Court File No.: 221/21

ONTARIO
SUPERIOR COURT OF JUSTICE
DIVISIONAL COURT

B E T W E E N :

DR. KULVINDER KAUR GILL

Applicant

– and –

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO (THE INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE)

Respondent

FACTUM OF THE APPLICANT, DR. KULVINDER KAUR GILL

December 7, 2023

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PART I — OVERVIEW

1. In today's political climate, people who hold and express opposing views are increasingly seen as adversaries (at best). And in such a climate, those who wield institutional and administrative powers may be tempted to use those powers to tip the scales against those with counter-narrative opinions. Reviewing courts must be mindful of this temptation, as they ensure that decisions made by administrative bodies are properly justified in relation to the facts, internally coherent and follow a rational chain of analysis.

2. The Covid period was a time of great upheaval in the approach to the management of pandemics. Never before had societies locked down the healthy on such a wide scale and for such a long period. Politicians acted quickly, often based on social pressure. An illusion of consensus soon emerged, as dissenting voices were stifled or punished. Some of those voices were extreme and uncivil; others were professional in tone but simply carried a message that, while generally correct, was considered heretical at a certain moment in time. This case is about the latter. The opinions expressed and censured here were correct—and were considered eminently reasonable—until suddenly they were not. Now they are becoming reasonable again.

3. The Applicant, Dr. Kulvinder Kaur Gill ("**Dr. Gill**"), is a specialist physician practicing at two allergy, asthma and clinical immunology clinics in Brampton and Milton. Her undergraduate training was in microbiology. She completed significant post-graduate training in pediatrics, and allergy and clinical immunology, including scientific research in microbiology, virology and vaccinology at the Public Health Agency of Canada's highest security level biosafety laboratory in Canada, and has published widely in these areas.[1]

[1] Letter from Rocco Galati to CPSO, dated October 14, 2020, at p. 25 [CPSO Record of Proceedings, at p. 111].

4. Dr. Gill has been active in her self-regulating profession, having been on the elected delegate council, and serving as an elected district chair to council of the Ontario Medical Association ("**OMA**"). She is heavily involved in Concerned Ontario Doctors ("**COD**"), a non-profit advocacy organization of frontline physicians, which has, amongst other issues, advocated regarding transparency issues at the OMA and the escalating cuts to frontline health care. Dr. Gill has represented the interests of Canadian patients and physicians with testimony on behalf of COD before legislative committees on healthcare policy at the Ontario Legislature, the House of Commons and the Senate of Canada.[2]

5. To date, Dr. Gill has never had a patient complaint to the CPSO. She is before this Honourable Court because she expressed opinions on social media with which some members of the public did not agree and filed complaints about those opinions to her regulator, the College of Physicians and Surgeons of Ontario ("**CPSO**" or the "**College**"). This led to an investigation being commenced by the Registrar under s. 75(1) of the *Health Professions Procedural Code,*[3] relating to Dr. Gill's Twitter account.

6. The Inquiries, Complaints and Reports Committee ("**ICRC**" or the "**Committee**") of the CPSO issued a total of seven decisions arising out of the public complaints, two of which ordered cautions-in-person and five of which were dismissed but referenced those cautions in the decision. Additionally, the s. 75 investigation resulted in a caution-in-person (the "**Decision**"), which is the subject of the within judicial review. A caution-in-person is the highest level of sanction available to the ICRC, short of sending the matter to a disciplinary panel.[4]

7. The decisions in the seven public complaints were reviewed by the Health Professions Appeal and Review Board ("**HPARB**"), which upheld the conclusions of the ICRC. A separate judicial review of those decisions, proceeding under Court File No. 243-23, is being heard contemporaneously. All eight decisions are interconnected, and the facts, law and argument in each factum apply, *mutatis mutandis*, to

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[2] Appendix to and Letter of Rocco Galati to CPSO, dated February 1, 2021 [CPSO Record of Proceedings, pp. 499 and 523].
[3] Schedule 2 to the *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18.
[4] Hon. Stephen Goudge, K.C., "*Report: Streamlining the Physician Complaints Process in Ontario*" (February 9, 2016), paragraph 148.

the other.

8. Not only did the s. 75 Decision fail to proportionately balance Dr. Gill's *Charter*[5]-protected expression rights with the statutory objectives of the College (canvassed in the companion factum), but it lacks reasonableness and procedural fairness for additional reasons: i) the ICRC failed to engage with the Applicant's written submissions on the central issues for which she was being cautioned, falling far short of the "culture of justification" demanded by the Supreme Court of Canada in *Vavilov*[6]; and ii) the ICRC made findings of fact that were unsupported by any evidence, which was beyond its powers as a screening committee (or any tribunal, for that matter).

PART II — SUMMARY OF THE FACTS

A. Dr. Gill's Opinions Contributed to Necessary Public Debate

9. Although she was initially alarmed about Covid-19 like most other people, Dr. Gill began examining the data more closely and, a few months into the pandemic, started sharing her evidence-based views on the social media platform now known as "X" (previously Twitter[7]).

10. Dr. Gill's general concerns that she expressed, properly understood, are that (1) the risks posed by Covid-19 were exaggerated; (2) lockdowns were scientifically unjustified; (3) the authorization and production of a Covid-19 vaccine should not be a condition precedent to ending harmful lockdowns; (4) early outpatient hydroxychloroquine ("**HCQ**") could be safely used in treating high-risk Covid-19 patients; (5) the critical importance of cellular (T-cell) immunity was being ignored; (6) pandemic measures did not reflect the known age-stratified risk of Covid-19 (i.e. a 1000 times greater risk to the elderly than to the youth); and (7) the importance of returning to Canada's and the World Health

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[5] *Canadian Charter of Rights and Freedoms*, Part 1 of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11. Section 2(b) provides that everyone has "freedom of thought, belief, opinion and expression…"; section 2(a) protects Canadians' "freedom of conscience and religion" (the "***Charter***").

[6] *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65 (CanLII), [2019] 4 SCR 653 ("***Vavilov***"), at paragraph 14.

[7] References to "Twitter" and "tweets" will continue to be used herein.

Organization's response plans (prepared prior to the pandemic), which were abruptly abandoned in favour of unprecedented and damaging lockdowns.

11. At the time her comments were made, they were well-supported in the developing medical and scientific literature, much of which she provided to the ICRC and which she typically referenced in her social media commentary. The Applicant was compelled by concern for marginalized communities in Canada and the developing world to speak against harmful government policies.[8] Her comments were also within the range of rational public debate and in accordance with a long history of public health pandemic plans and World Health Organization guidance.

12. Although she has expressed reservations about the necessity of the Covid-19 injection for every single person (regardless of their risk profile), Dr. Gill has always been pro-vaccination. She has been an advocate for existing routine childhood vaccinations for years on her personal Twitter account.[9] She supported giving the Covid-19 vaccine to high-risk individuals with their informed consent. Dr. Gill is a medical professional who regularly administers vaccines, including to children, and has devoted years of her life to conducting scientific research for the development of HIV-1 candidate vaccines.[10] She approached this issue, like the other impugned comments, from the perspective of an ethical, evidence-based, medical scientist, whose opinions are subject to change on better evidence. Indeed, in the early days of the pandemic, she had lobbied the government for more and better measures to protect healthcare workers and the public.[11]

13. But that evidence-based approach, which led her to criticize governments' public health policies, was at odds with the regulator of the medical profession, the CPSO, which had taken a different approach during the pandemic: centralized messaging for all of Ontario's physicians.

