bridle Report, p. 16, para. 28
[97] Bridle Report, p. 16, para. 28
[98] Bridle Report, p. 17, Figure 6
[99] Bridle Report, p. 19, para. 35
[100] Bridle Report, p. 20, para. 35
[101] Bridle Transcript, p. 20, lines 7-11
[102] Bridle Transcript, p. 22, lines 23-25, p. 23, lines 1-10

that induces an immune response against diseases.[103]

- All historically mandated vaccines are ones that confer sterilizing or near-sterilizing immunity. They protect the person from disease and prevent transmission of disease.[104]
- The duration of Covid vaccine immunity is horrifically short. It is challenging to make a vaccine that would have such a short duration of immunity.[105] Childhood vaccines produce good quality duration of immunity – long-term protection.[106]
- The very first clinical trials to achieve the licensing are still ongoing. They have not ended. By definition, ***the vaccine is in the experimental phase***. They won't be completed for some time, until the year 2023. They are being used experimentally and have conditional licensing in Canada.[107]
- In response to a question about an open letter from Guelph faculty saying that he was disseminating factually incorrect and misleading information: It is a job of a faculty member to answer questions to the public within our areas of expertise. Anything he disseminates is based on solid scientific foundations. His colleagues did not back any of their complaints up with science. When he raised the safety issues about the Covid-19 vaccines (AstraZeneca blood clots, and myocarditis in young males) they have always ended up coming true. He put out the warnings (which came true) months in advance. He is an expert in vaccinology and sees the potential problems that could come from this.
- The way that scientific data has been disclosed during the declared pandemic has been highly unusual. Companies have been allowed to disclose the science to the scientific community through media releases, which is highly unusual. There was no opportunity to study any raw scientific data or peer-reviewed scientific data at any point to determine this. The public messaging was that the vaccine stays at the injection site. It shocked him that it was completely untrue. Based on the preclinical studies, most of the vaccine dose was not remaining at the injection site, so it is an obvious scientific

[103] Bridle Transcript, p. 32, lines 7-11
[104] Bridle Transcript, p. 38, lines 1-5
[105] Bridle Transcript, p. 42, lines 8-10, 13-15
[106] Bridle Transcript, p. 42, lines 23-25; p. 43, lines 1-5
[107] Bridle Transcript, p. 45, lines 13-25; p. 46, lines 1-2

safety question to ask.

- The top evidence as a scientist that I would rely upon is peer reviewed published scientific papers and raw data interpreted by an expert.
- When asked if he would support a requirement that a person awaiting a [redacted] transplant be vaccinated with a Covid-19 vaccine that could achieve sterilizing or near sterilizing immunity: He would support a recommendation for a person awaiting a [redacted] transplant to have a Covid vaccine that achieved sterilizing or near sterilizing immunity. He would promote it in the same way he promotes all other vaccines he believes in. If it was effective and could prevent the disease and block transmission. But nobody should be forced to take a vaccine.[108]

[108] Bridle Transcript, p. 136, lines 19-20; p. 137, lines 1-9

APPENDIX E – Highlights of Dr. Turner's Evidence

Dr. Benjamin Turner

Written Report

- The goal of any medical act must be the health of the patient subject to that act.[109]
- Denying the Applicant a [redacted] transplant for which she is otherwise a candidate, when the alternative is death, is an example of doing harm.[110]
- Attempts to influence a patient's decision with threats or promises demonstrate a lack of respect for autonomy; they are intended to make the patient choose something other than his own preferred means or ends.[111]
- An attempt to coerce the patient toward vaccination by means of fear is not compatible with patient autonomy. The patient is faced with the alternatives of a treatment she does not want and certain death in the medium term. If she permits herself to be vaccinated at this point, she will have undergone medical treatment under duress, and therefore without free consent.[112]
- The Applicant is refusing Covid-19 vaccination, not out of neglect of her health, but precisely to preserve it from the risks of vaccine adverse events. Her refusal is a good indication that unlike the ongoing drinker, she will take all ordinary means to preserve herself and the graft in question.[113]
- The Applicant has done everything requested of her by the transplant team, except get the Covid vaccine. Her default position is strongly in favour of her physicians' recommendations.[114]
- Dr. Kates' study citing an estimated Covid fatality rate of 18% for Ms. Lewis cannot be relied upon as it is not a valid estimate of the risk for Ms. Lewis. The study investigates outcomes in hospitalized patients. Hospitalized patients are much more likely to die of Covid-19 than non-hospitalized patients. Since we don't know whether

