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(Winnipeg Centre)
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COURT OF QUEEN'S BENCH OF MANITOBA

B E T W E E N:	)	COUNSEL
	)	
SAMUEL GOLUBCHUK by his Committee, PERCY GOLUBCHUK and MIRIAM GELLER,	)	Plaintiffs: Neil H. Kravetsky
	)	
	)	Defendant Hospital and Dr. Cowden:
Plaintiffs,	)	E. W. Olson, Q.C., and
- and -	)	Catherine Tolton
	)	
	)	Defendant Dr. Paunovic:
THE SALVATION ARMY GRACE GENERAL HOSPITAL, DR. ANAND KUMAR, DR. BOJAN PAUNOVIC and DR. ELIZABETH COWDEN,	)	Helga Van Iderstine
	)	
	)	Judgment delivered:
Defendants.	)	February 13, 2008

SCHULMAN J.

I. THE ISSUE

[1] The issue before me on this motion is not whether the doctors may disconnect the ventilator and other life support systems for Samuel Golubchuk ("the plaintiff"). It is not whether, in the circumstances of this case, Jewish law prohibits the disconnecting or Jewish law trumps the decisions reached by the doctors. The issue is whether this court should continue until trial the interim injunction granted to the plaintiffs on an emergency basis, without notice to the defendants, on November 30, 2007, that the defendants "are hereby restrained

from removing the plaintiff, Samuel Golubchuk, from life support care, ventilation, tube feeding, and medication . . .". In deciding this question, this court must decide whether it is "just or convenient to do so" (s. 55(1) of the ***Court of Queen's Bench Act***, C.C.S.M., c. C280).

[2] The issue of what is "just or convenient" is rooted in the laws of England going back centuries, long before the invention of ventilators, and became part of the laws of Manitoba when Manitoba became a province in 1870. It is a concept that has evolved over the years. The issue is whether, In February 2008, it is just and convenient to maintain the plaintiff on a ventilator and life supports until the trial of his claim.

[3] In reaching a conclusion on what is just or convenient, this court must place in the balance the answers to the following considerations (***Pereira v. Smith***, [1993] M.J. No. 469 (C.A.)):

> 15 . . . the Court must consider the strength of the plaintiff's case at the same time as it considers the balance of convenience between the parties. The more equal the balance of convenience is, the stronger should the plaintiff's case appear and, of course, if the balance of convenience favours the defendant, the interlocutory relief should be refused.
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> . . . . .
>
> 17 It is to achieve a result on that basis that the undernoted factors should be balanced once the judge is satisfied that damages are an inadequate remedy. I do not list them in order of their importance. Their relative importance depends on the circumstances of the case. The factors are:
>
> (1) The extent to which damages are inadequate as a remedy for the plaintiff, assuming ultimate success;

(2) The extent to which damages, on the plaintiff's undertaking to pay them if unsuccessful at the trial, would be an adequate remedy for the defendant;

(3) The balance of convenience;

(4) The strength of the plaintiff's case;

(5) The desirability of maintaining the status quo;

(6) Any special circumstance.

II. FACTS AGREED TO

[4] The plaintiff is very ill. Since November 7, 2007, he has been a patient in the intensive care unit ("the ICU") at the Salvation Army Grace General Hospital ("the Hospital") in Winnipeg, and he has been hooked up to a ventilator with a tube that has been inserted surgically into his throat. This assists him to breathe or, if the medical evidence is correct, permits him to breathe. He is fed through a tube that has been surgically inserted into his stomach. His brain is functioning, although the extent to which it is functioning is in dispute. He does not speak. He does not ambulate. He suffers from a cardiac condition, as a result of which his heart does not beat properly. His heart condition cannot be improved by inserting a pacemaker. For several medical reasons, he cannot be given a pacemaker. At one point, his kidneys started to fail. They have since plateaued. At several places in their notes, doctors have expressed the opinion that he was dying. Several discussions have taken place between doctors and the plaintiff's children, more about which will be discussed in ¶6 hereof.

[5] The plaintiff's most recent medical problems began in 2003 when, after a fall, he suffered severe brain damage, which affected his physical and mental capacities. On that occasion, he experienced a traumatic closed head injury. In 2005 he underwent brain surgery for removal of part of his temporal lobe. He was a patient at Deer Lodge Care Facility for several years when, on October 26, 2007, he was transferred to the Hospital while suffering from pneumonia and pulmonary hypertension, and as indicated, was later transferred to the ICU.