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[8] Letter from Rocco Galati to CPSO, dated February 1, 2021, p. 2 [CPSO Record of Proceedings, p. 487].
[9] Ibid, p. 5 [CPSO Record of Proceedings, p. 490].
[10] Letter from Rocco Galati to CPSO, dated October 14, 2020, p. 25 [CPSO Record of Proceedings, p. 111].
[11] Ibid, p. 29 [CPSO Record of Proceedings, p. 115].

14. In the CPSO's publication, *COVID-19 FAQs for Physicians*[12], in effect since April of 2020, the College gives the following "guidance" with respect to social media posts and Covid:

> *What should I be thinking about as I engage on social media about issues relating to the pandemic?*
>
> Physicians are reminded to be aware of how their actions on social media or other forms of communication could be viewed by others, especially during a pandemic. Your comments or actions can lead to patient/public harm if you are providing an opinion that does not align with information coming from public health or government. It is essential that the public receive a clear and consistent message. [Emphasis added.]

15. Physicians who pushed for draconian measures, engaged in fearmongering, used aggressive and intemperate language on Twitter—often directed at other physicians—and who condemned public health policies as they became less stringent, do not appear to have been subject to this edict.

16. Dr. Gill's opinions about governments and their public health Covid policies went in the wrong direction, as far as the CPSO was concerned, but they were certainly not "misinformation." In the three years since the ICRC's decisions in February 2021, the arc of history continues to bend toward Dr. Gill. Much of the public paranoia and anxiety during the pandemic has passed, and criticism of lockdowns and other measures is now widespread. People have moved on. But Dr. Gill's prescient and conscientious early objections have left long-term strikes against her on her Public Register, the impact of which is canvassed more fully in the companion factum.

B. The Investigation Covered the Same Ground as the Complaints

17. In addition to the seven separate public complaints that were initiated against Dr. Gill, the Registrar saw fit to commence an additional investigation, appointing at least thirteen investigators who collected Dr. Gill's tweets.[13] The compiled tweets were taken out of their surrounding context, often removed from threads which had included cited studies. Sometimes they were curated or altered in such

[12] *Covid-19 FAQs for Physicians*, updated October 19, 2020 [CPSO Record of Proceedings, p. 540].
[13] Appointment of Investigators, dated November 19, 2020 [CPSO Record of Proceedings, p. 181].

a way as to make it appear that Dr. Gill was retweeting "right wing" provocateurs[14] (she was not). The entire investigation resulted in three tweets being the subject of a caution order by the ICRC, two of which were also the subject of the cautions in the public complaints.

18. In other words, Dr. Gill received *three* separate caution orders for the *same two tweets*. The s. 75 Decision referenced a third—a quote tweet of a post by former Harvard infectious disease epidemiologist and public health scientist, Dr. Martin Kulldorff.

19. The tweets for which the Applicant was to be cautioned stated the following:

> *There is absolutely no medical or scientific reason for this prolonged, harmful and illogical lockdown. #FactsNotFear* [the "**Lockdown Tweet**"]
>
> *If you have not yet figured out that we don't need a vaccine, you are not paying attention.* [the "**Vaccine Tweet**"]
>
> *Contact tracing, testing and isolation…is ineffective, naïve & counter-productive against COVID-19… and by definition, against any pandemic.* [the "**Kulldorff Retweet**"]

20. The ICRC took the view that these statements demonstrated a "lack of professionalism and failure to exercise caution in her posts on social media, which is irresponsible behaviour for a member of the profession and presents a possible risk to public health." It ordered her to appear before the Committee to be cautioned in person.[15]

C. The Reasoning of the Committee

21. In concluding that these tweets merited a caution, the ICRC noted that the issues for their consideration were: i) whether statements made by Dr. Gill would have been verifiably false (i.e. "misinformation") at the point in time they were disseminated; and ii) whether the statements were consistent with the guidance posted by the CPSO.[16]

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[14] Tweet screenshots [CPSO Record of Proceedings, p. 21]; Letter from Rocco Galati to CPSO, dated September 17, 2020 [CPSO Record of Proceedings, p. 36]; see in particular, attachment to letter from Rocco Galati to CPSO, dated February 1, 2021, concerning the selectiveness and manipulation of tweets presented to the ICRC [CPSO Record of Proceedings, pp. 500 ff.].
[15] ICRC Decision, p. 3 [CPSO Record of Proceedings, p. 552].
[16] ICRC Decision, p. 4 [CPSO Record of Proceedings, p. 553].

22. The ICRC apparently failed to recognize that there could be an inherent conflict between these two considerations. Something might be *both* not verifiably false *and at the same time* inconsistent with the guidance posted by the CPSO. In other words, true—but not permissible to say aloud.

23. For some of the tweets that the ICRC reviewed in the related public complaints (in particular with respect to HCQ and T-cell immunity), it looked at the resources provided by Dr. Gill and concluded that there was sufficient support for her statements at the relevant time, such that they were not verifiably false and therefore not "misinformation."

24. Instead of performing a similar analysis to the Lockdown and Vaccine Tweets, the Committee appeared to apply a different standard.

25. For the Lockdown Tweet, the Committee found that[17]:

i) Dr. Gill did not question whether benefits outweigh negative aspects of lockdowns, but stated unequivocally that there was no medical or scientific reason for lockdown, without providing evidence;

ii) her statement did not align with information from public health;

iii) her statement was inaccurate, since China and South Korea provide evidence that lockdowns can and did work in reducing the spread of Covid-19;

iv) for Dr. Gill to state otherwise was "misinformed and misleading and irresponsible to state on social media during a pandemic."

26. For the August 2020 Vaccine Tweet (which pre-dated the completion of preliminary Covid-19 vaccine clinical trials, and pre-dated government authorization of any Covid-19 vaccine anywhere globally by at least five months), the Committee found, in February 2021 (then six months after the

[17] ICRC Decision, p. 4 [CPSO Record of Proceedings, p. 553].

tweet), that it was unprofessional on the basis that[18]:

i) Health Canada had [now] approved several vaccines and that a safe, tested vaccine is the ideal solution to protecting the population and bringing about the end of the pandemic with the lowest possible number of deaths;

ii) while it is possible for a return to "normal life" without vaccinating the public, this is a high-risk strategy and one that could potentially take years to achieve;

iii) in the absence of a vaccine, complete eradication of the virus from the human population as occurred with SARS or herd immunity are the only choices, and the herd immunity route would involve considerable death among vulnerable populations;

iv) Dr. Gill did not provide any evidence to support her statement that a vaccine is not necessary.

27. For the Kulldorff Retweet, the ICRC found it was "irresponsible and careless" on the basis that[19]:

i) testing, contact tracing and isolation are the core components of federal and provincial efforts to flatten the curve of infection and thereby reduce deaths from Covid-19;

ii) for these efforts to be successful, it is essential that members of the public recognize their own responsibility to protect themselves and others by adhering to public health restrictions and recommendations;

iii) Dr. Gill's retweet does not align with the official public health message the public has been receiving with regard to contact tracing, testing and isolation;

iv) it is valid to debate and question whether these efforts have been sufficiently effective; however, for Dr. Gill to undermine the public health message by declaring without evidence that these measures are counter productive, which is to say that they have the opposite of the

[18] ICRC Decision, p. 5 [CPSO Record of Proceedings, p. 554].
[19] ICRC Decision, pp. 5-6 [CPSO Record of Proceedings, pp. 554-555].

desired effect, seems indefensible to the Committee; and

v) given Dr. Gill's identification on Twitter as a physician, her comments could cause people not to follow public health rules which could have significant negative consequences for public health.

