

ONTARIO

SUPERIOR COURT OF JUSTICE

**B E T W E E N:**

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THE CHILDREN’S AID SOCIETY OF	)	Judith Hupé, for the Applicant
OTTAWA-CARLETON	)	
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	)	
Applicant	)	
	)	
- and -	)	
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	)	
M. C.	)	No one appearing
	)	
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Respondent	)	
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	)	<b>HEARD:</b> May 30, 2008

2008 CanLII 49154 (ON SC)

**MÉTIVIER J**

**DECISION**

[1] This matter came before me on an urgent basis on May 30, 2008 when the CAS sought authorization to comply with the medical recommendation of palliative treatment only for a child the Society had apprehended at birth.

[2] Briefly stated, this “crack baby” weighed 1.8 pounds at birth. He had a major brain hemorrhage. His blood pressure was either dangerously high or dangerously low; he had blood sugar levels which required injections of insulin in his heel every two hours. He had a serious heart abnormality which required cardiac surgery and so he was transferred to the Children’s hospital of Eastern Ontario. His weight was 1.6 lbs. at the time of the hearing.

[3] The child was in distress and the doctors were recommending termination of treatment rather than the surgery he needed. The mother of the child was aware of his condition but had not returned to the hospital despite repeated communications with her.

[4] I rendered an initial, oral decision on that day. I authorized the CAS to consent to such treatment by way of the following endorsement:

The Society is authorized to consent to treatment in the best interests of D., including the withdrawal of such treatment.

[5] The transcript of my oral reasons is in the Continuing Record.

[6] Given the importance of the question, I undertook on that day to write a more fulsome decision and I now do so, notwithstanding that the matter has become moot, as I have learned that the child died shortly after the May 30<sup>th</sup> date.

[7] The issue raised is whether the authority granted to the CAS pursuant to the s. 62 (3) of the *Child and Family Services Act, R.S.O. 1990, c. C.11* (CFSA) includes, as part of the definition of the term “treatment”, the authority to consent to a medical decision to withdraw or cease treatment.

[8] Section.62 (3) of the *CFS A* is as follows:

**Court order**

(3)Where a parent referred to in an order made under subsection (1) refuses or is unavailable or unable to consent to medical treatment for the child and the court is satisfied that the treatment would be in the child’s best interests, the court may authorize the society to consent to the treatment.

[9] “Treatment” is considered to be an active positive concept, and would constitute an assault without the requisite consent. However, the withdrawal or withholding of treatment is a different concept and it is unclear whether consent is similarly required.

[10] One of the few Acts to have defined the term ‘treatment’ is the *Consent to Treatment Act, 1992*, R.S.O. 1992, Ch. 31, which was subsequently repealed on March 29, 1996. When in force, that Act defined ‘treatment’ as “anything that is done for a therapeutic, preventive, *palliative*, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment or plan of treatment but does not include a prescribed thing.” [emphasis added] The inclusion of the word ‘palliative’ in that definition points to an understanding that treatment can include efforts to provide pain relief without attempting to cure or actively address the underlying disease.

[11] Unfortunately, there is very little case law in Canada on the meaning of the word ‘treatment’, and there is particularly little discussion of whether ‘treatment’ can include a decision to cease treatment where a patient is terminally ill or has very little chance of survival.

[12] One of the few cases to discuss this issue in some detail is the Manitoba Court of Appeal decision in *Child and Family Services of Manitoba v. R.L.*, [1997] M.J. No. 568. While that decision is not binding on the Superior Court of Justice in Ontario, it provides one of the only Canadian judicial commentaries on the need for consent when withdrawing treatment.

[13] The case involved a three month old infant who was in a vegetative state after having been assaulted. The infant’s guardian had received an order authorizing the guardian to provide a “Do Not Resuscitate” direction to the medical staff in charge of the infant. This order was granted pursuant to s. 25 (3) of *The Child and Family Services Act*, C.C.S.M., c. C80. That section of the Manitoba Act reads as follows:

- s. 25(3) An agency may apply to court for an order...
- (b) authorizing medical...treatment for an apprehended child where
- (i) the parents...of the child refuse to consent to such treatment...

