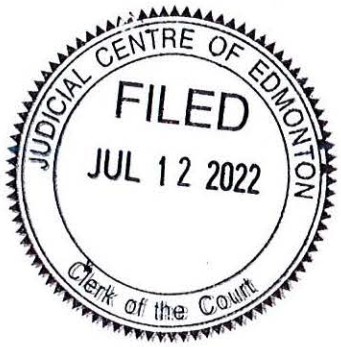

Court of Queen's Bench of Alberta

Citation: Lewis v Alberta Health Services, 2022 ABQB 479

Date:
Docket: 2203 06698
Registry: [redacted]

Between:

Annette Lewis

Applicant

- and -

Alberta Health Services, ABC Hospital, Dr. A, Dr. B, Dr. C, Dr. D, Dr. E and Dr. F

Respondents

Reasons for Decision
of the
Honourable Justice R. Paul Belzil

The Application

[1] On May 24, 2022 Annette Lewis filed an Originating Application against Alberta Health Services, ABC Hospital, and Dr's A-F seeking the following relief:

> Remedy Sought:
>
> 20. A Declaration pursuant to section 52(1) of *Constitution Act, 1982* or section 24(1) of the *Charter* that the Respondents' Requirement to take the experimental Covid-19 injection as a prerequisite to life-savings surgery is a definitive violation of Ms. Lewis' fundamental freedom of conscience protected under section 2(a) of the *Charter* and is therefore void and no force or effect;

21. A Declaration pursuant to section 52(1) of the *Constitution Act, 1982* or section 24(1) of the *Charter* that the Respondents' Requirement to take experimental Covid-19 injections as a prerequisite to life-saving surgery is a definitive violation of Ms. Lewis' right to life, liberty, and security of the person protected under section 7 of the *Charter,* is not in accordance with the principles of fundamental justice, and is therefore void and of no force or effect;

22. A Declaration pursuant to section 52(1) of the *Constitution Act, 1982* or section 24(1) of the *Charter* that the Respondents' Requirement to take the experimental Covid-19 injection as a prerequisite to life-saving surgery is a definitive violation of Ms. Lewis' section 15 *Charter* right to be free from arbitrary discrimination, and is therefore void and of no force or effect;

23. Further, or in the alternative, a declaration that the Respondents' requirement to take the experimental Covid-19 injection as a prerequisite to life-saving surgery infringes on section 1 of the Alberta Bill of Rights, RSA 2000 c A-14;

[2] The Originating Application involves a claim by the applicant that she has Constitutionally protected rights, which are being breached by the respondents relating to her desire to undergo life saving [redacted] transplantation which is subject to a requirement that she take the Covid-19 vaccine prior to surgery, which she objects to.

[3] On the same date, an application was filed for an Interim Order enjoining the respondents from removing the applicant from the [redacted] transplant list pending the hearing of the Originating Application.

[4] A Consent Order was entered into, wherein the applicant remains on the [redacted] transplant list pending the outcome of this Originating Application.

[5] This Originating Application engages a number of issues, including the nature of the legal relationship between the applicant and her Treating Physicians, and whether any of the applicant's Constitutionally protected rights are engaged along with public policy issues.

[6] It is the position of the respondents that no constitutionally protected rights of the applicant are engaged, thus the Originating Application should be dismissed in its entirety.

The Parties

[7] The applicant, Annette Lewis, requires a double [redacted] transplant and is presently on a waitlist for this procedure. The respondent, Alberta Health Services, administers the health care system in the Province of Alberta. The respondent ABC Hospital is the hospital where the surgical procedure would take place.

[8] The respondents Dr's A-F comprise the [redacted] transplant team at the ABC Hospital (Treating Physicians).

Factual Background

[9] The factual background of this Originating Application is very sad. Annette Lewis is dying. In 2018 she was diagnosed with Idiopathic Pulmonary Fibrosis. The disease is terminal, and she has been advised that she will not survive unless she receives a double [redacted] transplant.

[10] In January 2019, she met with the team of doctors and other health professionals who comprise the [redacted] transplant program team (LTPT) at the ABC Hospital.