28. It should be noted that Dr. Gill's tweet was a "quote tweet" of Dr. Kulldorff. His full tweet was visible within hers. She summarized it and added her own commentary, but the full context was evident to anyone viewing it. In its decision, the ICRC left out the context entirely. As written (and criticized) in the Decision, the quote tweet says:

> *Contact tracing, testing and isolation…is ineffective, naïve & counter-productive against COVID-19… and by definition, against any pandemic.*

29. What the embedded and visible quoted tweet said was:

> *Contact tracing, testing and isolation is important against many infectious disease outbreaks, such as Ebola and post-vaccine measles. It is ineffective, naïve and counter-productive against COVID19, influenza, pre-vaccine measles, etc, and by definition, against any pandemic.*

30. Bearing in mind that Dr. Kulldorff is an epidemiologist, biostatistician, public health scientist and infectious disease specialist who was then at Harvard University, this was not an uninformed statement and the full context would have been more appropriate for the ICRC to consider.

D. The Submissions the Committee Ignored

31. The ICRC further stated in its Decision that, although Dr. Gill provided references to articles that she believed provide medical and scientific support for the opinions she expressed in her tweets, they were "not swayed," and some of the articles were not freely available for review. Additionally, the Committee claimed she "quoted some of them selectively."[20] It made no other reference to the materials, as it had done in related decisions on the HCQ tweet, where it cited relevant sources in support of Dr.

[20] ICRC Decision, p. 7 [CPSO Record of Proceedings, p. 556].

Gill's opinion.

32. The Committee failed to adequately investigate the support for the impugned statements made by Dr. Gill, declining to engage with the weight of authority she submitted on these points entirely.

i) Support for the Lockdown Tweet

33. With respect to the Lockdown Tweet, at least 40 references to both peer-reviewed scientific and medical studies and popular articles critiquing lockdowns had been provided to the CPSO in various submissions. Yet the Committee inaccurately stated in its Decision that no evidence was provided by Dr. Gill to support her contention.

34. If the Committee meant by that statement that she did not provide evidence in the space of a single 240-character tweet, without regard to the surrounding timeline filled with commentary, evidence reviews, posting of studies, etc., then no doctor could comment on Twitter. While tweets can be threaded together to present a more complete position, that would not have helped in this instance—the CPSO's investigators captured Dr. Gill's tweets without providing even the rest of the thread for context.[21]

35. Had the Committee taken the time to review the materials, even a small fraction of them, it would have found that in August of 2020, and certainly by February of 2021 when it was considering the matter, a sizeable and growing number of scientists and physicians around the world were calling into question the propriety and effectiveness of lockdowns and pointing to their harmful consequences, including Dr. Sunetra Gupta of Oxford University, Dr. Martin Kulldorff of Harvard University, and Dr. Jay Bhattacharya of Stanford University.

36. While there may have been disagreement between scientists and physicians, then and now, with respect to lockdowns, disagreement does not equate to misinformation and should not be punishable or

[21] Letter from Rocco Galati dated February 1, 2021, and appendix thereto [CPSO Record of Proceedings, pages 486 and 500 ff.].

silenced.[22]

37. What follows is a sampling of the evidence and submissions with which the ICRC failed to engage and failed to address in its reasons. This evidence was directly responsive to the first part of the ICRC's stated test—whether statements made by Dr. Gill would have been verifiably false (i.e. misinformation) at the point in time they were disseminated. As will be discussed further in Part III, this failure by the Committee to engage meaningfully with the submissions prevented the development of a rational chain of analysis through to its logical conclusion, rendering the ultimate decision unreasonable and not justified.

38. Each of the articles was linked in the October 14, 2020, submission from Dr. Gill's former lawyer to the CPSO.[23] While the ICRC can and should have clicked on the links to review the materials provided, in many instances the contents were quoted directly into the letter and were easily reviewable. Only those references which were, in fact, readily visible in the submissions (without clicking a hyperlink) are included below.

39. The very first citations in Dr. Gill's submissions were for the World Health Organization's 2019 Report, "*Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza*" as well as "*The Canadian Pandemic Influence Plan for the Health Sector*", dated 2006. The accompanying submission noted that "it must be said that neither the long-established pandemic preparedness reports for Canada nor the World Health Organization had included widespread lockdowns of healthy individuals as an evidence-based, non-pharmaceutical measure in response to a pandemic."[24]

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[22] *Canadian Centre for Bio-Ethical Reform v Grande Prairie (City)*, 2018 ABCA 154 (CanLII), para. 73.
[23] Letter from Rocco Galati to CPSO, dated October 14, 2020 [CPSO Record of Proceedings, pages 87-139]; the ICRC also had before it submissions from Dr. Gill's former counsel in a November 23, 2020 letter, containing additional links regarding lockdowns [CPSO Record of Proceedings, pp. 358 ff.]; and further submissions dated January 16, 2021 [CPSO Record of Proceedings, pp. 269 ff.].
[24] Letter from Rocco Galati to CPSO, dated October 14, 2020, p. 3 [CPSO Record of Proceedings, page 89, citing https://apps.who.int/iris/bitstream/handle/10665/329438/9789241516839-eng.pdf; and https://www.longwoods.com/articles/images/Canada_Pandemic_Influenza.pdf].

40. The Great Barrington Declaration was another reference provided to the ICRC.[25] The authors, who were physicians and/or scientists and professors of epidemiology and public health at respected institutions including Harvard, Stanford and Oxford, stated the following in their declaration in October of 2020:

> As infectious disease epidemiologists and public health scientists we have grave concerns about the damaging physical and mental health impacts of the prevailing COVID-19 policies, and recommend an approach we call Focused Protection.
>
> Coming from both the left and right, and around the world, we have devoted our careers to protecting people. Current lockdown policies are producing devastating effects on short and long-term public health. The results (to name a few) include lower childhood vaccination rates, worsening cardiovascular disease outcomes, fewer cancer screenings and deteriorating mental health – leading to greater excess mortality in years to come, with the working class and younger members of society carrying the heaviest burden. Keeping students out of school is a grave injustice.
>
> Keeping these measures in place until a vaccine is available will cause irreparable damage, with the underprivileged disproportionately harmed.
>
> Fortunately, our understanding of the virus is growing. We know that vulnerability to death from COVID-19 is more than a thousand-fold higher in the old and infirm than the young. Indeed, for children, COVID-19 is less dangerous than many other harms, including influenza.
>
> As immunity builds in the population, the risk of infection to all – including the vulnerable – falls. We know that all populations will eventually reach herd immunity – i.e. the point at which the rate of new infections is stable – and that this can be assisted by (but is not dependent upon) a vaccine. Our goal should therefore be to minimize mortality and social harm until we reach herd immunity.
>
> The most compassionate approach that balances the risks and benefits of reaching herd immunity, is to allow those who are at minimal risk of death to live their lives normally to build up immunity to the virus through natural infection, while better protecting those who are at highest risk. We call this Focused Protection. [Emphasis added.]

