In the Court of Appeal of Alberta

Citation: Lewis v Alberta Health Services, 2022 ABCA 359

Date: 20221108
Docket: 2203-0163AC
Registry: Edmonton

Between:

Annette Lewis

Appellant

- and -

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

Respondents

Restriction on Publication

Identification Ban – By Court Order, information that could identify the Respondent Physicians, including their medical specialization, the specific organ at issue, and the location of the transplant program, must not be published, broadcast, or transmitted in any way.

NOTE: Identifying information has been removed from this judgment to comply with the ban so that it may be published.

The Court:

The Honourable Justice Frederica Schutz
The Honourable Justice Michelle Crighton
The Honourable Justice Dawn Pentelechuk

Memorandum of Judgment

Appeal from the Decision by
The Honourable Justice R.P. Belzil
Dated the 12th day of July, 2022
(2022 ABQB 479, Docket: 2203 06698)

Memorandum of Judgment

The Court:

I. Introduction

[1] The appellant, Annette Lewis, suffers from an idiopathic condition which is progressive and debilitating; she now requires an [organ] transplant. While it is not guaranteed that receiving an [organ] transplant will extend Ms Lewis' life, it is a virtual certainty that she will not survive without one.

[2] Ms Lewis is a patient in the [organ] transplant program (the Program) at the respondent ABC Hospital. To date, Ms Lewis has been unable to obtain an [organ] transplant. This is the result of numerous factors, including one which is the subject of the present appeal: Ms Lewis refuses to be vaccinated against COVID-19. Subject to a demonstrated medical exemption, the Program has made it mandatory that patients receive a vaccine against COVID-19 prior to transplantation, with the result that Ms Lewis is currently inactive (or "Status 0") on the Program waitlist.

[3] In an effort to remain active on the transplant waitlist without having to be vaccinated against COVID-19, Ms Lewis sought, among other things, a declaration that the COVID-19 vaccine requirement is of no force or effect because it violates her *Charter* rights – specifically, freedom of conscience under s 2(a), the right to life, liberty and security of the person under s 7, and the right to equality under s 15. The chambers judge dismissed her application on the basis that the COVID-19 vaccine requirement did not engage the *Charter*: ***Lewis v Alberta Health Services***, 2022 ABQB 479 (Decision).

[4] Ms Lewis appeals, arguing the chambers judge made a number of errors in disposing of her application. She seeks from this Court the same *Charter* declaration sought below.

II. Background

[5] The Program's process of referral, acceptance and ongoing eligibility screening was described by Dr A, one of the Program's physicians. She is one of six physician respondents who, apart from Dr F, collectively comprise the specialists working in the Program. These specialists make the medical decisions for the Program.

[6] The process is complex. Usually, patients are referred to the Program by their own specialist. Once referred, one of the Program specialists will meet with the patient to assess their baseline eligibility for transplant from the standpoint of their disease severity, and to review any obvious contraindications. These appointments include patient education on transplantation and the processes involved. If the patient is clinically assessed as being a potential candidate for the Program, the Program specialist will order a transplant evaluation. The transplant evaluation then

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 Program specialist will present the data to a committee which includes physicians, surgeons, and allied health professionals from both the Program's surgical centre and its satellite clinics. The committee will decide whether a patient is accepted into the Program, whether further assessment is required due to specific circumstances, or whether to reject the potential candidate. Rejection is based on the committee's consensus that [organ] transplantation would unacceptably increase the patient's risk of death without a meaningful chance of improving duration and quality of life.

[8] If the patient is accepted into the Program, they are invited to a rehabilitation and education program. During this pre-transplant rehabilitation, patients are provided physiotherapy to improve strength and endurance, and are educated about transplantation. Pre-transplant rehabilitation typically accommodates five to six patients for four weeks; however, the COVID-19 pandemic created disruptions, limiting appointments to only three to four patients, shortening the duration, and requiring some patients to attend appointments virtually.

[9] During pre-transplant rehabilitation, patients are listed on the transplant waitlist if clinically appropriate, meaning they join a list of patients actively waiting for a deceased donor's [organ] to become available which is a clinically suitable match. The Program 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 they are anticipated to need a transplant in the future. "Status 1" indicates a patient is stable, meets the criteria for transplantation and would benefit from it. "Status 2" is the highest priority and indicates the patient is deteriorating and would most benefit from transplantation.