[11] From August of 2019 to March of 2020, she underwent extensive testing, and it was determined that aside from her [redacted] condition, she is in excellent health and thus qualified for a double [redacted] transplant.

[12] She was placed on the waitlist for a double [redacted] transplant in June of 2020 and was prescribed a series of medications, which she took as directed.

[13] Starting in January of 2020, she was advised that she would have to have a series of vaccinations, including childhood vaccinations, as her vaccination history could not be located and verified. The applicant agreed and received multiple vaccinations.

[14] In March of 2021, she was advised that in order to receive a double [redacted] transplant, she would have to take the Covid-19 vaccine.

[15] To date the applicant has refused to take the Covid-19 vaccine.

[16] With the exception of the Covid-19 vaccination requirement, the applicant has completed all other preconditions for [redacted] transplantation.

[17] At paragraph 36 of her supporting affidavit filed on May 24, 2022, she stated the following:

> Taking this vaccine offends my conscience. I ought to have the choice about what goes into my body, and a lifesaving treatment cannot be denied to me because I chose not to take an experimental treatment for a condition- Covid-19- which I do not have and which I may never have.

[18] She has never asserted that she has a recognized medical exemption from taking the Covid-19 vaccine.

[redacted] Transplant Program

[19] In her affidavit filed on June 1st of 2022, Dr. A. outlined the [redacted] Transplant Program, and the key portions of her affidavit are as follows:

> 3. The LTP provides healthcare to individuals with severe advanced [redacted] disease and aims to help patients live longer and improve their quality of life through [redacted] transplantation. The LTP has performed over 1000 transplants since 1986. Currently, it provides [redacted] transplant services for Alberta, Saskatchewan, Manitoba, eastern British Columbia, Northwest Territories, and parts of Nunavut. The LTP has satellite clinics in Calgary, Saskatoon, and Winnipeg, which assist in pre-transplant assessment and management, and post-transplant longitudinal care, however [redacted] is the surgical center for all LTP transplants and assists with coordinating care for all patients.
>
> 5. The LTP is run through Alberta Health Services **("AHS").** In [redacted], the LTP currently includes five respirologists (the"**LTP Respirologists")** three transplant surgeons (the **"LTP Surgeons")** an allied health team (nurse coordinators, dieticians, social workers, physiotherapists, occupational therapists), and administrative staff. I and the other Respondent physicians, with the

exception of Dr. F, comprise the LTP Respirologists. Medical decisions for the program are made by the LTP Respirologists with input from the LTP Surgeons and allied health as required.

6. Typically, patients are referred to the LTP by their own respirologist. Once referred, one of the LTP Respirologists will meet with the patient to assess their baseline eligibility for transplant from a disease severity standpoint and to review any obvious contraindications. These appointments also provide education on. transplantation and the process. If the patient is considered to be a potential candidate for the LTP, the LTP Respirologist will order a transplant evaluation. The transplant evaluation further explores potential contraindications and barriers to transplantation. One such contraindication is non-adherence to medical advice.

7. Once the transplant evaluation is completed, the initial LTP Respirologist will present the data to a committee (the "**LTP Committee**"), which includes physicians, surgeons, and allied health members from [redacted] and satellite clinics. The LTP Committee will decide whether a patient is accepted to the LTP, whether further assessment is required due to specific circumstances, or whether to reject the potential candidate. Rejection is based on LTP Committee consensus that [redacted] transplantation would unacceptably increase the patient's risk of death without a meaningful chance of improving duration and quality of life.

LTP Waitlist Status

10. The LTP has three waitlist statuses. "**Status 0**" indicates a patient has been accepted for transplantation but is currently inactive on the waitlist. Patients may be Status 0 if their medical condition does not require transplantation but are anticipated to need transplantation in the future. "**Status 1**" indicates that a patient is stable and meets criteria for transplantation and would benefit from transplantation. "**Status 2**"is the highest priority and indicates that the patient is deteriorating and would benefit from transplantation urgently.