[109] Turner Report 1, page 2, para 6
[110] Turner Report 1, page 3, para. 2
[111] Turner Report 1, page 4, para. 2
[112] Turner Report 1, page 4, para. 3
[113] Turner Report 1, page 9, para. 2
[114] Turner Report 1, page 20, para. 3

Ms. Lewis would be hospitalized or not in the event she contracted Covid, we can't take the mortality rate in the hospitalized as representative of her risk. The correct figure is the mortality rate in all transplant patients, not just the sickest. Her 18% estimate must be discarded completely.[115]

- The UK Health Security Agency reports efficacy against death of only 59% at 25 or more weeks after the second dose. Waning effectiveness is the rationale for giving supplemental doses, and the same document reports 95% effectiveness after a third dose. But as Kates says, these same patients are likely to mount a suboptimal immune response to post-transplant doses. The long-term effectiveness of vaccination in Ms. Lewis' case is likely to be less than in the general population.[116]
- If vaccination were so beneficial as to constitute an absolute ethical requirement, transplant could be just as unethical in a patient who cannot be vaccinated as in one who will not be vaccinated. Since the transplant program does not think it would be unethical in the former case, they ought not to think it would be unethical in the latter.[117]
- The benefit of the vaccine is likely not enough that an unvaccinated patient would enjoy significantly less benefit from the transplant organ than a vaccinated one, and Kates' citations are compatible with that claim.[118]
- Dr. Kates says that patients should either be vaccinated or be able to demonstrate immunity to Covid-19 going forward. The Respondents made no effort to determine whether Ms. Lewis might have acquired immunity to Covid-19 by prior infection. If she were able to present serological evidence of prior infection, the transplant program could immediately assign Ms. Lewis the same priority as if she had been vaccinated.[119]
- Dr. Kates raises an ethically troubling argument, She alleges a duty to deny treatment to Ms. Lewis because of the risk her presence might pose to others in the transplant centre. That scarcity can interfere with the practical possibility of providing care to all applies only to the question of the transplant organ itself. The fact that Ms. Lewis will

[115] Turner Report 2, page 15, para 6; page 17, para 5
[116] Turner Report 2, page 18, para. 1
[117] Turner Report 2, page 21, para. 2
[118] Turner Report 2, page 22, para. 1
[119] Turner Report 2, page 23, para. 1

come into contact with other people, who could contract Covid-19 from her, is not a matter relating to scarce resources. Given the vaccine-resistant and extremely infectious nature of Omicron, all transplant patients will eventually be exposed to Covid-19. Ms. Lewis herself will spend only a very small proportion of her life in the transplant centre and will be exceedingly unlikely to have Covid at any one time she is there.[120]

- It is ethically dubious to make transplant contingent on a vaccination whose long-term efficacy is in doubt.[121]
- If vaccinated transplant patients' Covid immunity is so weak that briefly sharing well ventilated space with an unvaccinated person is a major Covid risk, then the effectiveness of vaccination simply cannot be anywhere near the high figures Kates adopted. If vaccination is highly effective, then Ms. Lewis will pose minimum risk to her fellow transplant patients. If it is not highly effective, then it cannot be claimed that it is enough of a benefit to her to constitute an absolute ethical rule.[122]
- Although the scarcity of transplant organs affects the patient's reasonable expectations for treatment, it does not give the treating teams indiscriminate control over the allocation of organs. On the contrary, it further constricts their ethical boundaries, by introducing the estimation of comparative need and maximum benefit from a given organ. The considerations above argue that the Applicant's removal from the transplant list is not supported by careful consideration of risk and benefit. If this is so, her removal from the waiting list was an exercise not of responsible stewardship of scarce organs, but of indiscriminate power.[123]

