Justice Centre
for Constitutional Freedoms

March 16, 2020 **Sent by E-mail to** [redacted]

College of Physicians & Surgeons of Nova Scotia
Professional Conduct Department
Suite 400-175 Western Parkway
Bedford, NS B4B 0V1

Attention: [redacted], Investigations Lead

Dear Ms. [redacted]:

RE: Dr. Christopher Ross Milburn

The Justice Centre for Constitutional Freedoms has been retained by Dr. Christopher Milburn with respect to a formal complaint filed against him, dated January 17, 2020, by lawyer [redacted] and 13 others (the "**Complaint**").

Dr. Milburn has provided his responses to the specific allegations, which we detail in Part II below in his own words. Legal submissions follow in Part III.

Part I – Executive Summary

On November 16, 2019, Dr. Milburn, an Emergency Department ("**ED**") physician in Sydney N.S., wrote an opinion piece for The Chronicle Herald. In the wake of two special constables being convicted of criminal negligence for the death of a drunk man being held in custody, Dr. Milburn opined that while police and jail guards should be held to a high standard, they should not be held to an impossible one. He noted the deleterious effects on already over-taxed EDs of the necessity of police and guards bringing some of the most "wild-behaving and impaired" people to the ED for medical clearance.

Dr. Milburn's piece was read widely, and many people, both within and outside the profession, expressed support for his views both publicly and privately. A number of others spoke out against his views. Various letters to the editor were written which showed a split in public thinking on the matter – some were critical of what they perceived to be his dismissive attitude toward those with addiction issues; still others were grateful for his comments as being a breath of fresh air.

To respond to his critics, Dr. Milburn wrote a rebuttal piece on Nov. 27 in which he confirmed that he has no hesitation to provide appropriate care to any patient, 'criminal' or not, and noted the 'soft bigotry of low expectations' exhibited by one of his detractors, a criminal defence lawyer, in her article critiquing his opinions.

A piece was also written by his wife, Dr. Julie Curwin (a psychiatrist) on the same day, in which she defended her husband but went on to address concerns about 'victimhood culture' and the bigotry of low expectations from the perspective that both are, in fact, psychologically unhealthy for the 'victim'.

A compilation of letters to the editor on Nov. 30, under the headline "Milburn op-eds stoke serious debate about personal responsibility" showed how the public appreciated the opportunity to discuss the issues, despite opinions being divided. Indeed, matters unfolded exactly as they should have in a free and democratic society – opinions on all sides were publicly aired, including by one of the complainants, [redacted], and important discussions on questions of public policy were had.

Unfortunately, that wasn't the end of the matter. On January 17, 2020, a group of 14 activists, led by a Halifax lawyer, filed a formal complaint against Dr. Milburn with the College of Physicians and Surgeons of Nova Scotia (the "**College**"), seeking to censure and threaten the livelihood of Dr. Milburn merely for expressing opinions with which they disagreed.

On behalf of Dr. Milburn, the Justice Centre respectfully requests that this Complaint be dismissed in accordance with section 89 of the *Medical Practitioners Regulations – Medical Act (Nova Scotia) (*the "***Regulations***"), on the following grounds:

i) the Complaint is an abuse of process;

ii) Dr. Milburn's actions do not constitute professional misconduct or conduct unbecoming, or merit a caution;

iii) sanctioning a physician for expressing an opinion in the public sphere is contrary to the fundamental freedoms protected under section 2(b) of the *Canadian Charter of Rights and Freedoms* (the "***Charter***"); and

iv) such an infringement of s. 2(b) of the *Charter* would not be reasonable and demonstrably justified in a free and democratic society.

Should the Complaint not be dismissed at this stage, we seek leave of the Registrar to permit the publication of the Complaint pursuant to s. 46(2)(d) of the *Medical Act*, SNS 2011, c. 38 (the "***Act***"), as being necessary and consistent with the objects of the College to govern the profession in the public interest.

Part II – Dr. Milburn's Response In His Own Words

A. Summary of Involvement with the Complainants

I have had no involvement with any of the complainants, nor have I even met them. They appear to be a group of activists who object to my opinion. Several seem to reside outside Cape Breton, where I practice emergency medicine.