11. The waitlist status of patients is dynamic and requires ongoing assessment by the LTP. Simply being a patient on either the Status 1 or Status 2 waitlist consumes a significant amount of LTP resources, including communication with nurse coordinators and potentially other allied health professionals, regular clinic visits, and consultation with other health care providers if hospitalized.

12. Therefore, when patients have contraindications to [redacted] transplantation, they may be moved to Status 0 on the waiting list if the condition is reversible or removed entirely from the waiting list if it is felt to be irreversible. In cases where contraindication is reversible based on the LTP's clinical assessment of the patient, the patient can be relisted to their previous status if their circumstances change and they are clinically assessed as being once again eligible for transplant. The LTP endeavours to ensure that all patients know and understand their status so that they can manage their expectations accordingly.

Donor Organ Allocation and Transplant Process

14. There are misconceptions about numerical prioritization on the waitlist statuses between candidates. If a potential [redacted] donor is found, the LTP does not allocate the [redacted] based on numerical prioritization. Rather, the LTP Respirologist on call in [redacted] will assess the donor's medical status including factors such as: blood type, age, sex, height, weight, clinical status, comorbidities, chest imaging, oxygen status, bronchoscopy, information, serology, and human leukocyte antigens ("**HLA**") status. Donors are screened to assess compatibility and ensure there are not any contraindications for donation such as poor oxygen challenges, or medical conditions such as cancer.

19. [redacted] transplantation is a challenging surgery that requires expertise from various specialities including surgery, anesthesia, intensive care, infectious disease, and respirology. Transplant surgery may require special life support measures including cardiopulmonary bypass or intraoperative nonarterial extracorporeal membrane oxygenation to help circulate blood and provide oxygen while the recipient's [redacted] are being removed and the donor's [redacted] are being connected to the recipient. Surgical complications, including bleeding, infection, stroke, cardiac injury, limb ischemia, graft dysfunction from reperfusion injury, hemodynamic instability, cardiac injury, and other complications are possible.

22. [redacted] transplantation requires balancing the risks of advanced [redacted] disease with the significant risks and likelihoods of post-transplant complications; it is not a cure as transplant recipients still need close follow-up and medical attention for the rest of their lives. Despite patients being on intense medication regimens designed to maximize positive outcomes, post-transplant mortality is still high. One year survival post-transplant in out program is approximately 90%, five year survival is approximately 65-70%, and ten year survival is approximately 50%. The most common causes of death post-transplant are from chronic [redacted] allograft dysfunction (where [redacted] function progressively declines), malignancy, infection, and chronic kidney disease.

[redacted] Transplantation and Rationale for Vaccination

23. Unfortunately, [redacted] donors are a scarce resource and the LTP has a waitlist mortality of approximately 20%, meaning one in five patients waitlisted will die prior to transplant. In order to honour the precious gift from donors and maximize the utility of a scarce treatment resource, the LTP endeavours to select candidates in a manner that provides organs both to those most in need and who have the best probability of short and long-term survival. This approach recognizes the ethical obligations that the LTP has to the donor, donor family, recipient and other candidates who could also benefit from the organ. 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 organ.

24. The LTP requires that candidates be as medically optimized as possible for a successful [redacted] transplantation.

25. If a [redacted] transplantation is successful, post-operatively transplant recipients are places on strong immunosuppressant or anti-rejection medication to prevent their bodies' immune systems from attacking the new donated [redacted] (called rejection); these medications have many significant side effects and associated risks but are necessary to prevent rejection.

26. The post-operative immunocompromised state makes a recipient very susceptible to infection. Infection is a significant cause of post-transplant mortality and morbidity, which is why LTP patients are required to be up to date on their vaccine schedules for Hepatitis B, Diphtheria-Tetanus-Acellular Pertussis (Dtap), Influenza, Pneumococcus, Polio, Measles Mumps Rubella, Varicella (if the candidate did not have chicken pox previously), Hemophilus influenzae type B, Meningococcus, and now also COVID-19 as explained below. This requirement increases the likelihood of robust immunity against these diseases before being exposed to immune suppression, which greatly diminishes the ability to form immune response to vaccines. The LTP educates patients in regard to vaccination and the clinical importance of being vaccinated against these diseases, which is a pre-condition of transplantation barring a valid medical exemption to vaccination supported by expert consultation.