[10] Following pre-transplant rehabilitation, patients attend ongoing appointments with the Program specialists to update their clinical status, reassess transplant eligibility, and ensure optimal medical management. Typically, the appointments are every three months; however, that period may vary depending on the specific needs of the patient.

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

[12] Therefore, when patients have contraindications to [organ] transplantation, they may be moved to "Status 0" if their condition is assessed to be medically reversible or removed entirely from the waitlist if their clinical condition is determined to be irreversible. In cases where the contraindication is reversible based on the Program's clinical assessment of the patient, the patient can be returned to their previous status if their circumstances change and they continue to be

clinically eligible for transplantation. The Program endeavours to equip patients with knowledge and understanding of their status to help manage their expectations.

[13] However, simply being "Status 2" is no guarantee that a patient will receive an [organ] transplant, [organ]s not being allocated solely based on numerical prioritization. Instead, compatibility between a donor and potential recipient is assessed using a number of metrics.

[14] Ms Lewis was initially assessed on January 9, 2020. She was accepted into the Program after review by the Program committee on May 4, 2020 and placed on the transplant waitlist as "Status 1" on May 20, 2020. Her status was changed to "Status 2" on October 5, 2020. However, Dr A notes that Ms Lewis has several physical and medical conditions which have made finding an appropriate donor for her more difficult. Ms Lewis remained on the "Status 2" waitlist without finding a suitable donor until November 2021, when she was moved to "Status 0" because of her decision not to get a COVID-19 vaccine.[1]

[15] Ms Lewis was told by Program specialists beginning in March 2021 that she would have to take the COVID-19 vaccine to receive an [organ] transplant. The Program specialists determined that being unvaccinated against COVID-19, in the absence of a valid medical exemption supported by expert consultation, is a contraindication to [organ] transplantation based on the following factors:

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

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

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

(d) the scarcity of [organ] 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 [organ] transplant candidates;

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[1] Ms Lewis was allowed to remain on the "Status 2" waitlist as a result of a Consent Order dated December 6, 2021, pending the determination of her special chambers application, which occurred on July 12, 2022. Since that time, Ms Lewis has been "Status 0" on the waitlist.

(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. after transplant.

[16] Dr A deposed that Program patients are required to be fully vaccinated against a host of diseases and conditions. This has come to include COVID-19, a policy of the Program which was decided internally by the respondent specialists and in discussion with national colleagues in other transplant programs.

[17] The COVID-19 vaccine requirement is in keeping with a November 2021 National consensus statement on "COVID vaccination in [organ] transplant candidates" (the Consensus Statement) from the Canadian Society of Transplantation, [Organ] Section, comprised of professionals and medical transplantation experts from across Canada. The Consensus Statement concludes: "[i]mmunocompromised solid organ transplant (SOT) recipients have significantly less immunologic response to COVID-19 vaccinations and therefore less protection when given post-transplant", further noting that there is "a 25-30% mortality rate in patients who are infected with COVID-19 post-[organ] transplantation". Based on this understanding of the clinical risks, the Consensus Statement provides:

> 1. All patients listed for [organ] transplantation in Canada are required to be fully vaccinated against SARS-CoV2 [the virus which causes COVID-19]. This includes:
>
> a. All patients currently listed
> b. All prospective patients undergoing evaluation
>
> 2. 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.
>
> 3. 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 [organ] transplant. In circumstances where a critically ill patient cannot engage in consent, their substitute decision maker may consent on their behalf.

According to Dr A, all other Canadian [organ] transplant programs have now adopted and are adhering to the Consensus Statement.

[18] Ms Lewis consented to and obtained all required vaccines except COVID-19. The Program made efforts to inform Ms Lewis regarding COVID-19 vaccination and [organ] transplantation, but on November 18, 2021, Ms Lewis emailed the Program advising she would not be obtaining the COVID-19 vaccine.

[19] Since Ms Lewis does not assert a medical exemption for refusing the vaccine, the Program specialists consider her refusal to follow their medical advice a contraindication for [organ] transplantation and moved her to "Status 0". As of the date of this appeal, Ms Lewis remains unvaccinated against COVID-19 and "Status 0" on the transplant waitlist. We understand Ms Lewis could be reinstated to "Status 2" when she receives a COVID-19 vaccine, assuming she is otherwise clinically assessed as eligible for transplant.