B. Written Response to Concerns Raised by the Complainant

While I will respond individually to some of the issues raised in this Complaint, I wish to be clear that I see this primarily as an issue of freedom of expression. What is at stake here is not the content of my recent editorial, nor whether my word choices offended certain people, but whether the College of Physicians and Surgeons of Nova Scotia wishes to go down the road of policing the social and political opinions and word choices of its members. As far as I am aware, this has never been the role of the College.

In a 2017 article for *Psychology Today Canada*, social psychologist Dr. Lee Jussim describes the emergence of a "New McCarthyism" characterized by "Intimidation. Harassment. Censorship. Blacklisting." Unlike the original version of McCarthyism (defined in the Oxford dictionary as, *"a campaign or practice that endorses the use of unfair allegations and investigations"*) the new version is led primarily by left-wing academics and "social justice" advocates. I would respectfully submit to the College that this describes the backgrounds of most, if not all of, the signatories to this Complaint. Their goal has little to do with providing better care to patients in the emergency department, and much to do with silencing someone they perceive as having opposing political views. To be blunt, I believe this is a witch hunt by left wing activists who are attempting to silence someone whose views they perceive as 'incorrect'.

Although dissenting opinions were expressed (and published) in response to my editorial letter, the overall reaction to my published letters and interviews was overwhelmingly positive.

As Steve Bartlett, the senior managing editor of the Saltwire Network of newspapers, which includes the Chronicle Herald, said of my opinion piece in an editorial entitled *"ER doc's commentary reaches hundreds of thousands:"*

> Wherever you fall on what he said, Milburn sparked an important discussion and introduced the public to concerns they may not have considered. It shows the real value of the opinion section, that it's a forum for people to express fears about an issue they feel is wrong or to trumpet something that's going right. I hope that Milburn's piece prompts decision-makers to pause and see if there's a way to make the system or policy better for all—patient, physician and police. If there's no such remedy, at least they considered the issue. I also hope Milburn's commentary prompts others to share their systemic or societal concerns through the opinion sections of our newspapers and websites. Fostering such discussions and provoking thought to make our communities better are important parts of what we do.

Feedback from my colleagues on the front lines of health care and the criminal justice system was likewise almost universally positive. I received letters of thanks from across the country and beyond. The initial letter to the editor was shared extensively on social media. Some colleagues indicated that they were actually in tears when they read my first letter, stating that they felt as if they'd been given a voice for the first time. They expressed relief that someone was finally raising these uncomfortable issues, which they perceived

as urgently needing to be addressed. Disturbingly, almost all said they felt unable to speak publicly on these issues for fear of precisely the kinds of reprisals represented by this Complaint. Some feared losing their jobs if they spoke openly.

Interestingly, Dr. Trevor Jain, an emergency physician in Charlottetown, expressed very similar views in an article published a few weeks after mine in the Charlottetown Guardian. My wife, Dr. Julie Curwin, also wrote a follow-up letter to the editor which explains some of the deeper philosophical issues underlying this cultural debate. She too received overwhelmingly positive feedback and many letters of thanks.

As a custodian of limited resources, my job is to be concerned for ALL of the patients under my care—including those in the waiting room—and to ensure that we do not expend excessive resources on any one individual or group at the expense of others. I have to balance my concern and care for the patient at hand with the needs of all the other patients under my care, including those I have yet to see. I have to be concerned with the 100, not with the 1.

Those who do not work in acute medicine with limited resources (i.e. the signatories of the letter) do not understand that there is no such thing as certainty in our business. Dr. Sam Campbell describes this well in a follow-up article when interviewed about my opinions, and when expressing his own. As the follow-up article states, “But Campbell said the overall pressure on emergency medicine in Nova Scotia has reached a crisis point. He sympathizes with the frustrations of frontline doctors like Milburn.”

Physicians cannot, and are not expected to, be correct 100% of the time. Every child with a cold may develop a pneumonia or meningitis by the next day. But admitting them all for observation would overwhelm our system within a few hours. We assess as best as possible, and make a decision about care based on probabilities, not certainty. Caring for those in custody (violent or not) is the same. We cannot be 100% certain that they will be safe after discharge. But this is true of all our patients. Should we be held to a HIGHER standard with those in custody? Or just a reasonable standard that we are held to with every patient? The result of what [redacted] et al. are suggesting is that our critically limited supply of active ED beds would become a *de facto* jail. This would result in other patients suffering from serious or life-threatening medical problems receiving poorer care. Who would the complainants suggest we allow to suffer longer? Who will we place at higher risk? The elderly man with pneumonia? The teenage girl with suicidal depression? The febrile infant? The middle-aged man with a bowel obstruction? Would the complainants volunteer the bed (or the priority of treatment) of their own child or elderly relative for this purpose? I would respectfully suggest that the complainants may indeed have a great deal of empathy for the disadvantaged, but know absolutely nothing about what it means to be a compassionate emergency physician in Nova Scotia.