27. COVID-19 has been a significant challenge for the LTP. COVID-19 infections have been a major cause of morbidity and mortality in the LTP. The LTP has continually discussed COVID-19 internally as studies, vaccination approvals, and information have become available.

30. As physicians, the LTP Respirologists' endeavour to practice evidence-based medicine, which involves exercising clinical judgment informed by the best available data.

31. Once the COVID-19 vaccines became available, the LTP Respirologists determined that it was in the best interests of pre-transplant candidates from a clinical perspective to be vaccinated in order to minimize both the risk of adverse outcomes post-transplant and the risk associated with contracting COVID-19 while waiting to be transplanted given their severe [redacted] diseases. In addition to promoting COVID-19 vaccination, we also discussed the importance of masking, hand hygiene, distancing, and maintaining a small cohort or "bubble" of trusted individuals that were following the restrictions as per Alberta Health.

32. In the fourth wave of the COVID-19 pandemic between September and November 2021, the LTP experienced a mortality rate in [redacted] transplant recipients infected with COVID-19 of nearly 40%. Unfortunately, the transplant recipients that died did not have an opportunity for pre-transplant COVID-19 vaccinations; most were vaccinated against COVID-19 but received the vaccine after their [redacted] transplantation surgery.

33. The Canadian Society of Transplantation- [redacted] Section, which consists of [redacted] transplant professionals and experts from Canada, released a consensus statement on November 3, 2021 ("**National Consensus Statement**"), wherein it notes that transplant recipients have significantly less immunologic response to

COVID-19 vaccinations and therefore less protection when vaccinated post-transplant...

34. The National Consensus Statement (Exhibit "A") states that the mortality for [redacted] transplant recipients infected with COVID-19 is between 25-30%. Accordingly, the National Consensus Statement proposes that:

a) All patients listed for [redacted] transplantation in Canada are required to be fully vaccinated against SARS-CoV2. This includes:

   i. All patients currently listed; and

   ii. All prospective patients undergoing evaluation.

b) Patients actively listed or patients who are ready for activation who refuse vaccination against SARS-CoV2 will be made inactive on the waitlist and followed clinically by the program until they are ready to move forward with vaccination. Ongoing education and support regarding the rationale for vaccination will be provided to the patient and family

c) Critically ill patients- either due to COVID-19 or otherwise- are required to be fully vaccinated or willing to receive at least the 1st dose of vaccination against SARS-CoV2 prior to being considered for [redacted] transplant. In circumstances where a critically ill patient cannot engage in consent, their substitute decision maker may consent on their behalf.

35. To the best of my knowledge, all other Canadian [redacted] transplant programs have now adopted and are adhering to the proposal in the National Consensus Statement.

39. The LTP has determined that being unvaccinated for COVID-19, in the absence of valid medical exemption supported by expert consultation, is a contraindication to [redacted] transplantation based on the following factors:

a) The significant morbidity and mortality risk that COVID-19 presents to unvaccinated and highly immunosuppressed [redacted] transplant recipients;

b) The LTP's responsibility to donors and donor families to use donated [redacted] in a manner that provides the best possible outcomes for the graft;

c) The risk that an unvaccinated transplant recipient would pose to other [redacted] transplant recipients during routine post-operative care (e.g. in clinic and in physiotherapy);

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

e) The demonstrated safety, both in initial studies and now surveillance data, of the currently approved and available COVID-19 vaccines, which present negligible risk to [redacted] transplant candidates;

f) The attenuated/ineffective response and resultant protection if the vaccine is administered after transplant; and

g) The now published and demonstrated benefit of COVID-19 vaccination before transplant vs. and transplant.

The Bodily Integrity of the Applicant and Her Concerns About the Safety and Efficacy of Covid-19 Vaccines

[20] It is beyond dispute that the applicant is the sole arbiter of what goes into her body.

[21] I accept without hesitation that her concerns about the safety and efficacy of Covid-19 vaccines are genuine and deeply rooted. Unquestionably, she is entitled to her beliefs.