41. The evidence, even at the time of Dr. Gill's Lockdown Tweet in August 2020, showed that lockdowns achieved little benefit (today, we have many more studies about their harms). This study, entitled: "*A country level analysis measuring the impact of government actions, country preparedness and socioeconomic factors on COVID-19 mortality and related health outcome*" in August of 2020,

[25] Ibid, p. 6 [CPSO Record of Proceedings, p. 92, citing: https://gbdeclaration.org].

linked in Dr. Gill's submissions and published in the Lancet,[26] found that rapid border closures, full lockdowns, and wide-spread testing were **not** associated with COVID-19 mortality per million people. In other words, they did not make a positive difference.

42. A preprint initially published on May 1, 2020, entitled "*Full lockdown policies in Western Europe countries have no evident impacts on the COVID-19 epidemic*"[27] was provided to the Committee. It concluded:

> This phenomenological study assesses the impacts of full lockdown strategies applied in Italy, France, Spain and United Kingdom, on the slowdown of the 2020 COVID-19 outbreak. Comparing the trajectory of the epidemic before and after the lockdown, we find no evidence of any discontinuity in the growth rate, doubling time, and reproduction number trends.

43. An article published by Cambridge University Press on August 12, 2020, entitled "*Public Health Lessons Learned from Biases in Coronavirus Mortality Overestimation,*"[28] Professor Emeritus of Public Health, Dr. Ronald Brown, was quoted at length in Dr. Gill's written submissions, and argued in its conclusion:

> This article presented important public health lessons learned from the COVID-19 pandemic. Reliable safeguards are needed in epidemiological research to prevent seemingly minor miscalculations from developing into disasters. Sufficient organizational quality assurance procedures should be implemented in public health institutions to check, catch, and correct research biases and mistakes that underestimate or overestimate associated risks of disease and mortality. Particularly, the denominator of fatality rates should clearly define the group to whom fatalities apply. Public health campaigns based on fear can have harmful effects, and the ethics of such campaigns should be reevaluated. People need to have a greater voice in a transparent process that influences public health policy during an outbreak, and educational curricula should include basic research methods to teach people how to be better consumers of public health information. The public should also be fully informed of the adverse impacts on psychological well-being, human rights issues, social disruption, and economic costs associated with restrictive public health interventions during a pandemic. [Emphasis added.]

44. Dr. Martin Kulldorff, the Harvard epidemiologist and co-author of the Great Barrington

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[26] Ibid p. 3 [CPSO Record of Proceedings, page 89, citing: https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(20)30208-X/fulltext].
[27] Ibid, p. 4 [CPSO Record of Proceedings, page 90, citing: https://www.medrxiv.org/content/10.1101/2020.04.24.20078717v1].
[28] Ibid, p. 9 [CPSO Record of Proceedings, page 95, citing: https://www.cambridge.org/core/journals/disaster-medicine-and-public-health-preparedness/article/public-health-lessons-learned-from-biases-in-coronavirus-mortality-overestimation/7ACD87D8FD2237285EB667BB28DCC6E9].

Declaration, stated the following in an interview, which was included in the submissions[29]:

> The media suggests there is a scientific consensus in favour of lockdown, but that is not the case. I have two concerns. One is about the collateral damage lockdown causes to other aspects of public health. One of the basic principles of public health is that you do not just look at one disease – you have to look at health as a whole, including all kinds of diseases, over a long period. That is not what has been done with Covid-19. As a public-health scientist, it is stunning to see how focused people are on this one disease and on the short term. The collateral damage is very tragic: cardiovascular disease outcomes are worse, cancer screenings are down, and there are mental-health issues, for example.
>
> It's a unique experiment, and it's a terrible experiment. I'm amazed – as are many of my colleagues – at the total focus on this disease. In a short time, we are throwing all the principles of public health out the window. Most countries in Europe had a pandemic-preparedness plan which did not recommend lockdowns, but instead proposed a risk-based strategy to protect those at high risk, which is actually the same as the focused protection we put forward in the Great Barrington Declaration. What we are proposing is, therefore, nothing revolutionary. Many people have been advocating for it throughout this pandemic, but they have not had much attention.

45. A member of the World Health Organization, Dr. David Nabarro, questioned the success of lockdowns and praised the Great Barrington Declaration in an Australian news article, entitled "WHO backflips on virus stance by condemning lockdowns," dated October 12, 2020:[30]

> Dr. David Nabarro from the WHO appealed to world leaders yesterday, telling them to stop "using lockdowns as your primary control method" of the coronavirus.
>
> He also claimed that the only thing lockdowns achieved was poverty – with no mention of the potential lives saved.
>
> "Lockdowns just have one consequence that you must never ever belittle, and that is making poor people an awful lot poorer," he said.

46. Dr. Gill's former lawyer provided further written submissions to the Committee on February 1, 2021,[31] which included links to additional journal articles focused mainly on the ethics, harms and adverse impacts of lockdowns to mortality, marginalized groups, suicide rates, economics, global poverty, social relationships and mental health. None of these were referenced or apparently considered

[29] Ibid, p. 10 [CPSO Record of Proceedings, page 96, citing: https://www.spiked-online.com/2020/10/09/lockdown-is-a-terrible-experiment/].
[30] Ibid, p. 11 [CPSO Record of Proceedings, p. 97, citing: https://www.news.com.au/world/coronavirus/global/coronavirus-who-backflips-on-virus-stance-by-condemning-lockdowns/news-story/f2188f2aebff1b7b291b297731c3da74].
[31] Letter from Rocco Galati to CPSO, dated February 1, 2021 [CPSO Record of Proceedings, p. 486].

by the Committee.

47. One study on the efficacy of lockdowns was entitled, "*Assessing Mandatory Stay-at-Home and Business Closures Effects on the Spread of Covid-19*." This peer-reviewed research by Stanford epidemiologists and physicians in the *European Journal of Clinical Investigation* failed to find strong evidence supporting a role for more restrictive non-pharmaceutical interventions (**NPIs**) in control of Covid-19. "We fail to find an additional benefit for stay-at-home orders and business closures… We do not find significant benefits on case growth of more restrictive NPIs. Similar reductions in case growth may be achievable with less restrictive interventions."[32]

48. Another study was from the *Journal of Law and Biosciences*, and advanced the argument that the impact of the pandemic response would be to usher in a pandemic of authoritarianism: "An authoritarian response to a biomedical pandemic is not, and never will be, a humanitarian solution… With a gratuitous toll being inflicted on democracy, civil liberties, fundamental freedoms, healthcare ethics, and human dignity, this has the potential to unleash humanitarian crises no less devastating than COVID-19 in the long run."[33]

49. Dr. Gill's Lockdown Tweet was entirely in keeping with past pandemic plans, and with numerous esteemed scientists around the globe. It was certainly not "verifiably false" or "misinformation," and served to sound an alarm bell about the contentious policies being enacted by the government, which the CPSO edict evidently expected physicians to echo without question.

50. The ICRC noted that Dr. Gill's statement was "unequivocal." Nowhere in the referenced CPSO guidance does it say that all communications must present both sides, nor was this standard applied to those pushing for draconian Covid-Zero measures.