As Dr. Jain notes in his article, if we are to recruit and retain ED physicians and nurses and keep rural emergency departments functioning, we must take workplace safety seriously and we must ensure that front-line healthcare workers feel as if their opinions and concerns are being heard. As Dr. Jain noted, staff morale is low and the increasing

prevalence of (and perceived tolerance for) workplace violence is one of the major contributors to this. The complainants imply that ED staff should be willing to tolerate violence and harassment, and that my own statement that I was not willing to tolerate being assaulted was indicative of a lack of compassion. (I was, in fact, told by some of the people who disagree with me on these issues that being assaulted is “just part of the job.”) Again, I respectfully disagree. Any lawyer who is assaulted by a client would not tolerate it or consider it "part of the job". Any accused who spit on a judge would face assault charges. The expectation that front-line workers should absorb gross mistreatment by patients and accept it as routine is a factor driving them out of emergency medicine. We face a critical shortage of emergency staff across Canada, and in my area in particular it is not an exaggeration to say that the system is crumbling before our eyes. Violence and disrespectful behaviour towards staff (which the complainants imply we should consider normal) is a large factor in this breakdown.

To be clear, the issue is not that people in custody are treated differently than any other population (as above, we do not detain every child with a fever in the ED, even though there is a small chance they might go on to develop meningitis) but that the societal expectations around outcomes in this population are not realistic. Lack of cooperation with assessment (history and physical both) makes caring for these patients even more difficult, and limits the accuracy of our decision-making. We do our best, which is our job. I have never given a patient in custody any less than the best care possible, and never any less than any of my colleagues give. If the college would like a letter from police, jail guards, and our ED staff to support that statement, I am happy to provide one.

If a person *not* in custody refused to cooperate with diagnostic procedures and treatment recommendations, they would rightfully be seen as being at least partially responsible for any bad outcome they experienced. People in custody have the same rights, but also the same responsibilities as anyone else. My opinion (as suggested in my editorial) is that this is not the case in our current political climate, and those who care for people in custody are increasingly being held to an impossibly high standard. People are free to disagree with this opinion, but I believe it is a reasonable one and it is certainly one shared by the great majority of my coworkers and by Dr. Jain, whom I do not know personally.

Furthermore, I never once stated that I felt people in custody were less deserving of care, only that they make themselves more difficult to care for. Some patients in custody are completely compliant and we can care for them exactly as we would anyone else. But frequently their behaviours present unique challenges that put the safety of other patients, as well as front-line staff, at risk. These are facts—uncomfortable for the complainants, but facts nevertheless. The complainants seem to believe that pointing out these challenges constitutes “stigmatization” and therefore should not be discussed openly. I would suggest that perhaps they should spend some time talking to people who work in our EDs, and who have their own stories of being assaulted, threatened or harassed by this population. I would also direct them to read Dr. Jain's article, which outlines similar concerns.

Referring to Patients as the 'Criminal Element' or 'Criminals'

The complainants claim that I used "stigmatizing language" in my letters. They specifically take issue with the word "criminal." They do not provide any real evidence that the word "criminal" is stigmatizing. Rather, it seems that they have appointed themselves arbiters of "correct" language and set out to police the speech of others.

It goes without saying that when an individual is brought into the ED by police or corrections officials, I do not refer to them as "criminal." I refer to them by their name ("Mr. Jones"), the same as I do with any other patient, and I treat them with the same respect. My use of the word "criminal" in my letters to the editor was meant in the generic sense, to describe a group of people I interact with via the "criminal" justice system, and who engage in lawless and assaultive behaviour in the ED. It is hard to write an accurate editorial if one cannot use the term that actually means what one is trying to say, for fear that perhaps someone has decided that this term is no longer politically acceptable.