III. Analysis

[20] No one impugns Ms Lewis' right to refuse to be vaccinated against COVID-19. As a competent adult person, she is entitled to decide what to put into her body. Rather, the question this Court must answer is whether one discrete requirement – namely, that Ms Lewis obtain a COVID-19 vaccination – attracts *Charter* scrutiny.

[21] The analysis of this issue begins with a pivotal consideration of the nature of the COVID-19 vaccine requirement, as this informs whether the *Charter* applies.

The Nature of the COVID-19 Vaccine Requirement

[22] As the Supreme Court of Canada noted in ***Eldridge v British Columbia (Attorney General)***, [1997] 3 SCR 624 at paras 36-44, 151 DLR (4th) 577, it is only "government" action that engages the *Charter*, where (assuming legislation is not at issue) the party in question is either an apparatus of government or because the party is engaging in a governmental function or activity.

[23] Ms Lewis concedes the question is not the nature of the entity performing the impugned act that determines *Charter* applicability in this case; rather, it is the nature of the activity. In other words, are the respondent physicians engaging in a governmental function or activity in formulating pre-conditions for [organ] transplant? The short answer is no; the chambers judge did not err in so finding.

[24] The chambers judge determined the nature of the COVID-19 vaccine requirement was "the exercise of clinical judgment in formulating preconditions for [organ] transplantation": Decision at para 60. We agree. The respondents, in exercising their clinical judgment in formulating pre-conditions for [organ] transplantation, were not implementing a specific governmental policy or program.

The Findings of the Chambers Judge

[25] It is important to set out the facts found by the chambers judge, as follows:

> [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 [organ] 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 [organ] transplantation[.]
>
> [63] The [Program] 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.

[26] Even in *Charter* cases fact findings are entitled to deference. We are not persuaded the chambers judge made any palpable and overriding errors in his findings of fact.

[27] Ms Lewis argues that the COVID-19 vaccine requirement reflects government action through development and implementation of a policy "from the top down". She contends the COVID-19 vaccine requirement is now reflected in a policy of the respondent Alberta Health Services (AHS), which was in development during her application below and completed prior to the oral hearing before the chambers judge. Even accepting the policy has been completed, which the respondents dispute, we conclude this factual conflict between the parties has no material bearing on the outcome of this appeal.

[28] AHS concedes it is subject to the *Charter*. While AHS has and will make a variety of policy choices in relation to COVID-19, that does not prove that AHS unilaterally sets pre and post-transplant eligibility criteria. The contention that AHS formulates medical criteria which then irrevocably and arbitrarily binds physicians as government agents or actors is unsupported on the record before us. Accordingly, even if the policy was implemented by AHS or ABC Hospital, the clinical decision to support that policy does not equate to governmental action: ***McKitty v Hayani***, 2018 ONSC 4015 at para 217, aff'd in 2019 ONCA 805, 439 DLR (4th) 504 [***McKitty***]; ***Selkirk v Trillium Gift of Life Network***, 2021 ONSC 2355 at paras 6, 195-200, aff'd in 2022 ONCA 478 on other grounds, leave to appeal to SCC requested, 40364 (27 September 2022).

[29] It follows that a PowerPoint presentation for patients prepared by AHS which is relied on by Ms Lewis to suggest that AHS controls all aspects of the Program has no probative value to the core issue.

[30] It is not sufficient to establish that physicians are acting within a legislated, publicly-funded framework. Were that determinative, it would follow that all decisions made by physicians would be subject to *Charter* scrutiny, a proposition which is contrary to existing jurisprudence, where courts have explicitly held that physicians acting in the regular course of providing medical care are not government agents: see ***R v Dersch***, [1993] 3 SCR 768 at 777, 85 CCC (3d) 1; ***McKitty*** at para 48; ***Rasouli (Litigation Guardian of) v Sunnybrook Health Sciences Centre***, 2011 ONSC 1500 at paras 84-93, 105 OR (3d) 761, aff'd in ***Cuthbertson v Rasouli***, 2013 SCC 53 on other grounds.

[31] It is not sufficient to assert that because some clinical decisions apply to all transplant patients, including the COVID-19 vaccine requirement, or because medical best practices have been codified more broadly in literature emanating from a government entity, the inexorable conclusion is that the respondent physicians are acting as government agents. Simply put, when it comes to decisions about scarce cadaveric donor material, medical judgments regarding allocation must routinely be made.