[22] I do not accept however, that her beliefs and desire to protect her bodily integrity entitle her to impact the rights of other patients or the integrity of the LTP generally.

[23] I also do not accept that the sincerity and depth of her beliefs create legal rights which otherwise do not exist.

[24] On behalf of the applicant, it is argued that establishing transplantation preconditions amounts to medical coercion.

[25] I do not agree. No one has a right to receive [redacted] transplants, and no one is forced to undergo transplantation surgery.

[26] The applicant will make the final decision to proceed or not with [redacted] transplantation.

[27] It is illogical for the applicant to freely accept all other preconditions to transplantation and object to one on the basis of alleged medical coercion.

Conflicting Expert Evidence

[28] The parties filed a large volume of expert evidence on the subjects of the safety and efficacy of Covid-19 vaccines and whether the standard of care in [redacted] transplant surgery includes a requirement that potential [redacted] transplant recipients get vaccinated against Covid-19 prior to transplantation surgery.

[29] On behalf of the applicants, Dr. Mallard and Dr. Bridle prepared extensive reports raising concerns of the safety and the efficacy of Covid-19 vaccines. They are experts in Immunology but are not medical doctors and have no expertise in the field of [redacted] transplant surgery.

[30] Dr. Turner, called on behalf of the applicant is a general surgeon, with no expertise or experience with [redacted] transplantation. He opined that it would be medically unethical to require the applicant to have the Covid-19 vaccine as a pre-condition for receiving [redacted] transplantation.

[31] The respondents filed three expert reports in response.

[32] Dr. Olivia Kates is an attending physician of transplant and oncology infection diseases at Johns Hopkins University in Maryland, which is a hospital with a large transplant centre. She opined that the Covid-19 vaccines are safe and efficacious. She noted that while it is not a requirement in United States that transplant patients receive the Covid-19 vaccine prior to surgery, it is strongly recommended.

[33] Sir Michael Houghton is a Nobel Prize winning virologist, vaccinologist and is a professor at the University of Alberta Faculty of Medicine and Dentistry. He also opined that the Covid-19 vaccine are safe and efficacious.

[34] Doctor Marcelo Cypel is the Surgical Director of the Ajmera Transplant Centre in Toronto, which is the largest transplant facility in North America.

[35] He fully supports the requirement of Covid-19 vaccine vaccination as a precondition to [redacted] transplantation which requirement is enforced at the Ajmera Transplant Centre.

[36] He noted that this position aligns with the Canadian Society of Transplantation and most international transplant centres. All Canadian Transplant Centres have implemented this requirement since the onset of the Covid-19 pandemic.

[37] In the result, there is considerable conflict between these experts.

[38] While there is overwhelming evidence that the Covid-19 vaccines are safe and efficacious, this conclusion is not universally accepted.

[39] Not surprisingly, counsel for the applicant urge me to prefer the experts who support the applicant's position, while counsel for the respondents urge me to prefer their experts.

[40] I do not accept that either approach is correct, because I do not accept that the outcome of this Originating Application turns on the safety or efficacy of the Covid-19 vaccines or whether ethically a requirement can be imposed that a Covid-19 vaccination be required prior to [redacted] transplantation.

[41] The correct characterization of the imposition of a requirement of Covid-19 vaccination prior to [redacted] transplantation is properly viewed as the exercise of clinical judgment by the Treating Physicians in establishing a standard of care.

[42] In my view it is not necessary for the Treating Physicians to reconcile these differences in expert opinions rather, they must be free to decide which expert opinions they accept in exercising their clinical judgment, which informs the standard of care.

[43] In the result, I decline to decide which expert opinions should be preferred.

Defining the Legal Relationship Between Treating Physicians and the Applicant

[44] In ***Rasouli (Litigation Guardian of) v. Sunnybrook Health Sciences Centre***, 2011 ONSC 1500, the following passages are found at paragraphs 88 and 89:

> However, as noted by Ellen I. Picard and Gerald B. Robertson in their text Legal Liability of Doctors and Hospitals in Canada:
>
> In the great majority of cases, patients engage and pay their doctor (usually through medicare plans) and have the power to dismiss them. The hospital does not employ the physicians nor are they carrying out any of the hospital's duties to the patient. They are granted the privilege of using personnel, facilities and equipment provided by the hospitals but this alone does not make them employees. They are independent contractors who are directly liable to their patients, and the hospital is not vicariously liable for their negligence.