Failure to Cite Evidence in Support of Claims

The complainants further contend that I am not qualified to talk about infectious disease transmission (via spitting) because I am not an infectious disease specialist or an epidemiologist. This is akin to implying that only a respirologist is entitled to talk about the link between smoking and lung cancer. Indeed, the lay public is generally aware that diseases can be transmitted via saliva—hence parents' and coaches' admonition to children to avoid sharing water bottles. Our hospital has many infection control protocols dealing with "droplets" (i.e. saliva and phlegm). As a clinical teacher and associate professor in the Dalhousie Faculty of Medicine for the last 16 years, I would expect a medical student in their 3rd or 4th year during their EM rotation to have a basic understanding of infectious disease vectors (including the dangers involved in aerosol/saliva transfer) as well as a basic grasp of the epidemiology of infectious disease. Since being spit on does happen occasionally in the ED, understanding the dangers of this type of occurrence is essential for an any ED physician or trainee.

None of the complainants has ever, to my knowledge, worked in an Emergency Department, so they may not be aware that many of the patients brought in by police and corrections officials have been injured through involvement in physical altercations, motor vehicle accidents, self-injury, falls, or injuries sustained during resisting arrest. There is a significant incidence of bleeding from the mouth and facial area as a result of these injuries, which may be minor and hidden (a bitten tongue, a small lip laceration) or relatively serious and obvious (a broken nose, lost teeth, deep orofacial lacerations.) As such, when these patients spit at staff, they are at risk not only of transmitting the usual diseases contained in saliva but also bloodborne pathogens such as HIV, hepatitis B and hepatitis C.

Diseases that can be transmitted by saliva directly include (but are not limited to) tuberculosis, herpes simplex 1, Epstein-Barr virus, streptococcal infections, influenza, viral meningitis, cytomegalovirus, measles, mumps and rubella. In addition, several newly

emerging diseases such as those caused by novel coronaviruses (including SARS, MERS and the newly identified Covid-19 coronavirus) are transmissible by saliva transfer (thus the massive restrictions currently being implemented on social contact worldwide). The latter (Covid-19) is of particular concern given that, as of the time of this writing, has been elevated to a pandemic and has killed many thousands worldwide, including numerous front-line health care workers.

Many of these pathogens place front-line health care and law-enforcement workers at risk for serious disease, disability and death. However, even pathogens which are generally viewed as “not serious” such as HSV 1 can be harmful when spitting is the vector. Although I was not involved in the care of this patient, I am aware of a case in which a prisoner spit into the eye of a law enforcement officer who subsequently developed HSV1 keratitis and lost the vision in that eye due to corneal damage. Furthermore, pathogens such as rubella and CMV, while not generally associated with significant disease in healthy adults, can cause serious birth defects should a pregnant health care worker be exposed to them. Since many of our ER nurses and physicians work throughout their pregnancies, this too is a serious concern in the ER setting.

I have more-than-typical experience with patients in custody and the disease burden they carry. Again, if they care to educate themselves, I can recommend a number of good references to the complainants, but it is beyond argument that patients in custody have FAR greater odds than a member of the general public of carrying concerning infectious diseases. While rates of many of the above-named pathogens are not specifically known in the criminal and IV drug using populations, Corrections Canada data indicate that in the Canadian prison population (which has a great deal of overlap with the population I'm referencing): 1) overall health is poor, 2) vaccination rates are comparatively low, and 3) certain infectious diseases are markedly more common than in the general population. These include tuberculosis, HIV, hepatitis C and B, and various sexually transmitted infections. As someone who worked in the federal prison system earlier in my career and a long-time ERP, I am well aware of these statistics.

Obviously the detailed explanation provided here was beyond the scope a short letter to the editor of a newspaper, but for a group primarily composed of lawyers and social justice activists to imply that I don't have the expertise to speak about the issue of infectious disease transmission—or that doing so implies a lack of humility because I am not an ID specialist or an epidemiologist—is absurd, and underscores the frivolous and vexatious nature of this Complaint.

Furthermore, if the complainants believe that my comments are “contrary to accepted views of the profession” I would invite them to provide evidence of this or, alternatively, to survey my colleagues in emergency medicine, who, almost without exception, support my views. Again, I can have a letter signed by the vast majority of my ED colleagues (and those outside of ED work). Most support my view fully. There is a chilling side to the word "accepted" however as used above. Does "accepted" mean reasonable, arguable, majority, evidence-based, or does it mean "a view that the complainants find acceptable"? It seems to be the latter.