Cross Examination

- Dr. Turner said that one would not have to minimize every avoidable harm in order to qualify for a transplant because the question comes down to the maximum benefit to

[120] Turner Report 2, page 24, para. 1
[121] Turner Report 2, page 4, para. 2
[122] Turner Report 2, page 24, para. 2
[123] Turner Report 1, page 9

be derived from a particular transplant organ.[124]

- Dr. Turner referred to the Covid-19 vaccine as “experimental medication” because there are open questions remaining on the safety and efficacy of the vaccinations, which it is reasonable for someone to have before being vaccinated.[125]

[124] Turner Transcript, p. 37, lines 14-18
[125] Turner Transcript, p. 48, lines 4-19

APPENDIX F – Highlights of Dr. Kates' Cross Examination Evidence

Dr. Olivia Kates

Cross Examination

- When we discuss different criteria for transplantation, some may be more or less excellent examples of reasonable criteria. Criteria that impose a low burden and that are safe are excellent examples of reasonable criteria.[126]
- It would be ethically justifiable to proceed with a transplant in a patient who had a medical contraindication to vaccination. The vaccination is beneficial only to the extent that it is not specifically and directly harmful to a person whose unique circumstances makes them vulnerable. Individuals with a medical contraindication to vaccination stand to be directly harmed by vaccination, and I think that burden is excessive to impose.[127]
- It is possible to have a transplant without the Covid-19 vaccination.[128]
- Covid-19 vaccination of individuals who can safely be vaccinated is an ethically justifiable requirement.[129]
- NPR article, "Once Rare, [redacted] Transplants for Covid-19 Patients Are Rising Quickly" she is quoted, "I think Covid-19 patients should be subject to the same expectation that they should either be vaccinated or be able to demonstrate immunity to Covid-19 going forward, so that their next set of [redacted] is not subject to the same risk."[130]
- ***In response to the question of whether it is reasonable and responsible for a treating physician to determine whether Ms. Lewis has natural immunity: "I think it is reasonable to raise that question***."[131]
- She wrote in her article "Covid-19 Spurs Vaccination Policy" in American Journal of Transplantation, December 2021, "The goal is never to deny or prevent a

[126] Kates Transcript, p. 46, lines 14-21
[127] Kates Transcript. P. 50, lines 21-25; p. 51, lines 3-9
[128] Kates Transcript, p. 47, lines 12-14
[129] Kates Transcript, p. 51, lines 13-15
[130] Kates Transcript, p. 54, lines 11-18
[131] Kates Transcript, p. 57, lines 14-17

transplant."[132]

- In that article she also wrote, "Black Americans, for example, have historically experienced disparities in transplant also, their reluctance to be vaccinated may be based on authentic personal and community histories of medical abuse and surreptitious experimentation. She suggests that such reluctance be given special consideration so that vaccination policy does not disproportionately and unfairly prevent these patients from accessing transplants."[133] She also said, "Vaccine reluctance in some cases should be given special consideration so that the vaccine policy doesn't unfairly prevent patients from accessing transplants," and confirmed that the statement is specifically about Black Americans.[134]
- ***She agreed that she suggests giving special considerations to vaccine policies for Black Americans***.[135]
- Informed consent must not be influenced by threats or promises.[136]
- It's in the patient's best interest to survive.[137]
- Denying organs to patients in need has major ethical implications.[138]
- She agreed it's possible that the Applicant's quality of life could still possibly be high following the organ transplant event if she wasn't vaccinated with the Covid-19 vaccine.[139]
- She was quoted in a Huffington Post article entitled "Colorado Woman May Not Get an Organ Transplant Because She Won't Get Vaccinated." October 7, 2021: "Vaccine mandates are really not about punishing non-vaccination but promoting vaccination and ensuring that people who are not vaccinated are not made even more vulnerable to Covid-19 through transplantation and immunosuppression. I think the term "mandate" itself is interesting. ***Mandate refers not only to a rule or requirement but also to a calling or duty. I believe we all have a mandate, a calling, to be vaccinated ourselves***