[32] We conclude that setting [organ] pre-transplantation criteria is the result of myriad clinical and medical factors, including the collective judgment of numerous specialized medical and other personnel acting in concert to determine the standard of care for all patients on the [organ] transplant waitlist, including Ms Lewis. In our view, the respondent physicians' decisions made in respect of Ms Lewis are quintessentially clinical, made to maximize the best use of a scarce resource and the best possible outcome for Ms Lewis, with the greatest chance of a life free from life-threatening complications, through science-based and medical consensus-based management of all possible identifiable risks.

[33] The record amply supports the conclusion the Program referral, intake, and allocation processes are informed solely by clinically and medically appropriate information and optimal standard of care; nothing the Program team decided ceded their medical opinions about the best interests of Ms Lewis to government policy, government mandates, or otherwise. This included their clinical and medical decision that a pre-transplant COVID-19 vaccine is required.

The Declaratory Relief Sought by Ms Lewis

[34] As noted, Ms Lewis sought a declaration that the requirement to obtain a COVID-19 vaccination pre-transplant breached her rights under ss 2(a), 7 and 15 of the *Charter*.

[35] The chambers judge made no determination regarding Ms Lewis' *Charter* rights, having found the *Charter* had no application to the COVID-19 vaccine requirement. Whether Ms Lewis' *Charter* rights have been breached is not one of her formal grounds of appeal and her factum did not address why, in her view, the respondents have infringed her *Charter* rights. Since the

requested relief cannot be granted without determining this issue, we permitted all parties to file supplemental factums in advance of the oral hearing on October 20, 2022.

[36] Having found, like the chambers judge, that the *Charter* has no application to the COVID-19 vaccine requirement, we need not go further. Nevertheless, for the sake of completeness, we provide our opinion as to whether Ms Lewis' *Charter* rights have been breached, assuming, for the sake of argument, that the *Charter* applies.

Section 2(a) of the *Charter*

[37] Section 2(a) provides that everyone has the fundamental "freedom of conscience and religion".

[38] Ms Lewis challenges the COVID-19 vaccine requirement on the basis it offends her conscience – not due to any religious belief but rather, as she puts it, because "[b]eing threatened, under duress, to take an experimental medical treatment or face the loss of one's life is a complete affront to my conscience and my belief in free will". She submits that her strong belief in bodily autonomy is entitled to *Charter* protection.

[39] A similar argument was recently rejected in ***Costa, Love, Badowich and Mandekic v Seneca College of***, 2022 ONSC 5111 [***Seneca College***] at paras 56-63. In that case, students brought a *Charter* challenge of their college's policy requiring full COVID-19 vaccination to attend class in-person. No violation of s 2(a) was found notwithstanding the students' purported conscientious objection to obeying the COVID-19 policy and concern about being coerced to surrender their bodily autonomy and security. The court concluded the claim was not grounded in morality but concerns over vaccine safety. The same can be said of Ms Lewis, who argued the COVID-19 vaccine is experimental and no long-term safety data exists.

[40] The protection of "conscience" in s 2(a) of the *Charter* would appear to capture certain non-religious moral beliefs. As noted in ***Christian Medical and Dental Society of Canada v College of Physicians and Surgeons of Ontario***, 2019 ONCA 393 at para 82, "[t]he scope of freedom of conscience may be broader than freedom of religion, extending to the protection of strongly held moral and ethical beliefs that are not necessarily founded in religion". However, a conscientious *belief* in bodily autonomy adds nothing to the *right* to bodily autonomy Ms Lewis already enjoys under s 7 of the *Charter*. Thus, concerns about coercion are better addressed there.

Section 7 of the *Charter*

[41] Section 7 of the *Charter* provides that "[e]veryone 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". A claimant must "first show that the law interferes with their life, liberty or security of the person" such that s 7 is engaged; and second, "that the deprivation in question is inconsistent with the principles of fundamental justice": ***R v Ndhlovu***, 2022 SCC 38 [***Ndhlovu***] at

para 49; see similarly ***R v CP***, 2021 SCC 19 [***CP***] at para 125; ***Carter v Canada (Attorney General)***, 2015 SCC 5 [***Carter***] at para 55.

[42] Ms Lewis argues the COVID-19 vaccine requirement violates all three of the rights protected by s 7: life, liberty, and security of the person. We disagree. As will be explained, none of these rights are engaged by the pre-transplant COVID-19 vaccine requirement. Accordingly, as noted in ***Blencoe v British Columbia (Human Rights Commission)***, 2000 SCC 44 [***Blencoe***] at para 47, "if no interest in the … life, liberty or security of the person is implicated, the s. 7 analysis stops there".