As to my ability to comment reasonably on social and criminal issues, if sociologists and criminologists were the only people permitted to comment, our public discourse on important issues would be sadly limited. Indeed, [redacted] one of the signatories to this Complaint, would not have been qualified to write the rebuttal letter to my first letter to the editor, which was published [redacted] a short time later. [redacted] did not provide any evidence for her opinions—nor would I expect her to do so in an opinion letter to the editor of a newspaper. I am merely pointing out the hypocrisy of the complainants' claims. If they are going to be consistent in their policing of public discourse by physicians (for an alleged requirement that evidence must be cited) perhaps they should also lodge a complaint against [redacted] and her co-author. Furthermore, if they believe one must be an expert to comment on such issues, they should perhaps consider the fact that they, themselves are making claims about the practice of emergency medicine - a subject they clearly know very little about. If the College takes this claim seriously, they will take on a new role of policing and arbitrating every opinion that a physician expresses publicly that someone may disagree with. There are certainly opinions of [redacted] that I highly disagree with that she has stated publicly. I would have never dreamed of lodging a complaint, but the fact that the College has even entertained this Complaint opens that door. And perhaps next they should complain about Dr. Jain? And there are other physicians who have written controversial editorials on issues like the need to criticize Islam, etc. Should the College review all of these?

I made it clear during all of my interactions with the media that the opinions expressed were my own and that I did not have any "inside" information regarding the case involving the death in custody of Mr. [redacted]—nor did I wish to discuss the details of it. This case stimulated, but was not the focus, of my much more general argument. The only relevance of that particular case (as it was reported in the media) is that it made me and my coworkers feel vulnerable. We work within severe limitations in emergency medicine in Nova Scotia and we perceive increasingly unrealistic expectations being placed on us. Should a nurse who is late to check a patient because she was dealing with a second critical trauma patient go to jail if that first patient dies?

[redacted] et al. quoted me out of context with respect to the TV interview, in which a reporter asked me specifically about comments made by Mr. [redacted] mother, who had been very vocal in the media in condemning the officers charged in her son's death—as she was certainly entitled to do. I don't think it shows a lack of compassion on my part to suggest that there are no winners in this tragic situation and that we should have compassion for *all* involved. Ironically, the convicted jail guards are now "criminals" themselves, but I suspect that [redacted] et al. have no compassion for them despite their compassion for other criminals.

In closing, I trust that the College does not wish to go down the slippery slope of policing the political and social opinions and word choices of its members. I am confident that the College will see this Complaint for what it is and dismiss it outright.

Thank you for your consideration.

Part III – Legal Submissions

On behalf of Dr. Milburn, we submit that the Complaint against him should be dismissed on the following grounds, pursuant to section 89 of the *Regulations.*

A. Abuse of Process

This Complaint was filed by a group of individuals who disagree with Dr. Milburn's views on a matter of public debate, and seek to penalize him for holding them. They have never met nor worked with Dr. Milburn, have never seen him treat a patient, and did not seek to discuss the issue in person with him. Despite having no connection to him or his practice of medicine, their complaint has initiated discipline proceedings with his professional regulator in furtherance of their own political motives.

The College is tasked with keeping patients safe and regulating the profession in the public interest, and not with giving social justice activists a tool for 'cancelling' people with whom they do not agree.

To permit this Complaint to go forward is to endorse an abuse of process by complainants engaging the professional disciplinary process in bad faith.

B. No Evidence of Professional Misconduct or Conduct Unbecoming

It is respectfully submitted that the Complaint does not allege facts that, if proven, would constitute professional misconduct or conduct unbecoming, or would merit a caution.

1. General

"***Conduct unbecoming***" is defined in section 2(f) of the *Act* as "conduct outside the practice of medicine that tends to bring discredit upon the medical profession."

Pursuant to section 2(aj) of the *Act*, "***professional misconduct***" includes such conduct or acts in the practice of medicine that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional and that, without limiting the generality of the foregoing, may include breaches of

(i) the Code of Ethics approved by the Council,
(ii) the accepted standards of the practice of medicine, and
(iii) this Act, the regulations and policies approved by the Council.

The complainants allege that Dr. Milburn's opinion pieces, along with a related CTV interview, constituted "professional misconduct" or "conduct unbecoming" by virtue of his public communications not being compatible with the best interests of the public, or upholding the reputation of the medical profession. In the alternative, they allege, these opinion pieces and interview violate the College's professional standard on public communications.