> Doctors owe a duty of care to their patients that begins upon the formation of the doctor-patient relationship. When this duty is breached, it is the individual doctors who are liable in negligence, not the hospital.

[45] In the result, the Treating Physicians are independent contractors who owe the applicant a duty of care.

Is the Relationship Between the Applicant and Her Treating Physicians Governed by the Alberta Bill of Rights?

[46] Since the advent of the *Charter*, Courts have looked to the *Charter* to determine if constitutionally protected rights are affected as the *Charter* can be interpreted more generously than Provincial *Bills of Rights*. There is no need to consider the claim under the *Alberta Bill of Rights* because if the *Charter* claims fail, her claim under the *Alberta Bill of Rights* will necessarily fail as well.

Is the Relationship Between the Applicant and Her Treating Physicians Governed by the *Charter?*

[47] It is admitted that AHS is subject to *Charter* scrutiny.

[48] In the Brief of Law filed on behalf of the applicant, it is conceded that the Treating Physicians are independent contractors, but it is argued that they too are subject to *Charter* scrutiny.

[49] As noted, the respondents argue that none of the applicant's Constitutionally protected rights are engaged in this application.

[50] At paragraphs 114 and 115 of the applicant's brief, the following passages are found:

> 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 service 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.
>
> 115. In delivering medical services to the public pursuant to the 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.

[51] In support of this position, the applicant cites the Alberta Court of Appeal decision of ***UAlberta Pro-Life v Governors of the University of Alberta***, 2020 ABCA 1 at paragraph 128:

> Governmental action as part of a "public function" may be sufficient to bring that activity within the purview of government and attract *Charter* scrutiny: Greater Vancouver Transportation Authority at paras 15-16:

> 15 In Eldridge v. British Columbia (Attorney General), 1997 CanLII 327 (SCC), [1997] 3 S.C.R. 624, La Forest J. reviewed the position the Court had taken in McKinney v. University of Guelph, 1990 CanLII 60 (SCC), [1990] 3 S.C.R. 229 (university), Harrison v. University of British Columbia, 1990 CanLII 61 (SCC), [1990] 3 S.C.R. 451 (university), Stoffman v. Vancouver General Hospital, 1990 CanLII 62 (SCC), [1990] 3 S.C.R. 483 (hospital), Douglas/Kwantlen Faculty Assn. v. Douglas College, 1990 CanLII 63 (SCC), [1990] 3 S.C.R. 570 (college), and Lavigne v. Ontario Public Service Employees Union, 1991 CanLII 68 (SCC), [1991] 2 S.C.R. 211 (college), on the issue of the status of various entities as "government". Writing for a unanimous Court, he summarized the applicable principles as follows (at para. 44):
>
> ... the *Charter* may be found to apply to an entity on one of two bases. First, it may be determined that the entity is itself "government" for the purposes of s. 32. This involves an inquiry into whether the entity whose actions have given rise to the alleged *Charter* breach can, either by its very nature or in virtue of the degree of governmental control exercised over it, properly be characterized as "government" within the meaning of s. 32(1). In such cases, all of the activities of the entity will be subject to the *Charter*, regardless of whether the activity in which it is engaged could, if performed by a [page310] non-governmental actor, correctly be described as "private". Second, 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.
>
> 16 Thus, there are two ways to determine whether the *Charter* applies to an entity's activities: by enquiring into the nature of the entity or by enquiring into the nature of its activities. If the entity is found to be "government", either because of its very nature or because the government exercises substantial control over it, all its activities will be subject to the *Charter*. If an entity is not itself a government entity but nevertheless performs governmental activities, only those activities which can be said to be governmental in nature will be subject to the *Charter*.