51. The submitted articles were intended to demonstrate to the ICRC that there was ample expert

[32] Ibid, p. 11 [CPSO Record of Proceedings, p. 496, citing: https://onlinelibrary.wiley.com/doi/10.1111/eci.13484].
[33] Ibid, p. 10 [CPSO Record of Proceedings, p. 495, citing: https://academic.oup.com/jlb/article/7/1/lsaa064/5912724].

support around the world for Dr. Gill to make an unequivocal statement, as she did, that "there is absolutely no medical or scientific reason for this prolonged, harmful and illogical lockdown." Many of these articles were also shared by Dr. Gill on social media, ensuring that her timeline provided a thorough grounding for her various opinions. But the ICRC simply handwaved them away.

ii) Context Surrounding the Vaccine Tweet

52. The vaccine comment was taken entirely out of context and treated as though it were a general statement against vaccines (which, at that time, had not completed clinical trials and were still five months away from authorization anywhere in the world), rather than a statement against the notion that the vaccines were going to end damaging lockdowns.

53. The tweet was a direct response to an announcement by Chief Public Health Officer Theresa Tam, in which she said that even two to three years after the vaccine was approved, various restrictions would continue in effect. In other words, the mass vaccination campaign would not result in freedom from unprecedented lockdowns.

54. This context was explained to the ICRC in the submissions of October 14th, 2020, but does not appear to have been considered. The tweeted statement that "we don't need a vaccine" was made on August 4, 2020, and Dr. Gill was specifically responding to the press conference that same day by Dr. Tam, as well as the CBC article and CTV news story concerning the press conference, both of which were linked in the submissions.[34]

55. The headline of the CBC news story stated: "*Physical distancing, mask-wearing could be in place for 2-3 years even with vaccine, Tam warns*." The CTV's headline was no rosier: "*Even if there's a vaccine, pandemic may persist for years to come: Tam*".

[34] Letter of Rocco Galati to CPSO, dated October 14, 2020, p. 28 [CPSO Record of Proceedings, p. 114, referencing: https://www.cbc.ca/news/politics/covid-19-vaccine-tam-1.5673729].

56. Of note are the following statements made by Dr. Tam during the press conference[35]:

> "We're planning, as a public health community, that we're going to have to manage this pandemic certainly over the next year, but certainly it may be planning for the longer term on the next two to three years during which the vaccine may play a role. But we don't know yet."
>
> "People might think that if we get a vaccine then everything goes back to normal the way it was before. That's not the case…All of the measures we've put in place now will still have to continue with the new reality for quite some time."
>
> "Certainly I think that we need to temper people's expectations, thinking that the vaccines can be that silver bullet that will take care of everything, and everything we've done up to now won't be necessary in the future."

57. Dr. Tam was speaking frankly here, as little was known about what the vaccines, if approved, could accomplish. As Dr. Gill noted, there was a persistent lack of transparency for vaccine trial data, and clinical trials were not designed to assess whether the vaccine would reduce the rate of infection, transmission, hospitalization or mortality.[36]

58. The purpose of Dr. Gill's tweet was to point out that no one knew what the vaccines could accomplish, if anything, and we did not need to wait for mass vaccination as a condition precedent for ending lockdowns, in light of the fact that our own public health officials did not see a direct line between vaccines and the end of restrictions, including lockdowns.

59. The ICRC ignored the contextual evidence, substituted its own evidence, placed the tweet in an entirely different context, and found it to be inappropriate under those circumstances. This was incoherent, illogical, did not follow a rational chain of analysis, and is therefore unreasonable.

iii) The Kulldorff Retweet

60. There do not appear to have been submissions specifically directed toward the substance of the quote tweet of Dr. Kulldorff about contact tracing (it was impossible to know, from the dozens of tweets

[35] Ibid, p. 28 [CPSO Record of Proceedings, p. 114, referencing CPAC: Federal health officials provide COVID-19 update – August 4, 2020].
[36] Slide Presentation of Dr. Gill to the Region of Peel Council, dated November 12, 2020 [CPSO Record of Proceedings, p. 224].

identified in the CPSO's report, which one(s) the ICRC would zero in on); however, the slide deck from a presentation given by Dr. Gill, which investigators had obtained and included in the file provided to the Committee, contained several slides explaining why contact tracing during a pandemic is futile. A quote from Dr. Carl Heneghan, Professor and Director of Oxford University's Centre for Evidence-Based Medicine, physician, infectious disease epidemiologist and then Editor-in-Chief of the British Medical Journal's Evidence-Based Medicine Journal,[37] says:

> "PCR cycle thresholds are the times that the amplifying test has to be repeated to get a positive result. The higher the viral concentration the lower amplification cycles are necessary."
>
> "When you are picking up asymptomatic people, you have no idea if they have active SARS-Cov-2 infection or if they had it two months ago because PCR test being deployed in a sort of rag bag way with PCR cycle threshold greater than 25."

61. In the next slide, Dr. Gill provides a quote from Professor Jonathan Deeks of Birmingham University, from his editorial in the British Medical Journal[38]:

> False positives become a problem when individuals and their contacts have to self-isolate unnecessarily. Even with a specificity of 99%, proposals to do 10 million tests a day will generate many thousands of false positive results, causing unnecessary but legally enforced isolation of both cases and contacts with potentially damaging consequences for the UK economy and for civil liberties.

62. In a later slide, Dr. Gill quotes Dr. Jay Bhattacharya & Dr. Mikko Packalen from their article, "*On the Futility of Contact Tracing*": "[C]ontact tracing does not deserve the central place it has received in the tool kit public health authorities use to control COVID-19." The slide also contains the quote from Dr. Kulldorff that the ICRC found objectionable.[39]

63. Dr. Gill's final slide on the topic shows the WHO's guidance from 2019, recommending against contact tracing and other social distancing measures.[40] There was certainly plenty of evidence before the ICRC to confidently state that Dr. Gill's quote tweet of Dr. Kulldorff, like her other tweets, was not

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[37] Ibid [CPSO Record of Proceedings, p. 215].
[38] Ibid [CPSO Record of Proceedings, p. 216, citing: "*Operation Moonshot proposals are scientifically unsound*" BMJ 2020; 370 doi: https://doi.org/10.1136/bmj.m3699 (Published 22 September 2020)].
[39] Ibid [CPSO Record of Proceedings, p. 218, citing: https://inference-review.com/article/on-the-futility-of-contact-tracing].
[40] Ibid [CPSO Record of Proceedings, p. 219].

"verifiably false" or "misinformation."

PART III — ISSUES AND THE LAW

64. The issues for this Court are:

i) whether the ICRC proportionately balanced appropriate statutory objectives with the *Charter* rights of Dr. Gill;

ii) whether the Decision of the ICRC was reasonable and justified, having regard to its failure to engage with Dr. Gill's submissions on the central issues for which she was being cautioned and the preferencing of its own evidence instead; and

iii) whether the ICRC breached Dr. Gill's right to procedural fairness when, *ultra vires* its jurisdiction as a screening committee, it made findings of fact on controversial matters without evidence, or substituted its own unsupported evidence, without the opportunity for Dr. Gill to test that evidence in a hearing.

A. Reasonableness is the Standard of Review & Justification is the Focus

65. As confirmed by this Court in the recent *Peterson*[41] decision, there is no dispute that the standard of review is reasonableness, and that the principles set out in *Doré/Loyola* and *Vavilov* must be applied in reviewing the decisions.