The Right to Life

[43] The Program's requirement that patients be vaccinated against COVID-19 pre-transplantation to receive an [organ] transplant is characterized by Ms Lewis as a "death sentence": failure to comply with the COVID-19 vaccine requirement means she will die, no longer able to access life-saving treatment. Ms Lewis argues that the COVID-19 vaccine requirement violates the right to life by removing such health care from those who otherwise are entitled to receive it.

[44] The Supreme Court of Canada has described the right to life under s 7 of the *Charter* as being engaged "where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly": ***Carter*** at para 62. This statement summarizes the court's earlier decisions in ***Chaoulli v Quebec (Attorney General)***, 2005 SCC 35 [***Chaoulli***] and ***Canada (Attorney General) v PHS Community Services Society***, 2011 SCC 44 [***PHS***], where in each case legislation prohibiting access to certain forms of health care was found to engage the right to life. ***Chaoulli*** involved the constitutionality of legislative provisions in Quebec which prohibited private health care insurance, which effectively meant that some individuals would die given the evidence of wait times in the public health care system. ***PHS*** addressed the federal government's refusal to grant a safe drug injection site an exemption from provisions criminalizing drugs under the *Controlled Drugs and Substances Act*, SC 1996, c 19, thereby preventing individuals from accessing potentially life-saving medical care.

[45] We reject Ms Lewis' contention that transplant Program physicians or other respondents have deprived her of the right to life by imposing on her an increased risk of death. In order for a claimant to establish a deprivation of a s 7 right, a sufficient causal connection must exist between the state action and the prejudice suffered: ***Blencoe*** at para 60; ***Canada (Attorney General) v Bedford***, 2013 SCC 72 at para 75; Robert J. Sharpe & Kent Roach, *The Charter of Rights and Freedoms* (Toronto: Irwin Law, 2021) at 267. Here, no sufficient causal connection exists. It is one thing to assert that the state is unlawfully prohibiting one from accessing life-saving treatment; it is quite another for Ms Lewis to selectively choose which treatment criteria she will comply with.

[46] The unfortunate reality is this: Ms Lewis is dying because she has a terminal illness. The right to life was engaged in cases like ***Chaoulli*** and ***PHS*** because state prohibitions *prevented* individuals from accessing any health care. This is not the case with Ms Lewis. The COVID-19

vaccine requirement is not a prohibition on access to medical treatment at all; indeed, *it is part of the medical treatment*. Physicians in a clinical program where Ms Lewis remains a patient have determined that being vaccinated against COVID-19 is a necessary component of proper medical care for individuals, including Ms Lewis, who are seeking an [organ] transplant.

[47] The state has not deprived Ms Lewis from exercising her autonomous right to refuse to be vaccinated against COVID-19, which refusal is consistent with her right to refuse any medical treatment. However, the consequences that flow from her autonomous decision to refuse the COVID-19 vaccine were not caused by the respondents. As an aspect of medical self-determination, it is well understood that a patient's decisions can result in serious risks or consequences, including death: ***Carter*** at para 67.

[48] A further unfortunate reality is that Ms Lewis remains at risk of dying even if she were reinstated to "Status 2" on the transplant waitlist, and indeed, even if she were to receive a transplant. Patients who receive an [organ] transplant remain at high risk of dying post-transplantation, a risk that COVID-19 vaccination pre-transplantation is designed to *reduce*. It is true that Ms Lewis has a greater chance of survival by remaining at "Status 2", which in turn allows for some possibility of receiving an [organ]. However, as Ms Lewis appears to concede, she has no free-standing *Charter* right to an [organ] or remaining at "Status 2" on the Program's transplant waitlist. "The *Charter* does not confer a freestanding constitutional right to health care": ***Chaoulli*** at para 104.

[49] We agree with AHS that despite Ms Lewis' concession to the contrary, she is effectively seeking a *Charter* entitlement to remain on an organ transplant list contrary to prevailing s 7 jurisprudence, which does not "[place] a positive obligation on the state to ensure that each person enjoys life, liberty or security of the person": ***Gosselin v Québec (Attorney General)***, 2002 SCC 84 at para 81. Specifically, the government does not engage an individual's right to life by failing to financially compensate for, let alone provide, an organ transplant which, while potentially life-saving is deemed inappropriate based on accepted medical and ethical criteria: ***Flora v Ontario Health Insurance Plan***, 2008 ONCA 538, aff'g (2007), 278 DLR (4th) 45 (ONSC (Div Ct)).