No legal authority is provided by the main complainant, who is a lawyer, for any of the following propositions:

> i) that Dr. Milburn's communications fell below the applicable standard for public communications by physicians;
>
> ii) that, if they did fall below the standard, this would constitute "conduct unbecoming" or "professional misconduct" as defined under the *Act*;
>
> iii) that, despite the public communications not being made in connection with a specific physician-patient relationship, they could nonetheless be considered "conduct or acts in the practice of medicine".

The cases cited by the complainant to support the proposition that a physician's comments could constitute professional misconduct were not at all similar to Dr. Milburn's thoughtful opinion pieces. Indeed, there appear to be no reported cases involving censure for opinions in the public sphere before the College.

The complainants cite *Re Ezema*, 2018 CanLii 105365 (NS CPS), where Dr. Enyinnaya Ezema made inappropriate comments on a number of occasions to one of his colleagues in the workplace. While discussing a mutual patient with another work colleague, he put his arms around her and ran his tongue around her lower lip while holding on to her.

Such a case has no comparison to Dr. Milburn's opinion pieces and to equate them only highlights the vexatiousness of this complaint.

Going further afield, the complainants cite *Ontario (College of Physicians and Surgeons of Ontario) v. Wright* 2018 ONCPSD 19, "where inappropriate comments were made by a physician to other physicians in social media chats". [redacted] the main complainant, does not elaborate on the nature of these comments, but leaves the impression that the case is somehow an authority for the proposition that Dr. Milburn should be penalized for his opinion pieces.

Dr. Wright, by comparison, admitted to the following conduct:

- After befriending women in a Facebook group, Dr. Wright would immediately send numerous messages to them. The original messages were about shared issues from the Facebook groups (generally "progressive" feminist issues). In the messages, Dr. Wright referred to his status as a psychiatrist in Ontario and discussed therapeutic techniques and mental health issues in a general manner.

- Dr. Wright then rapidly sexualized the conversations, engaging in online sexual relationships in a lewd manner. This included sending the women naked pictures of himself, including his genitalia, and encouraging them to send him naked pictures of themselves, including their genitalia. He engaged in repeated, explicit

> and graphic intimate and online sexual behaviour with multiple women at the same time. When one of the women got upset with him about his continued sexualization of their discussions, he replied "No one is responsible for another's feelings. Cardinal rule in my line of work."

Once again, [redacted] has introduced a completely unrelated, egregious fact situation involving sexual misconduct to support the proposition that mainstream opinions he does not like should be grounds for professional discipline of a respected physician, who is often sought after by the media for his perspective and commentary.

Finally, the complainants cite *Strom v. Saskatchewan Registered Nurses' Association*, 2018 SKQB 110, where a nurse made specific comments relating to specific care providers on her public Facebook page in criticizing the care a relative received. The tribunal noted that the nurse had failed to voice her concerns about a specific patient through proper channels, and is thus a very different fact situation to that of Dr. Milburn. The matter is under appeal to the Saskatchewan Court of Appeal.

There is no evidence or legal precedent to support the complainants' allegation that Dr. Milburn's comments violate the professional standard on public communications, nor that they bring any sort of discredit upon the medical profession. They are simply communications that a group of community activists do not like, as they threaten their political narrative. It is not for the College to decide which political and policy perspectives are permitted to be held and expressed by physicians.

2. Referring to Patients as the "Criminal Element" or "Criminals"

The Complaint also took issue with Dr. Milburn's reference to certain patients in the ED being of the "criminal element" or "criminals", which they suggest was not only outside his scope of practice, but may constitute a breach of the physicians' Code of Ethics as being harmful to the patient-physician relationship. His use of "stigmatizing language" is not in the best interests of the public, the complainants say, and does not uphold the reputation of the medical profession.

Dr. Milburn has addressed this in his statement. In our society, we have a "criminal justice system", "criminal lawyers", and a "Criminal Code", all of which sit on a foundation of due process and a presumption of innocence. Using the word "criminal" in general to refer to people who have been arrested by police is in no way inappropriate. Dr. Milburn was referencing a problem that is impacting EDs across the country, as pressures increase on police and jail guards to avoid medical calamities in their custody. To point out the problems associated with bringing drunk, violent, drugged or otherwise challenging prisoners through busy EDs is an opportunity to address what has perhaps become an unworkable policy. Many readers of Dr. Milburn's columns, including doctors, agree – although thanks to people like the complainants and their vocal opposition to any sort of typically-conservative personal responsibility narrative, they are afraid to speak up.