66. *Vavilov*[42]focuses the reviewing court on the decision actually made by the decision maker, including both the decision maker's reasoning process and the outcome.[43] A reasonable decision "is one that is based on an internally coherent and rational chain of analysis and that is justified in relation to the facts and law that constrain the decision maker."[44]

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[41] *Peterson v. College of Psychologists of Ontario*, 2023 ONSC 4685 (CanLII) (Div. Ct.) ("***Peterson***"), at para. 29.
[42] *Vavilov*, *supra* note 6.
[43] *Vavilov*, *supra* note 6, at para. 83.
[44] *Vavilov*, *supra* note 6, at para. 85.

67. Further, and importantly in this case, "the degree of justification found in reasons, like the reasonableness review itself, must reflect the stakes of the decision."[45] The question of "stakes" or impact, is addressed more fully in the companion factum.

68. For questions of procedural fairness, a reasonableness standard and deference are not required, but the court is to apply the factors in *Baker* to determine the level of procedural fairness required in the circumstances of the case.[46]

B. The Decision was Unreasonable

i) The Committee failed to engage in a proportionate balancing

69. The *Doré* decision,[47] as modified by *Loyola*,[48] requires that, where *Charter* rights are at stake, a decision maker must engage in a proportionate balancing analysis. This is especially so when the speech being punished is of a political nature (as criticism of government and public health policy certainly is). The ICRC failed to consider the impact of its Decision on Dr. Gills's *Charter*-guaranteed freedoms of expression, conscience and opinion, to ensure that they were protected to the fullest degree possible while considering the regulator's mandate. This issue is fleshed out more fully in the companion factum.

ii) The Committee failed to engage with Dr. Gill's submissions

70. As the Committee itself identified in its Decision[49], the main question it had to determine was whether, at the time the impugned statements were made by Dr. Gill, there was evidence to support the opinions, such that they were not "verifiably false" or "misinformation." To then disregard the ample evidence provided by Dr. Gill to answer that question was patently unreasonable. As long as there was evidence to support her position, as there was, it was not reasonable to censure her.

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[45] *Peterson*, *supra* note 41, at para 37.
[46] *Vavilov*, *supra* note 6, para. 23. The criteria for assessing procedural fairness continue to be as set out in *Baker v. Canada (Minister of Citizenship and Immigration)*, 1999 CanLII 699 (SCC), [1999] 2 SCR 817 ("***Baker***"), para. 21-28.
[47] *Doré v. Barreau du Québec*, 2012 SCC 12 (CanLII), [2012] 1 SCR 395 ("***Doré***").
[48] *Loyola High School v. Quebec (Attorney General)*, 2015 SCC 12 (CanLII), [2015] 1 SCR 613 ("***Loyola***"), at para. 40.
[49] ICRC Decision, p. 4 [CPSO Record of Proceedings, p. 553].

71. It was also unreasonable for the Committee to expect Dr. Gill to provide "both sides" of a position when tweeting publicly, by criticizing her "unequivocal" position[50]. That expectation is nowhere to be found in any guidance, and is not expected of physicians arguing that public health and governments are doing too little. Dr. Gill was an advocate for a cause—an advocate for Canadians whose voice was not being heard at the policy table.

72. The ICRC was dismissive of the considerable trove of scientific literature that Dr. Gill submitted to support her statements and did not materially engage with it. The Committee simply said it was "not swayed" and handwaved it away. It then made its own findings of fact that were not supported by any evidence or expert opinion in order to prove that her statements were wrong. Without any particular expertise (the panel was comprised of surgeons—a general surgeon, an ophthalmologist and an ob-gyn—along with a public member)[51], it preferred its own views on controversial scientific matters, and deemed hers to be "misleading."

73. In a recent judicial review by this Court,[52] decisions of another ICRC, which imposed cautions on two nurses, were quashed on the basis that the failure to engage with the applicants' arguments on abuse of process and delay was unreasonable. Additionally, one nurse had mental health issues which triggered submissions about *Human Rights Code* accommodations, with which the ICRC did not engage. The Court held that, following *Vavilov*, "a decision-maker's failure to meaningfully grapple with key issues or central arguments raised by the parties may call into question whether the decision maker was actually alert and sensitive to the matter before it."

74. Under s. 26(1) of the *Code*, as the Court in *Young* noted, "the panel may determine the appropriate disposition after, among other things, 'considering the submissions of the member[.]'…[W]hen ordering

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[50] ICRC Decision, p. 4 [CPSO Record of Proceedings, p. 553].
[51] ICRC Decision, p. 7 [CPSO Record of Proceedings, p. 556]; Panel members' specialties are publicly available on the CPSO website.
[52] *Young v. College of Nurses of Ontario*, 2022 ONSC 6996 (CanLII) (Div. Ct.) ("***Young***"), para. 27, citing *Vavilov, supra* note 6, at para. 128.

a caution, the panel of the ICRC is required to articulate and provide a rationale. In doing so, the ICRC must take the member's submissions into consideration and show, through its reasons, that those submissions were considered."[53] Section 26(1) also requires the ICRC to make "reasonable efforts to consider all records and documents it considers relevant to the complaint or report."

75. This failure to do so by the Committee here reflects a general lack of internally coherent reasoning that is neither logical nor rational. As *Vavilov* tells us, a failure in this respect may lead a reviewing court to conclude that a decision must be set aside. The reviewing court "must be able to trace the decision maker's reasoning without encountering any fatal flaws in its overarching logic".[54] If an irrational chain of analysis is found, or the conclusion reached does not follow from the analysis undertaken, then the decision will be unreasonable.[55]

76. It is important to note that *Vavilov* now requires a "culture of justification" from administrative decision makers. As the Supreme Court described this culture:

> [14] On the one hand, courts must recognize the legitimacy and authority of administrative decision makers within their proper spheres and adopt an appropriate posture of respect. On the other hand, administrative decision makers must adopt a culture of justification and demonstrate that their exercise of delegated public power can be "justified to citizens in terms of rationality and fairness"…

77. To satisfy a culture of justification, administrative decision makers need to show their reasoning, and that requires that they consider evidence and explain why the evidence leads to one conclusion and not another. It was simply not good enough to gloss over or ignore Dr. Gill's submissions.

78. Setting the test for the decision, as the ICRC did at the start of its reasons, then altering it midstream when the evidence of the Applicant was not in accordance with its own views (or with the edict of the College telling physicians not to criticize the government), suggests an irrational break in the

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[53] Ibid, paragraph 24
[54] *Vavilov*, *supra* note 6, at para. 102.
[55] *Vavilov*, *supra* note 6, at para. 103.

chain of analysis.

79. In the related decisions in the companion judicial review, the ICRC applied this test to several of the impugned tweets, including those on HCQ and T-cell immunity, and found that evidence supported the substance of the Dr. Gill's tweet. It then went on to apply a completely different standard to the Lockdown and Vaccine Tweets, despite Dr. Gill providing scientific support for her tweets that likewise demonstrated that there was no basis to conclude she was deliberately attempting to mislead or misinform the public.

80. Again, *Vavilov* is instructive in summarizing the concerns with the failure to engage with the evidence presented by Dr. Gill.

> [127] The principles of justification and transparency require that an administrative decision maker's reasons meaningfully account for the central issues and concerns raised by the parties. The principle that the individual or individuals affected by a decision should have the opportunity to present their case fully and fairly underlies the duty of procedural fairness and is rooted in the right to be heard: *Baker*, at para. 28. The concept of responsive reasons is inherently bound up with this principle, because reasons are the primary mechanism by which decision makers demonstrate that they have actually *listened* to the parties.