[52] The fact that the Treating Physicians, who are independent contractors, work in publicly funded hospitals under the rubric of Provincial and Federal healthcare legislation, does not mean that they are state actors subject to the *Charter*.

[53] In ***McKitty v Hayani***, 2019 ONCA 805, the Ontario Court of Appeal rejected this argument, and the following passage appears at paragraph 48:

> Dr. Hayani is the only respondent in this application. As he is a private party and not a government actor, the *Charter* does not apply to him and cannot impose any duties on him unless, and only to the extent that, he is performing some specific government

> function or acting as a government agent: R. v. Buhay, 2003 SCC 30, [2003] 1 S.C.R. 631, at para. 25. It is not sufficient that he be carrying out some purpose that is regulated and for the public good: Eldridge v. British Columbia (Attorney General), 1997 CanLII 327 (SCC), [1997] 3 S.C.R. 624, at para. 43, McKinney v. University of Guelph, 1990 CanLII 60 (SCC), [1990] 3 S.C.R. 229, at p. 269. The appellant has not established that the respondent was performing a governmental function or acting as a government agent. The respondent does not, therefore, owe any duties to the appellant under the *Charter*, and the application judge made no error in this regard.

[54] See also ***Rasouli*** at paragraph 93:

> [93] Applying the relevant jurisprudence to the circumstances of the case before me, I am not persuaded that the *Charter of Rights* applies to the proposed decision of the physicians to withdraw treatment...

[55] I accept that medical doctors are not automatically exempt from *Charter* scrutiny by virtue of the fact that they are physicians treating patients.

[56] In ***R v Dersch*** [1993] SCR 768, it was held at para 20, that a doctor who illegally took a blood sample at the request of the police was acting as an agent of government subjecting the action of the doctor in taking the blood sample to *Charter* scrutiny.

[57] However, at para 18, the Court observed that the actions of emergency room physicians in providing emergency treatment to the accused did not render the physicians agents of government for the purposes of the *Charter.*

[58] Thus, they became agents of government for the limited purpose of illegally taking a blood sample and otherwise were not agents of government and not subject to *Charter* scrutiny.

[59] The analysis in ***Dersch*** reinforces the need to carefully consider the nature of the impugned actions of the Treating Physicians.

[60] In the context of this Originating Application, the nature of the impugned action is the exercise of clinical judgment in formulating preconditions for [redacted] transplantation.

[61] There is no evidence that at any time the Treating Physicians became agents of government in establishing preconditions for transplantation or that any governmental body was in any way involved in this process.

[62] There is no evidence that the preconditions for [redacted] transplantation were initiated by any governmental body, rather they were initiated by the Treating Physicians only and no evidence that any governmental body purported to mandate or control the conditions for [redacted] transplantation

[63] The LTP is not a part of government policy, rather it is a treatment program created by Treating Physicians, who are subject to a duty of care.

[64] There is no requirement that the Treating Physicians report their conditions to any governmental authority or seek the approval of any governmental authority prior to implementing them.

[65] AHS is in the process of preparing general policies pertaining to Covid-19 vaccination requirements.

[66] The proposed AHS policy, which has not been completed, mirrors the recommendations of the Treating Physicians who are exercising clinical judgment. There is no evidence that AHS is purporting to add any conditions not approved by the Treating Physicians.

[67] In ***Selkirk et. al. v. Trillium Gift of Life Network et. al.***, 2021 ONSC 2355, the court considered the issue of criteria for liver transplants; specifically, that potential recipients abstain from alcohol for a 6 month period before they could be considered for a transplant.

[68] At paragraph 198 the following passage appears:

> In contrast, the Living Donor Criteria is a policy shaped by medical criteria, as decisions about whether to proceed with a living donation turn on the medical risks and likely outcomes to both the patient and the donor. Patients and donors who are assessed for participation in the living donor program are the subject of clinical decision-making by the transplant team. The Living Donor Criteria is a guide for the transplant team on how to clinically assess patients. It is not a government function subject to the *Charter*.

[69] In order for the medical system to function properly, Treating Physicians who are providing clinical advice, must be free to do so and are not governed by the *Charter* but rather by the standard of care which is owed to every patient.