There is no evidence for the proposition that making a general statement about this situation had any impact on any patient, nor that there was any sort of physician-patient relationship that was specifically referenced, or that could attract censure.

The complainants argue that the use of “stigmatizing language” shows a lack of three of the virtues exemplified by the ethical physician, namely i) compassion; ii) commitment to respect for persons; and iii) non-discriminatory treatment.

It should be noted that there is another virtue of equivalent standing: the virtue of honesty. This commends a physician who is “forthright, respects the truth, and does their best to seek, preserve, and communicate that truth sensitively and respectfully.” The search for truth cannot be undertaken without the fundamental freedoms guaranteed under the *Charter* which these complainants seek to infringe.

3. Failure to Cite Evidence in Support of Claims

In an ironic turn, the complainants take issue with the lack of evidence provided by Dr. Milburn to support his claims, other than “20 years working in emergency departments”, but provide no evidence of their own. The Complaint alleges that the Code of Ethics requires a physician to uphold the virtue of humility and not to overstep the limits of their knowledge. They are also to provide opinions that are “consistent with the current and widely accepted view of the profession when interpreting scientific knowledge to the public.”

This was not a case of a physician standing up against the tide of accepted scientific understanding without evidence. This was a case of a physician expressing an opinion on a matter of public policy that was grounded in his personal experience as an emergency room physician.

4. Comparing the General Public to Nazis and Portraying Physicians as a Persecuted Group

The Complaint also goes on at length about the inappropriateness of Dr. Milburn ending his initial piece with a twist on the Pastor Niemöller quote, “First they came for the jail guards…” The complainants suggest over a space of about three pages that Dr. Milburn has some sort of persecution complex.

Dr. Milburn selected a common rhetorical device to emphasize his point – that as an emergency room doctor, he too risked abuse and liability for dealing with challenging and sometimes violent patients brought in for medical clearance, and that he felt a duty to speak up about the impact on emergency care that this practice engenders. It is a passage that is commonly used by all kinds of people to make the point that vigilance is necessary to protect freedoms. It is respectfully submitted that the complainants are grasping at straws to turn Dr. Milburn’s good faith commentary into a weapon against him.

C. Infringement of Freedom of Expression

The complainants disingenuously note that “none of the foregoing should be taken to suggest that physicians cannot or should not write op-eds or contribute to public policy debates,” but they evidently believe that those op-eds should only favour one side of the debate.

The appropriate response of the complainants would have been to write a piece, or several, in response – challenging Dr. Milburn’s views as was done in the Complaint itself. Indeed, there were several such responses written, including one by complainant, [redacted]. This is how ideas are presented, debated, dismissed, or affirmed in a free and functioning democracy.

To attempt to have Dr. Milburn professionally disciplined for his political opinions and commentary on a matter of public interest and policy amounts to bullying. To condone this sort of behaviour is to encourage more of the same.

A finding of professional misconduct or conduct unbecoming for the expression of opinion on a matter in the public sphere would be contrary to the fundamental freedoms protected under section 2(b) of the *Charter.* That section provides that:

> s. 2. Everyone has the following fundamental freedoms: (b) freedom of thought, belief, opinion and expression…

Physicians are not excluded.

Freedom of expression is of fundamental importance to democracy. As was noted by the Supreme Court of Canada in *Ford v. Quebec AG* [1998] 2 S.C.R. 712 at paragraph 56.

> Various attempts have been made to identify and formulate the values which justify the constitutional protection of freedom of expression. Probably the best known is that of Professor Thomas I. Emerson in his article, "Toward a General Theory of the First Amendment" (1963), 72 *Yale L.J.* 877, where he sums up these values as follows at p. 878:
>
> > The values sought by society in protecting the right to freedom of expression may be grouped into four broad categories. Maintenance of a system of free expression is necessary (1) as assuring individual self-fulfillment, (2) as a means of attaining the truth, (3) as a method of securing participation by the members of the society in social, including political, decision-making, and (4) as maintaining the balance between stability and change in society.

Dr. Milburn’s goals in expressing his opinion serve these values. To punish and therefore effectively prohibit the type of commentary that was being offered by Dr. Milburn would be to prevent doctors from participating in political discussion at all.