81. The ICRC may have bristled at Dr. Gill's opinions and felt inclined to dismiss them out of hand, but the question of whether her opinions could be supported on the evidence was at the very core of what the Committee had to decide. The Committee should have been responsive to the submissions she provided, however much it found them uncomfortable to hear or however much cognitive dissonance they created.

82. The essential point of *Vavilov* is to focus the reviewing court on the culture of justification and to require a critical assessment of whether that culture has been satisfied. **Deference accordingly follows justification. It does not precede it.**

iii) The Committee substituted its own opinions on matters of scientific dispute

83. In its reasons regarding all three of the impugned tweets, the Committee made findings of fact

for which there was no foundation. This was outside the scope of its jurisdiction and therefore unreasonable.

a. The Lockdown Tweet

84. With respect to the Lockdown Tweet, the Committee found[56], *inter alia*, that:

> Her statement does not align with the information coming from public health, and moreover, it is not accurate. The lockdowns in China and South Korea provide evidence that lockdowns can and did work in reducing the spread of COVID-19. For the Respondent to state otherwise is misinformed and misleading and furthermore an irresponsible statement to make on social medial [*sic*] during a pandemic.

85. The ICRC asserted *its own evidence* that lockdowns in China and South Korea worked. Even if that contention were correct, which it is not, it would still be entirely inappropriate for the Committee to make a finding of fact on a controversial issue. There was no evidence before the ICRC about lockdowns in China and South Korea, and "judicial notice" was wholly improper, particularly for a qualitative statement like that. Had that statement been made in disciplinary proceedings, evidence could have been adduced to counter it. Dr. Gill or her experts would have testified that China's approach was utterly inhumane and did not stop Covid—it only delayed the inevitable until lockdowns were lifted, causing immense suffering in the process. And she would have testified that that South Korea used a different approach than most countries, but it did not lock down its healthy population.

86. To use the Committee's own language, its assertion about lockdowns in Asia was "misinformed", "misleading" and "irresponsible."

b. The Vaccine Tweet

87. In its reasons for a caution about the Vaccine Tweet, the Committee again made findings of fact on controversial scientific matters without any evidence to support them. As outlined above, the ICRC took the tweet out of context and treated it as though it were a general disparagement of Covid-19

[56] ICRC Decision, p. 4 [CPSO Record of Proceedings, p. 553].

vaccines (which at the time of the Tweet, were a long way from authorization). Its Decision[57] was thus a full-throated defence of the vaccines which went well beyond an appropriate finding of fact for a screening committee.

88. The Committee asserted the following "facts":

i) that "a safe, tested vaccine is the ideal solution to protecting the population and bringing about the end of the pandemic with the lowest possible number of deaths";

ii) that "while it is possible for a return to 'normal life' without vaccinating the public, this is a high-risk strategy and one that could potentially take years to achieve";

iii) that "in the absence of a vaccine, complete eradication of the virus from the human population as occurred with SARS (by now an unlikely outcome for the widespread COVID-19 pandemic) or herd immunity are the only non-medical defences against COVID-19"; and,

iv) that "pursuing a policy of building up herd immunity to COVID-19 would involve a significant death rate among vulnerable patient populations and put sustained and continuing pressure on the healthcare system for an unforeseen amount of time."

89. At this point in time, the members of the Committee had no better knowledge about any of this than Dr. Gill. They were speculating and expressing wishful thinking, which they presented as fact. And then they cautioned Dr. Gill, who *did* have relevant expertise which informed her view that there was already significant immunity in the community, and that a vaccine was not necessary to end the lockdowns.

90. The Committee also provided no support for its claim that Dr. Gill's comments were a risk to public health. If these assertions of fact were presented in a hearing, where they could be properly tested on cross-examination and countered by opposing experts, Dr. Gill or her experts would have testified

[57] ICRC Decision, p. 5 [CPSO Record of Proceedings, p. 554].

that the vaccines did not stop transmission of infection anyway, and require constant top ups. Very few people are bothering with shots anymore, and Covid is now endemic. They would testify that the greater risk to public health was the failure of the CPSO and other institutions to pivot to policies that permitted individual risk-benefit analysis with informed consent.

c. The Kulldorff Retweet

91. For the Kulldorff Retweet[58], the ICRC found that it was "irresponsible and careless" on the basis that testing, contact tracing and isolation are the core components of federal and provincial efforts to flatten the curve of infection and thereby reduce deaths from Covid-19, and that for these efforts to be successful, it is essential that members of the public recognize their own responsibility to protect themselves and others by adhering to public health restrictions and recommendations.

92. This finding of fact is perhaps less egregious than the others, but the point of the Dr. Kulldorff's comment (and Dr. Gill's retweet) was that these measures *could never be successful.* As Dr. Kulldorff, then a Harvard epidemiologist and infectious disease specialist said, these measures are "ineffective, naïve and counter-productive". Accordingly the ICRC's assumptions, on which it founded a caution against Dr. Gill, started from an invalid premise.

d. Finding facts without evidence was ultra vires & unreasonable

93. The ICRC performs a screening function. It does not make findings of disputed fact and is not required to resolve every factual dispute through additional investigation or, for that matter, in its reasons. Neither does it make findings of professional misconduct. Rather, it investigates concerns and determines whether they warrant a referral to discipline or other, less intrusive, responses. [59]

94. Particularly in a case involving speech in the public square on issues of scientific controversy, the ICRC is not entitled to adjudicate the merits. Unlike in *Peterson*, where the ICRC was only concerned

[58] ICRC Decision, p. 5-6 [CPSO Record of Proceedings, p. 554-555].
[59] *Geris v. Ontario College of Pharmacists*, 2020 ONSC 7437 (CanLII) (Div. Ct.), at para. 32.

with tone and choice of language used by the notorious public intellectual in his tweets,[60] here, while the Committee did address the manner of presentation (e.g. stating opinions "unequivocally"), it went further to critique the content and merit of the tweets, and further still to substituting its own opinions on matters of scientific dispute. This was well outside of its proper scope—the ICRC cannot do this.

95. Nor can the ICRC simply create the evidence on which it then relies. In *Fingerote*,[61] the Committee made a determination that there was "no clinical reason for a physician conducting such an examination to rest his or her hand or arm anywhere on the patient's body." Yet there was no expert evidence before it to make this finding, and it had rejected the doctor's explanation, despite recognizing that it could not make findings of fact. The Divisional Court, in quashing the decision, noted that the Committee seemed to have relied upon some medical knowledge—perhaps the members who were doctors—but a tribunal's expertise is not a substitute for evidence. The Court recognized its duty to defer to the Committee's findings, but the lack of evidence could not stand:

> I am not re-weighing the evidence weighed by the Committee, "I am searching for its existence". I can find none. The decision cannot meet a reasonableness standard predicated on transparency and intelligibility. Therefore, the decision cannot stand and is set aside.[62]

96. Although this was a case involving an interim suspension, the principle is applicable here. The ICRC ignored or failed to engage properly with the Dr. Gill's evidence, and substituted its own "evidence" which it presented as fact on questions going to the crux of their decision (whether the tweets were "misinformation" or lacking in professionalism). It should similarly be quashed.