[70] The exercise of clinical judgment by the Treating Physicians is owed substantial deference.

[71] It is noteworthy that the applicant is not disputing that the Treating Physicians must establish preconditions for [redacted] transplantation, indeed she complied with all of the preconditions, with the exception of the requirement to take the Covid-19 vaccine.

[72] No case authority has been cited wherein it was decided that any patient has the right to set preconditions for any medical procedure let alone complex organ transplant surgery requiring significant post operative care.

[73] As noted by Dr. A, there are significant post operative issues associated with [redacted] transplantation, particularly relating to the high risk of infection affecting patients who are immunocompromised.

[74] It is beyond dispute that [redacted] transplantation surgery is complex, involving significant post operative care. Surgical preconditions are established in this context, which highlights the importance of considering them in their entirety and not individually in isolation from other preconditions.

[75] Moreover, deference to clinical judgment must include the decision to modify preconditions for transplantation as circumstances change.

[76] One such circumstance was the onset of the Covid-19 pandemic which poses a risk to potential organ recipients as outlined in the affidavit of Dr.A.

[77] In ***Sweiss v Alberta Health Services***, 2009 ABQB 691 at paragraph 60, the perils of the court attempting to interfere with the exercise of the clinical judgment were described:

> The overriding theme which pervades the reasons of the English Court of Appeal in Re J. relates to its concern over the Court ordering a medical professional to

> treat his or her patient in a fashion which is contrary to clinical judgment. The Court in Re J. expressed its rationale as follows at 519:
>
> ...The Court is not, or certainly should not be, in the habit of making orders unless it is prepared to enforce them. If the Court ordered a doctor to treat a child in a manner contrary to his or her clinical judgment, it would place a conscientious doctor in an impossible position. To perform the Court's order it could require the doctor to act in a manner which he or she generally believed not to be in the patient's best interests; to fail to treat the child as ordered would amount to a contempt of court. Any judge would be most reluctant to punish the doctor for such a contempt, which seems to me to be a very strong indication that such an order should not be made.

Public Policy Implications

[78] If the plaintiff were successful in this Originating Application, there would be significant adverse public policy implications.

[79] The proposition that Treating Physicians exercising clinical judgment would be subject to the *Charter* would result in medical chaos with patients seeking endless judicial review of clinical treatment decisions.

[80] If the applicant's position is correct, what would prevent other patients from raising their own objections to other parts of the preconditions?

[81] The standard of care for [redacted] transplants must be the same for all potential recipients, all of whom are subject to the same surgical preconditions. I do not accept that the applicant, or any other potential recipient, has the right to demand that the LTP be modified at their request.

[82] The LTP is designed to maximize the success of [redacted] transplants, one of the effects of which will be to increase the number of families wanting to donate the organs of a deceased loved one.

[83] As pointed out in Dr. A's Affidavit, there is a scarcity of donor organs which must be allocated carefully in accordance with the protocols established by the Treating Physicians.

[84] If the plaintiff is successful in the Originating Application, the result would be to create two classes of organ recipients; one for the applicant and another for all other recipients who voluntarily complied with all of the surgical preconditions.

[85] This would result in unfairness to the other recipients and disrupt the LTP.

[86] As noted in the affidavit of Dr. A, the preconditions established by the Treating Physicians are intended to allow the LTPT to make the difficult decision respecting who will receive the transplantation and who will not.

[87] Maintaining the integrity of the LTP is very much in the public interest and strongly militates against the position of the applicant.

[88] No one is obligated to comply with the terms of the LTP and given the scarcity of donor organs and the need to maintain the integrity of the program, policies need to be established and adhered to.

Conclusion

[89] In the result, I conclude that the *Charter* has no application to clinical treatment decisions made by the Treating Physicians, and in particular has no application to the Treating Physicians establishing preconditions for [redacted] transplantation. The Originating Application is dismissed in its entirety.

Heard on the 29th and 30th day of June, 2022.
Dated at the City of [redacted], Alberta this 12th day of July, 2022.

R. Paul Belzil
J.C.Q.B.A.

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