[132] Kates Transcript, p. 71, lines 6-8
[133] Kates Transcript, p. 72, lines 12-25; p. 73, lines 1-2
[134] Kates Transcript, p. 73, lines 19-25; p. 74, lines 2-3
[135] Kates Transcript, p. 74, lines 15-18
[136] Kates Transcript, p. 94, lines 10-12
[137] Kates Transcript, p. 96, lines 16-17
[138] Kates Transcript, p. 96, lines 23-25
[139] Kates Transcript, p. 97, lines 7-11

and promote vaccination in others for the good of our communities."[140]

- She was quoted in an article entitled "Anti-Racist Public Health Response to Demonstrations: Against Systemic Injustice", "When Kates arrived at the office, she talked to a colleague. Together they crafted a letter calling for an anti-racist public health response to the protests. ***White supremacy is a lethal public health issue that predates and contributes to Covid-19***." She also was quoted as saying, "Covid is out of control for the same reasons that racism is out of control, an individualistic orientation that comes off as a lack of compassion for your fellow man. We see that people may not universally be willing to correct their behavior or attitudes to reduce transmission of Covid."[141]
- She admitted that in one of her studies there has been an overrepresentation of hospitalized patients and a higher mortality rate than in the general transplant population. Her study cautioned against this overrepresentation.[142]

[140] Kates Transcript, p. 104, lines 24-25; p. 105, lines 1-7
[141] Kates Transcript, p. 106, lines 20-22, 25; p. 107, lines 1-2, 14-23
[142] Kates Transcript, pp. 79-80, lines 22-25, 1-5

APPENDIX G – Highlights of Dr. Cypel' Cross Examination Evidence

Dr. Marcelo Cypel

Cross Examination

- He is aware that patients with severe and chronic respiratory diseases were excluded from the initial clinical trials for the Covid-19 vaccines.[143]
- Agrees that when he says they are safe in his expert report, he is not referring to long-term safety because no one has data long-term.[144]
- Agrees he doesn't know what will happen to any of the transplant patients who received the Covid-19 vaccine 5 or 10 years after they were vaccinated.[145]
- Agrees his [redacted] transplant program requires some of the childhood vaccines for transplant candidates, such as measles, pneumococci. Agrees they have been around for many years and long-term safety data is available for those other vaccines.[146]
- Agreed that heart muscle damage from Covid-19 vaccine-induced myocarditis would be a concern for the Applicant if she was to develop it.[147]
- He was aware of the Health Canada warning about the risk of thrombosis with the AZ and the Johnson and Johnson vaccines. These vaccines can lead to thrombocytopenia.[148]
- The [redacted] transplant team at his hospital recommends Pfizer and Moderna for their transplant candidates, not Johnson and Johnson or AZ because of the level of efficacy and the safety profile of the mRNA vaccines is higher.[149]
- Agrees that thrombosis and thrombocytopenia are serious conditions.[150]
- He is not aware of the previous use of mRNA technology as a vaccine strategy.[151]
- Agrees that patients should do things that will help keep their immune system as

[143] Cypel Transcript, p. 16, lines 4-8;
[144] Cypel Transcript, p. 16, lines 9-13
[145] Cypel Transcript, p. 16, lines 24-25; p. 17, lines 1-4
[146] Cypel Transcript, p. 17, lines 5-25; p. 18, lines 1-2
[147] Cypel Transcript, p. 19, lines 11-25
[148] Cypel Transcript, p. 24, lines 5-19
[149] Cypel Transcript, p. 25, lines 1-10
[150] Cypel Transcript, p. 25, lines 19-22
[151] Cypel Transcript, p. 28, lines 22-25; p. 29, lines 1-3

strong as possible before the transplant, and be in the best health possible while waiting for a transplant. He also agrees that Covid-19 can be harmful to someone who has a terminal [redacted] disease.[152]