C. The ICRC Breached Dr. Gill's Right to Procedural Fairness

97. Making findings of fact takes the ICRC out of the role of a "screening committee" and into one where the *Statutory Powers Procedure Act* would otherwise apply. It purported to exercise a statutory power to make a decision prescribing the privileges and duties of Dr. Gill (to practice without a public

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[60] *Peterson*, *supra* note 41, para. 71 & 72
[61] *Fingerote v. The College of Physicians and Surgeons of Ontario*, 2018 ONSC 5131 (Div. Ct.) ("***Fingerote***"), at para. 22 & 23.
[62] Ibid, para. 34

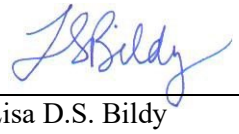
censure on her permanent record). This affects her legal interest to protect her reputation and her liberty interest in exercising her freedom of conscience and expression. Accordingly, procedural fairness was required and was denied.

98. By substituting its own factual findings on matters of scientific dispute, the ICRC breached Dr. Gill's right to procedural fairness. The Committee had three choices: i) it could have grounded the caution on Dr. Gill's alleged lack of professionalism in the presentation of her opinions, or adhered to its own test of determining whether there was any evidence to support the tweets, such that it could be said that they were not verifiably false; ii) it could have declined to act; or iii) it could have sent the matter to the disciplinary committee for a determination of whether Dr. Gill's statements were, in fact "misinformation". That was the proper role of a screening committee. Instead, it played the role of an adjudicative body, which breached Dr. Gill's right to procedural fairness and due process[63] to such a substantial degree, and with such a significant impact on the Decision, that the Decision cannot stand.[64]

PART IV — ORDER REQUESTED

99. The Applicant requests that this application be allowed and that the Decision be quashed.

ALL OF WHICH IS RESPECTFULLY SUBMITTED this 7th day of December, 2023.



Lisa D.S. Bildy
Counsel to the Applicant

[63] Having regard to the *Baker* factors, as summarized in *Vavilov*, *supra* note 6, at para. 77: (1) the nature of the decision being made and the process followed in making it; (2) the nature of the statutory scheme and the provisions of the legislation under which the decision-maker operates; (3) the importance of the decision to the individuals affected; (4) the legitimate expectations of the person challenging the decision; and (5) the choices of procedure made by the decision-maker "particularly when the statute leaves to the decision-maker the ability to choose its own procedures, or when the agency has an expertise in determining what procedures are appropriate in the circumstances".

[64] *Dr. Luay Ali Al-Kazely v. College of Physicians and Surgeons of Ontario*, 2022 ONSC 44 (CanLII) (Div. Ct.), at para. 48.

SCHEDULE "A" - LIST OF AUTHORITIES

Jurisprudence

1. *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65 (CanLII), [2019] 4 SCR 6532

2. *Canadian Centre for Bio-Ethical Reform v Grande Prairie (City)*, 2018 ABCA 154 (CanLII)

3. *Peterson v. College of Psychologists of Ontario*, 2023 ONSC 4685 (CanLII) (Div. Ct.)

3. *Baker v. Canada (Minister of Citizenship and Immigration)*, 1999 CanLII 699 (SCC), [1999] 2 SCR 817

4. *Doré v. Barreau du Québec*, 2012 SCC 12 (CanLII), [2012] 1 SCR 395

5. *Loyola High School v. Quebec (Attorney General)*, 2015 SCC 12 (CanLII), [2015] 1 SCR 613

6. *Young v. College of Nurses of Ontario*, 2022 ONSC 6996 (CanLII) (Div. Ct.)

7. *Geris v. Ontario College of Pharmacists*, 2020 ONSC 7437 (CanLII) (Div. Ct.)

8. *Fingerote v. The College of Physicians and Surgeons of Ontario*, 2018 ONSC 5131 (CanLII) (Div. Ct.)

9. *Dr. Luay Ali Al-Kazely v. College of Physicians and Surgeons of Ontario*, 2022 ONSC 44 (CanLII) (Div. Ct.)

Secondary Sources

1. Hon. Stephen Goudge, K.C., "*Report: Streamlining the Physician Complaints Process in Ontario*" (February 9, 2016)

SCHEDULE "B" - STATUTES AND LEGISLATION

1. *Health Professions Procedural Code*, being Sched. 2 of the *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18, s. 26:

What a panel may do

26 (1) A panel, after investigating a complaint or considering a report, considering the submissions of the member and making reasonable efforts to consider all records and documents it considers relevant to the complaint or the report, may do any one or more of the following:

1. Refer a specified allegation of the member's professional misconduct or incompetence to the Discipline Committee if the allegation is related to the complaint or the report.
2. Refer the member to a panel of the Inquiries, Complaints and Reports Committee under section 58 for incapacity proceedings.
3. Require the member to appear before a panel of the Inquiries, Complaints and Reports Committee to be cautioned.
4. Take action it considers appropriate that is not inconsistent with the health profession Act, this Code, the regulations or by-laws. 2007, c. 10, Sched. M, s. 30.

Prior decisions

(2) A panel of the Inquiries, Complaints and Reports Committee shall, when investigating a complaint or considering a report currently before it, consider all of its available prior decisions involving the member, including decisions made when that committee was known as the Complaints Committee, and all available prior decisions involving the member of the Discipline Committee, the Fitness to Practise Committee and the Executive Committee, unless the decision was to take no further action under subsection (5). 2007, c. 10, Sched. M, s. 30.

…

Complaint in bad faith, etc.

(4) If the panel considers a complaint to be frivolous, vexatious, made in bad faith, moot or otherwise an abuse of process, it shall give the complainant and the member notice that it intends to take no action with respect to the complaint and that the complainant and the member have a right to make written submissions within 30 days after receiving the notice. 2007, c. 10, Sched. M, s. 30.

Same

(5) If the panel is satisfied, after considering the written submissions of the complainant and the member, that a complaint was frivolous, vexatious, made in bad faith, moot or otherwise an abuse of process, the panel shall not take action with respect to the complaint. 2007, c. 10, Sched. M, s. 30.

2. *Health Professions Procedural Code*, being Sched. 2 of the *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18, s. 75(1):

Investigators

75 (1) The Registrar may appoint one or more investigators to determine whether a member has committed an act of professional misconduct or is incompetent if,

(a) the Registrar believes on reasonable and probable grounds that the member has committed an act of professional misconduct or is incompetent and the Inquiries, Complaints and Reports Committee approves of the appointment;

(b) the Inquiries, Complaints and Reports Committee has received information about a member from the Quality Assurance Committee under paragraph 4 of subsection 80.2 (1) and has requested the Registrar to conduct an investigation; or

(c) the Inquiries, Complaints and Reports Committee has received a written complaint about the member and has requested the Registrar to conduct an investigation. 2007, c. 10, Sched. M, s. 53.

3. *Canadian Charter of Rights and Freedoms*, Part 1 of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11, s. 2:

Fundamental freedoms

2 Everyone has the following fundamental freedoms:

(a) freedom of conscience and religion;

(b) freedom of thought, belief, opinion and expression, including freedom of the press and other media of communication;

(c) freedom of peaceful assembly; and

(d) freedom of association.

DR. KULVINDER KAUR GILL -and-	**COLLEGE OF PHYSICANS AND SURGEONS OF ONTARIO**	
Applicant	Respondents	Court File No. 221/21

ONTARIO
SUPERIOR COURT OF JUSTICE
(DIVISIONAL COURT)

PROCEEDING COMMENCED AT TORONTO

FACTUM OF THE APPLICANT, DR. KULVINDER KAUR GILL

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