In *Klein v. Law Society of Upper Canada* the rules of the governing body for lawyers prohibited members from contacting the news media on matters in which they were involved in a professional capacity. In addressing a challenge to the rule based on s. 2(b) of the *Charter*—which was ultimately successful—the court said:

> [143] A lawyer has a moral, civic and professional duty to speak out where he sees an injustice. Furthermore, lawyers are, by virtue of their education, training and experience, particularly well-equipped to provide information and stimulate reason, discussion and debate on important current legal issues and professional practices: see Rule 12. Speech of this kind surely lies at the core of the constitutional right guaranteed by s. 2(b). Rule 13, Commentary 18, restricts such right. Again, a client's interest in many situations and, more particularly, a client's freedom of expression may be legitimately served by having his lawyer initiate contact with the news media. The effect of this Rule is to prevent or impede the client through his lawyer from exercising his constitutionally-guaranteed right. In addition, the public has a constitutional right to receive information with respect to legal issues and matters pending in the courts and in relation to the profession and its practices. This right is substantially impaired by the said Rule in that it significantly restricts the right of the press and other media to offer — and the right of the public to receive and discuss — information of important public issues relating to the law and the operation of legal institutions. **A threat of discipline by one's governing professional body is a grave and weighty one which will substantially restrict the willingness to speak out on matters of public interest.** The effect of the Rule, in my view, is to impair the right of the lawyer, client and the public to disseminate and receive information to an extent which greatly exceeds any legitimate legislative or regulatory purpose of the respondent Law Society. **This Rule, in my view, will have an unjustifiable chilling effect on the exercise of the freedom of expression.** Even lawyers who do not "initiate" contact with the news media or who "initiate" contact for a purpose will be dissuaded from exercising their freedom of expression as the Law Society itself has taken the position that:
>
> ... any interview with the media about court proceedings invites the inference that it was given to publicize a lawyer and carries the danger of being a contempt of court. The Society intends to institute discipline proceedings where appropriate to ensure that the Rule is observed. [Emphasis added.]

Similarly, physicians like Dr. Milburn have opinions and views which are not only his right to express, but the public's right to hear.

Although the right to freedom of expression is not absolute, any infringement of s. 2(b) of the *Charter* must be justified under s. 1 thereof as reasonably necessary in a free and democratic society. This is not, and should not, be an easy threshold, and it is submitted that any penalty under the circumstances of this case would be a blatant violation of 2(b) which cannot be so justified.

D. Confidentiality

Should the Complaint not be dismissed at this stage, we seek leave of the Registrar to permit the publication of the Complaint pursuant to s. 46(2)(d) of the *Act*, as being necessary and consistent with the objects of the College to govern the profession in the public interest.

This is a novel case. There are few similar matters which have been fully adjudicated. If the College intends to prosecute Dr. Milburn for his speech, it is in the public interest that this be disclosed. There are no patient interests to protect, as was the intent of the confidentiality provisions in section 46. The Registrar has the power under this section to "disclose information with respect to a complaint for purposes of administration of this Act or to comply with the objects of the College." It is submitted that this is an appropriate case in which to exercise this power.

Part IV – Conclusion

Democracy requires the freedom to engage with challenging issues through the airing of ideas, regardless of how controversial or even offensive they may be to some.

As an institution created by statute, the College is bound by the *Charter* and may not restrict the content of lawful expression. Further, the College is legally obligated to uphold, as part of freedom of expression, the right of citizens to hear and consider all views and perspectives. Section 2(b) of the *Charter* protects the right to receive expressive material as much as it does the right to speak.

As articulated by the Supreme Court of Canada, freedom of expression "was entrenched in our Constitution…so as to ensure that everyone can manifest their thoughts, opinions, beliefs, indeed all expressions of the heart and mind, however unpopular, distasteful, or contrary to the mainstream." The *Charter* describes this protection as fundamental "because in a free and democratic society" such as Canada, "we prize a diversity of ideas and opinions for their inherent value both to the community and the individual."

Finally, Dr. Milburn is an emergency room physician and we are on the cusp of a pandemic. Attempting to have him removed from his position, or causing him the stress of possible censure, over his policy views is an abuse of the complaints process. We therefore request your prompt resolution of this matter.

All of which is respectfully submitted.

Lisa D.S. Bildy, JD, BA
Staff Lawyer, Justice Centre for Constitutional Freedoms

Tel: [redacted]
Fax: 587.352.3233
Email: [redacted]
"Defending the constitutional freedoms of Canadians"