[50] Accordingly, the COVID-19 vaccine requirement does not deprive Ms Lewis of her right to life under s 7 of the *Charter*.

The Right to Liberty

[51] Ms Lewis contends the COVID-19 vaccine requirement violates her "liberty" under s 7, though there is some overlap with the right to "security of the person". For instance, she suggests s 7 of the *Charter* protects a patient's "informed consent" and the COVID-19 vaccine requirement precludes such informed consent, thereby violating both her liberty and security of the person. According to Ms Lewis, it is coercive to ask patients like her to take a pre-transplant COVID-19 vaccine when the alternative is death, and any consent given will necessarily have been made under duress.

[52] The right to liberty and security of the person in s 7 guarantees competent adult individuals the ability to direct the course of their medical care by making decisions regarding their own bodily integrity: ***Carter*** at para 67. This grants Ms Lewis the right, for example, to decline vaccination against COVID-19 – a right she has exercised. However, her decision to consent to taking the COVID-19 vaccine, or not, is not made under duress simply because she is terminally ill. Were this proposition sound, then as a matter of logic neither Ms Lewis nor any similarly situated patient would be able to provide informed consent to any pre-condition to [organ] transplantation, including the host of other vaccinations required, and which Ms Lewis consented to receive. We conclude the pre-transplant COVID-19 vaccine requirement is not coercive and it does not interfere with the right to make choices about one's own body, as protected under s 7 of the *Charter*.

[53] Ms Lewis seeks to rely on the right to "liberty" in s 7 specifically insofar as it protects "fundamental personal choices": ***Blencoe*** at para 54; ***Carter*** at para 64; ***Ndhlovu*** at para 51. Alternately described as "inherently private choices", such decisions are protected from state interference only where "they implicate basic choices going to the core of what it means to enjoy individual dignity and independence": ***Association of Justice Counsel v Canada (Attorney General)***, 2017 SCC 55 at para 49, citing ***Godbout v Longueuil (City)***, [1997] 3 SCR 844 at para 66. Ms Lewis particularly focuses on the following statement of the Supreme Court of Canada in ***Carter*** at para 66: "An individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy".

[54] ***Carter*** held that *Criminal Code* provisions outlawing physician-assisted suicide violated the right to life, liberty and security of the person under s 7 of the *Charter* to the extent the law prohibited individuals from seeking physician-assisted death under certain circumstances despite suffering from "a grievous and irremediable medical condition": para 147. The right to "liberty" was infringed because the decision when and how a person with a grievous and irremediable medical condition chooses to die "represents their deeply personal response to serious pain and suffering": para 68.

[55] It is unclear how the *ratio* in ***Carter*** applies to Ms Lewis, or precisely what she seeks to protect from government intrusion over and above what goes into her own body. However, if Ms Lewis contends she has a *Charter*-protected right to insist on medical treatment while refusing to abide by medically appropriate clinical pre-conditions, she is wrong. No such "liberty" is protected by the *Charter*. While Ms Lewis has the right to make fundamental personal choices, "such personal autonomy is not synonymous with unconstrained freedom": ***Blencoe*** at para 54.

[56] The Program and the respondent hospital and physicians must balance Ms Lewis' medical needs against those of many others awaiting an [organ] transplant. The linkage between "Status 2" and compliance by others with medically appropriate pre-conditions that serve to optimize the successful allocation of [organ]s, does not ground a violation of Ms Lewis' s 7 *Charter* rights. Ms Lewis has freely made, and will continue to be free to make, fundamental personal choices without

state interference; the respondents have not trenched upon, impaired, or eroded her individual autonomy or dignity.

The Right to Security of the Person

[57] Finally, Ms Lewis argues the COVID-19 vaccine requirement infringes her security of the person due to the severe emotional stress it has caused her. Security of the person under s 7 of the *Charter* is engaged by state interference that causes "serious psychological suffering" (***Carter*** at para 64), it being necessary that the impugned state action has "a serious and profound effect on a person's psychological integrity" (***New Brunswick (Minister of Health and Community Services) v G(J)***, [1999] 3 SCR 46 at para 60).