[14] The infant’s parents were opposed to this course of action; they appealed the order and were successful, but only because the Court of Appeal came to the conclusion that whether or not to withdraw treatment was a matter entirely within the doctor’s discretion and such a decision did not require consent from any parties outside of the medical profession.

[15] Twaddle J.A., writing for the Court, explains at paragraphs 13-15 that:

[...] The word ‘treatment’ when used in s. 25 (3) is used only in a positive sense. There is no need for a consent from anyone for a doctor to refrain from intervening.

There is no legal obligation on a medical doctor to take heroic measures to maintain the life of a patient in an irreversible vegetative state. Indeed, the opposite may be true. Consent to the use of heroic measures, they being necessarily intrusive, might technically be required to avoid the intervention amounting to a trespass. The only fear a doctor need have in denying heroic measures to a patient is the fear of liability for negligence in circumstances where qualified practitioners generally would have thought intervention warranted.

He also says:

The question of whether a medical doctor can lawfully direct that resuscitation measures be withheld from a patient has not, as far as I am aware, been considered previously by a Canadian court.

[16] Given the lack of Canadian case law on the issue, the Court of Appeal turned to a few American decisions on point, and cited from the Appeals Court of Massachusetts in *Matter of Dinnerstein*, 380 N.E. 2d 134 (1978). In that case, Armstrong J., delivering the opinion of the Court, noted at p. 139 that:

[The case] presents a question peculiarly within the competence of the medical profession of what measures are appropriate to ease the imminent passing of an irreversibly, terminally ill patient in light of the patient’s history and condition and the wishes of her family. That question is not one for judicial decision, but one for the attending physician, in keeping with the highest traditions of his profession, and subject to court review only to the extent that it may be contended that he has failed to exercise “the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession.”

[17] Twaddle J.A. states that the views expressed in that U.S. decision coincide with the views of the Court of Appeal that the question of how, or whether, to treat a patient in such circumstances is best left to the discretion of medical professionals.

[18] The case at bar involves somewhat different considerations on the facts. The child was not in an irreversible vegetative state as in the Manitoba case, nor were the family's wishes known as in the Massachusetts case.

[19] Nevertheless, his situation was such that the lack of surgery would likely lead to his demise.

[20] After his arrival at CHEO and his evaluation by the cardiac surgeon and others, there was a meeting of all disciplines (nursing, ethics and cardiology). The resulting report included the following::

It is the team's recommendation that palliative care with the goal of providing D. with maximal comfort is both medically and ethically appropriate...

and

... withdrawal of life support...[is] the course most in keeping with D's best interests.

It was also their view that the needed surgery would be invasive and painful.

[21] The facts in this case are similar to the case of *Re L.I.C., Dependant Adult*, [2006] ABQB 130, a proceeding for Advice and Directions by the Public Guardian in Alberta. The latter sought direction as to whether the power given by the legislation to the Public Guardian "to consent to any health care that is in the best interests of the Dependent Adult," includes the authority to consent to the withdrawal of medical treatment or care. It should be pointed out that the *Act* in question defines "health care" as including various procedures and therefore was open to be read "as broadly as necessary to achieve the best interests and substantial benefits purposes of guardianship".

[22] The judge reviewed the relatively few cases on point, including the Manitoba case already referred to and said:

Similar issues have arisen, at least tangentially, in other jurisdictions. *Airedale NHS Trust v. Bland*, [1993] 1 All E.R. 821 (H.L.) involved an application for a declaration regarding the legality of the withdrawal of

life support services for a young man in a persistent vegetative state. The House of Lords concluded that the withdrawal of life support was not illegal without a Court order, but it also held that at least for a time following the decision, applications should be made seeking Court approval. In his reasons, Lord Keith stated: “the decision whether or not the continued treatment and care of a PVS [persistent vegetative state] patient confers any benefit on him is essentially one for the practitioners in charge of his case” (at p. 862).