- He agreed if someone's white blood cell count was reduced to below 1,000, that person could generally be more susceptible to an infection. He agreed that there would be some instances where he would be concerned if there was a lower white blood cell count in someone waiting for a [redacted] transplant.[153]
- Was shown a document called Pfizer Request for Priority Review, Covid-19 Vaccine May 2021, section on Safety at page 8. It said, "Clinical laboratory evaluations showed a transient decrease in lymphocytes that was observed in all age and dose groups after dose 1 which resolved in approximately one week."[154]
- He agreed that lymphocytes are white blood cells. He agreed that the document is saying that after dose 1, for one week, Pfizer's data shows that people who took the Pfizer vaccine had a decrease in white blood cells.[155]
- He agreed that doctors need to explain the risks and benefits of treatments to a patient, and normally that would be described in a clinical note.[156]
- ***When asked whether every time new risks of the medical treatment become known, they should be explained to a patient before the patient chooses to take that medical treatment, he agreed that the patient should be made aware of concerning information***.[157]
- He agreed that the Health Canada labels on the Covid-19 vaccines are "safety warnings".[158]
- He agreed that it would be good practice to educate a patient who expresses fear of the Covid-19 vaccines about the safety information from Health Canada, and it's a reassuring discussion to have. He agrees it is important that the discussion occurs with

[152] Cypel Transcript, p. 39, lines 5-23
[153] Cypel Transcript, p. 40, lines 5-17
[154] Cypel Transcript, p. 40, lines 18-25; p. 41, lines 1-20
[155] Cypel Transcript, p. 41, lines 22-25; p. 42, line 1
[156] Cypel Transcript, p. 44, lines 9-21
[157] Cypel Transcript, p. 45, lines 19-25; p. 46, line 1
[158] Cypel Transcript, p. 48, lines 9-19

a patient who repeatedly expresses fears of the Covid vaccines.[159]

- He agreed that it's possible that there are adverse events that we are still learning about as a result of the Covid-19 vaccines because they are so new.[160]
- He agreed that it is "impossible to know" the long-term effects for these vaccines because "we just started these vaccines a year ago."[161]

[159] Cypel Transcript, p. 49, lines 20-25; p. 50, lines 1-2, 22-25; p. 51, lines 1-2
[160] Cypel Transcript, p. 54, lines 19-23
[161] Cypel Transcript, p. 55, lines 22-25; p. 56, line 1

APPENDIX H – Highlights of Dr. Houghton' Cross Examination Evidence

Dr. Michael Houghton

Cross Examination

- He agrees that having recovered from Covid-19 can protect people from Covid-19, "in a limited time frame". He also agrees that the Covid-19 vaccines are transient in their protection.[162]
- People who have received the Covid vaccines still get Omicron.[163]
- He does not know whether the clinical trials for the original Covid-19 vaccines are still continuing.[164]
- He agreed that the Pfizer clinical trial was done on healthy individuals.[165]
- He agreed that the clinical trial would exclude people who would be on immunosuppressive therapy in the next 6 months.[166]
- He agreed that his conclusion about the safety and efficacy of the Covid-19 vaccines in respect of Ms. Lewis cannot be derived from the result of the Pfizer clinical trial.[167]
- He wasn't sure he had seen the Moderna clinical trial document.[168] But he agreed in looking at it that having a respiratory disease would exclude a person in the Applicant's position from the clinical trial, if she was requiring daily medications in the last five years.[169]
- When asked to verify that he had not included peer-reviewed sources for his conclusions, he gave answers such as: "If I referred to all the peer-reviewed publications that I could have, all the statements from public health agencies around the world and all of the general media references, this document would be 10,000