[58] Ms Lewis deposes to being profoundly stressed due to uncertainty about whether she will receive a potentially life-sustaining [organ] transplant. This uncertainty, first and foremost, is the result of there being insufficient cadaveric [organ]s to match her specific medical situation, a fact which cannot be attributed to government. As noted in ***Blencoe*** at para 59, "[i]t would be inappropriate to hold government accountable for harms that are brought about by third parties who are not in any sense acting as agents of the state". But, Ms Lewis also claims that additional stress has been created as a result of the uncertainty of her status on the transplant waitlist, relying on the following statement from ***R v Morgentaler***, [1988] 1 SCR 30 [***Morgentaler***] at 56, per Dickson CJ and Lamer J: "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".

[59] ***Morgentaler*** is of no assistance to Ms Lewis. In that case, the Supreme Court of Canada struck down a *Criminal Code* provision prohibiting a woman from seeking an abortion without first obtaining a certificate from a therapeutic abortion committee that her life or health was endangered by the pregnancy. A majority of the court reasoned that it was harm to health caused by delay that violated a pregnant woman's "security of the person" under s 7 rather than, as Ms Lewis emphasizes, loss of control over decision-making. Further, the uncertainty and accompanying stress caused by a criminal prohibition which severely restricts a woman's ability to seek a safe medical procedure is in no way comparable to Ms Lewis' "Status 0" on the waitlist emanating from the COVID-19 vaccine requirement, the fulfillment of which is entirely within her control.

[60] As matters currently stand, the reassessment of Ms Lewis' waitlist status is predicated on her obtaining a vaccine against COVID-19. The consequences of Ms Lewis' refusal have caused her anguish but s 7 of the *Charter* only protects against serious psychological stress which is "state-imposed": ***Blencoe*** at para 57, citing ***Morgentaler*** at 56. We are not persuaded the COVID-19 vaccine requirement, deemed medically necessary to protect Ms Lewis and others in the transplant context, amounts to serious state-imposed psychological stress.

[61] For these reasons, because Ms Lewis' s 7 *Charter* rights have not been implicated, the analysis stops here.

Section 15 of the *Charter*

[62] Section 15(1) provides: "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability".

[63] Under the current two-part test, s 15 is infringed where: 1) the challenged law or government action creates a distinction, on its face or in its impact, on the basis of an enumerated or analogous ground; and 2) the distinction imposes a burden or denies a benefit in a discriminatory manner, by having the effect of reinforcing, perpetuating or exacerbating disadvantage: ***CP*** at paras 56, 141; ***Ontario (Attorney General) v G***, 2020 SCC 38 [***G***] at para 40; ***Fraser v Canada (Attorney General)***, 2020 SCC 28 at para 27; ***Centrale des syndicats du Québec v Quebec (Attorney General)***, 2018 SCC 18 at para 22; ***Quebec (Attorney General) v Alliance du personnel professionnel et technique de la santé et des services sociaux***, 2018 SCC 17 [***Alliance***] at para 25; ***R v Sharma***, 2022 SCC 39 at para 28.

[64] Ms Lewis' s 15 claim fails on the first part of the test. Any distinction created by the COVID-19 vaccine requirement is not based on an enumerated or analogous ground.

[65] There is no suggestion the pre-transplant COVID-19 vaccine requirement discriminates on the basis of any enumerated ground in s 15(1), namely "race, national or ethnic origin, colour, religion, sex, age or mental or physical disability". Nor does this COVID-19 vaccine requirement discriminate on the basis of any of the four grounds recognized by the Supreme Court of Canada to date as being analogous, which include i) citizenship (***Andrews v Law Society of British Columbia***, [1989] 1 SCR 143); ii) marital status (***Miron v Trudel***, [1995] 2 SCR 418; ***Nova Scotia (Attorney General) v Walsh***, 2002 SCC 83); iii) sexual orientation (***Egan v Canada***, [1995] 2 SCR 513); and iv) off-reserve residence for Indigenous Peoples (***Corbiere v Canada (Minister of Indian and Northern Affairs)***, [1999] 2 SCR 203 [***Corbiere***]): Peter W. Hogg & Wade Wright, *Constitutional Law of Canada*, 5th ed (Toronto: Thomson Reuters, 2022) [Hogg] at §55:26.