[23] Still in *Airedale NHS Trust v. Bland*, [1993] 1 All E.R. 821 (H.L.) the Court stated (at page 869):

... the question is not whether it is in the best interests of the patient that he should die. The question is whether it is in the best interests of the patient that his life should be prolonged by the continuance of this form of medical treatment or care.

[24] The judge in *Re L.I.C. (supra)*, having reviewed the legislation under which the Public Guardian operates, found it “broad enough to support the legal authority of the Public Guardian to consent to the withdrawal of life-sustaining medical treatment in appropriate circumstances. He went on to note that the Public Guardian is only authorized to consent to health care “that is in the best interests of the dependent adult”

[25] The CFSA legislation engaged in this hearing has as its paramount purpose “to promote the best interests, protection and well being of children”. While “treatment” is not legislatively defined, I am of the view that the best interests of a child can, in appropriate circumstances, require refraining from invasive treatment or withdrawing medical treatment other than palliative care.

[26] Justice Acton in *Re L.I.C. (supra)* stated the principle correctly in my view when he says that the decision to withdraw or withhold life-sustaining treatment is inherently a medical one, “within the sole purview of a patient’s treating doctors”.

[27] The issue of end of life decisions remains a thorny one.

[28] Very recently, in February of 2008 the Manitoba Court of Queen's Bench in *Golubchuk v. Salvation Army Grace Hospital*, 290 D.L.R. (4<sup>th</sup>), 46 again dealt with a related issue where the hospital wished to discontinue life support while the patient's family refused on religious and other grounds including their Charter rights.

[29] The patient was on a ventilator. The doctors wanted to remove it because they had ethical concerns that further treatment would not benefit the patient and were of the view that they should not be required to do so but should exercise their professional judgment to do what was required. The family obtained an interim injunction to prevent the removal and sought to maintain it until trial.

[30] The judge found there were special circumstances in that case: for example there were religious tenets of the Jewish faith which opposed the removal of the ventilator; there was also a dispute between the family and the hospital as to the patient's cognitive function and level of consciousness; and the respective experts did not argue. Therefore, a trial was necessary to settle these disputes and all the tests for prolonging the injunction were met.

[31] In his reasons, Justice Schulman noted the fact that physical intervention would be required to actually disconnect the ventilator and again if morphine were administered after that to keep the patient comfortable, and therefore he was of the view that consent would then be required.

[32] But he raised difficult questions which remain to be answered in such cases.

- “ – should this issue be resolved by whether the treatment in question is an act of commission or omission? This categorization has proven to be nebulous, unhelpful, elusive and hair splitting.
- should withholding of treatment and withdrawal of treatment be treated the same?
- Does the plaintiff [patient] have a right to continuation of the treatment that is in place, either at common law or under the **Charter**? ”

[33] Following the reasoning in *Child and Family Services of Manitoba v. R.L.*, (*supra*) and *Re L.I.C. Dependant Adult*, (*supra*), as well as *Airedale NHS Trust v. Bland*, (*supra*), in the case at bar, this would mean that while legislative authority has been granted to the CAS to consent to treatment, if the medical practitioners decide or propose to withdraw treatment because they no longer believe that the child has any chance of survival, the CAS does not need to make use of its authority under s. 62(3) of the *CFSA*. Consent is not needed for the doctors to make use of their professional judgment and discretion to cease treatment or give only palliative care.

[34] However, until further clarification of this issue and particularly in cases where the parents of the child disagree or the medical opinions diverge, the CAS should continue to seek an order from the court. As stated by Lord Keith, in *Airedale*, *supra*, at page 862 “Court endorsement of medical decisions can protect the patients and doctors while at the same providing reassurance for both the patients’ families and the public. As well, all interested persons would have an opportunity to be heard.”

**Released:** October 1, 2008

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**The Honourable Madam Justice M. Métivier**