[162] Houghton Transcript, p. 29, lines 7-16
[163] Houghton Transcript, p. 35, lines 15-21
[164] Houghton, Transcript, p. 38, lines 18-25; p. 39, lines 1-4
[165] Houghton Transcript, p. 41, lines 20-22; p. 41, lines 9-11
[166] Houghton Transcript, p. 44, lines 15-25; p. 45, lines 1-5
[167] Houghton Transcript, p. 47, lines 18-23
[168] Houghton Transcript, p. 49, lines 22-25
[169] Houghton Transcript, p. 56, lines 12-19

pages long."[170]

- When asked if he wasn't sure whether the Covid-19 vaccines were going to damage the [redacted] of a patient waiting for a [redacted] transplant, he said his expert report said "usually Covid mRNA vaccines do not appear to damage the [redacted] of recipients waiting for a [redacted] transplant" because vaccines can have side effects and he didn't want to rule out the possibility that someone could suffer [redacted] damage from a Covid vaccine.[171]
- Omicron is less pathogenic than Delta, and less severe on a per case basis.[172]
- He agrees that many Canadians suffer from Vitamin D deficiency because of dark winters, and that truly Vitamin D deficient patients may benefit from supplementation for Covid-19 related protection and outcome.[173]
- He was not aware of Health Canada's safety warnings for the Covid-19 vaccines.[174]
- He agrees that there is a warning label on the Pfizer vaccine in August 2021 due to the risk of Bell's Palsy.[175]
- He was not aware of the February 2022 WHO report which listed hearing loss as a potential side effect of the Covid-19 vaccines.[176] He agreed that the WHO is reporting hearing loss and tinnitus as being associated with Covid vaccination.[177]
- He was not aware that Pfizer has had to comply with a court order in the United States to release thousands of pages a month of its clinical trial data.[178]
- Some of the adverse events are specific to the vaccine. The blood clots stimulated by the adenovirus vaccine, you know, those are real. Those occurred and they were caused by the vaccine.[179]
- He agreed we do not have safety information five years after the rollout of these vaccines, or 10 years.[180]

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[170] Houghton Transcript, p. 58, lines 20-25; p. 59, lines 3-7
[171] Houghton Transcript, p. 62, lines 11-25
[172] Houghton Transcript, p. 68, lines 4-5; p. 68, lines 13-16
[173] Houghton Transcript, p. 70, line 20; p. 71, lines 14-18
[174] Houghton Transcript, p. 72, lines 14-18
[175] Houghton Transcript, p. 77, lines 11-15
[176] Houghton Transcript, p. 83, lines 15-20
[177] Houghton Transcript, p. 83, lines 13-16
[178] Houghton Transcript, p. 87, lines 1-8
[179] Houghton Transcript, p. 90, lines 15-17
[180] Houghton Transcript, p. 93, lines 17-25

- He agreed we do not know the long-term risks that these vaccines may pose to the billions of people who took them.[181]
- He agreed that we have long-term safety data for many vaccines, but none for vaccines introduced in the last few years.[182]
- ***He agreed that it would be "a reasonable thing to do" to test a patient who is waiting for a [redacted] transplant for natural immunity to Covid-19***.[183]
- When asked to verify again that he had not provided any peer-reviewed research to his conclusion, he stated that he considers the CDC, NIH, Canadian Public Health, UK Public Health, and Israeli Public Health to be very accurate[184] (even though he never cited any data or sources from Canadian Public Health, NIH, UK Public Health or Israeli Public Health in his expert report). He also stated that these sources are "worth a lot more than a publication that's been peer reviewed by two scientists" and stated "you're getting very confused about the quality of peer review of scientific manuscripts".[185]
- When it was pointed out to Dr. Houghton that his conclusion had no source, he stated that "if I were to reference that statement, I would never end. I would still be referencing it today."[186]

[181] Houghton Transcript, p. 94, lines 1-6
[182] Houghton Transcript, p. 94, lines 10-17
[183] Houghton Transcript, p. 97, lines 12-17
[184] Houghton Transcript, p. 98, lines 3-10
[185] Houghton Transcript, p. 98, lines 6-15
[186] Houghton Transcript, p. 98, lines 16-25