[66] Rather, Ms Lewis urges this Court to recognize "medical status" as an additional analogous ground under s 15(1) of the *Charter*. We decline to do so. It is more correct, and precise, to analyse her s 15(1) discrimination claim on the basis of what is actually at issue: "COVID-19 vaccination status". The COVID-19 vaccine requirement is said to be discriminatory because it treats potential transplant recipients differently depending on whether they consent to receiving a COVID-19 vaccination – denying those who refuse but are otherwise eligible the benefit of having an active status on the Program's waitlist for transplantation. The impugned requirement is therefore not about "medical status" in any general sense (which covers an almost infinite range of conditions) but rather, pre-transplant "COVID-19 vaccination status".

[67] The criteria for identifying an analogous ground under s 15(1) of the *Charter* is a personal characteristic which is either immutable (i.e., cannot be changed) or constructively immutable, that

is, "changeable only at unacceptable cost to personal identity": ***Corbiere*** at para 13. The rationale for this standard is set out in Hogg at §55:26:

> The primary reason that discrimination on these bases is objectionable is that it is generally morally wrong to disadvantage a person by reason of a personal characteristic that is *outside the person's control* (as with immutable personal characteristics) or that is central to their personal identity, and therefore changeable only with great personal cost or difficulty (as with constructively immutable personal characteristics). *What is objectionable about using such personal characteristics as the basis for legal distinctions is that consequences should normally follow what people do, not who they are*. [Emphasis added]

[68] Ms Lewis' COVID-19 vaccination status is not who she *is*. It is not an immutable personal characteristic, nor is it one that is changeable only at unacceptable cost to personal identity. Her choice not to get vaccinated against COVID-19 is just that – a choice. And while the decision whether to get a COVID-19 vaccine is personal, it remains fluid, made at a moment in time, based on available information and often in response to specific circumstances and influences. The decision can change, and often does, all with minimal or no cost to personal identity.

[69] Accordingly, "COVID-19 vaccination status" is not, in our view, an analogous ground under s 15(1) of the *Charter*. See similarly: ***Seneca College*** at paras 91-95.

[70] Such a finding is determinative of Ms Lewis' claim. "Where there is no distinction based on an enumerated or analogous ground, there is no remedy under s. 15": Hogg at §55:26. To be clear, this is no mere technicality. The requirement that the law create a distinction based on enumerated or analogous grounds is aimed at ensuring that s 15 of the *Charter* is being accessed by those it is designed to protect: ***G*** at para 41; ***Alliance*** at para 26.

The Expert Evidence

[71] Finally, we briefly comment upon the expert evidence presented to the chambers judge opining on the efficacy and safety of COVID-19 vaccines.

[72] The chambers judge declined to resolve the conflicting expert evidence on this topic, having concluded it was not necessary to do so: Decision at paras 28-43. The efficacy and safety of COVID-19 vaccines is not on trial and this Court need not address this issue to dispose of this appeal, and in any event, this Court would be ill-equipped to make any evidentiary determinations. The expert evidence before the chambers judge was conflicting and these fundamental conflicts remain unresolved on appeal.

[73] Further, there was a complete absence of any determination by the chambers judge about the *admissibility* of the evidence, despite vigorous arguments on that score. Each side argued their experts' qualifications were superior. The respondents questioned the impartiality of Ms Lewis' experts. Both concerns go to admissibility not simply weight: ***White Burgess Langille Inman v***

Abbott and Haliburton Co., 2015 SCC 23 at paras 34, 45, 52-54. On this record, we decline to resolve the conflict.

IV. Conclusion

[74] This is not the first time medical judgments about allocation of scarce resources have been made in the face of competing needs. While such decisions are doubtless exceedingly difficult, they nevertheless must be made. In this case, the *Charter* does not apply to the respondents' exercise of clinical judgments in formulating pre-conditions to [organ] transplant, including requiring vaccination against COVID-19 in the wake of the pandemic.

[75] In conclusion, we are not persuaded this Court can, or ought to, interfere with generalized medical judgments or individualized clinical assessments involving Ms Lewis' standard of care. In the circumstances of this appeal, while Ms Lewis has the right to refuse to be vaccinated against COVID-19, the *Charter* cannot remediate the consequences of her choice.

[76] The appeal is dismissed.

Appeal heard on October 20, 2022

Memorandum filed at Edmonton, Alberta
this 8th day of November, 2022

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08 Nov 2022
KM
Court of Appeal of Alberta

Schutz J.A.

Crighton J.A.

Authorized to sign for: Pentelechuk J.A.

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