[6] While the plaintiff was in the ICU his family met with doctors on a number of occasions. The occasions of particular concern on this motion took place between November 20 and 30, 2007. On the first occasion, the physician discussed with the plaintiff's son and daughter his view that the ventilator and life supports should be withdrawn. He had obtained a plan of action from an ethicist, but there is nothing to suggest that the family members were advised of the ethicist's opinion. He concluded the meeting by saying that, if the family objected to withdrawal of the ventilator, they should "contact the unit director, the Chief Medical Officer or the WRHA". On November 20, 2007, the family telecopied a letter to the Chief Medical Officer objecting to the physician's plan to take the plaintiff off the ventilator and made this request: "We would like a copy of the rules in writing and on what grounds they are doing this, so we can show this to our lawyer to take legal action". On November 29, 2007, the family met twice with the director of the ICU, and once with the Chief Medical Officer. The director later telephoned them. At the request of the family, an emergency

physician from another hospital examined the plaintiff and reported his findings to the family and to the director of the ICU. In his report, he made it clear that he had no expertise in ICU medicine.

III. FACT IN DISPUTE

[7] There is an issue between the Hospital physicians and their expert on the one hand and the plaintiff's children and their out-of-province experts on the other hand about the plaintiff's level of consciousness and cognitive function.

[8] The affidavit of the director of the ICU states that the Hospital records show that the plaintiff had a complete loss of consciousness and rarely opened his eyes. Nurses noted that he is unresponsive to stimuli. In his November 29, 2007, examination of the plaintiff, he found him unable to follow simple commands. He stated in his affidavit sworn December 9, 2007:

> 9. . . . . He was then and continues to be non verbal. He does not follow simple commands. He does not respond appropriately to noxious stimuli. He has spontaneous eye opening and reflexive foot and arm movement. He has a reflexive blink to confrontation and has reflexive grasps and foot withdrawal. He is not moving when being suctioned (suctioning excess from lungs via the tracheotostomy and of the oral cavity). Suctioning of the lungs is a very uncomfortable procedure for a patient. A patient with even limited awareness will purposefully attempt to avoid the procedure. He does not. He had doll's eyes intact and his pupil's [*sic*] are reactive, meaning there continues to be some minimal brain function. Specifically his brain stem reflexes remain intact. Brain stem function regulates only the most basic functions such as respiratory effort, blinking, coughing and gagging.
>
> 10. A reflexive blink to confrontation means that when his eyes are opened he will blink to protect his eyes. This is a basic brain function, however he doesn't blink to command or to indicate a level of awareness. His failure to respond to noxious stimuli means that he is not able to react to pain and this again indicates gross neurologic dysfunction. The family describes him grasping their hands. This is what is described

> above as a reflexive grasp. It is not purposeful and he will grasp any object which is put into his hand in a similar manner.
>
> 11. While in hospital his neurological status has not improved.

[9] Members of the family have deposed to having observed a level of cognition on the part of their father, and that their observations have been discounted, or rather, denied, by the defendants. They have produced an affidavit of a neurologist who practises in New York and has reviewed the entire hospital record of Grace Hospital. He has noted an absence of any examination of the plaintiff by a neurologist, any brain-imaging such as with CT scan or MRI, or other measurement of brain activity. He stated that the record contains many references to the plaintiff being awake and making purposeful movements that have not been reported by or explained by the defendants' deponents. He stated that the plaintiff has not been assessed for aphasia, locked-in syndrome or other treatable neurological illnesses, which could account for his apparent lack of consciousness. He concluded on that point:

> 11. Furthermore, according to the documentation in the medical records, Mr. Golubchuk's condition has demonstrably improved (Exhibit "D"). There is no evidence whatsoever that he is brain dead, close to brain dead, or dying, from a neurological point of view. He has enough higher cognitive function to not only be considered awake but to make frequent, purposeful movements and engage in other purposeful activities.

Counsel for the defendant physicians and for the director of the ICU filed in reply an affidavit of a neurologist who practises in London, Ontario, and has reviewed the entire Hospital record. He confirmed an absence of any examination of the plaintiff by a neurologist or CT scan or like equipment. He stated the plaintiff

may well be aphasic, that he makes some purposeful movements, and "occasionally establishes visual fixation and (rarely) follows or tracks with his eyes". He expressed the opinion that CT scan or MRI are not indicated, that the plaintiff does not suffer from locked-in syndrome, and that he is "probably best classified as being in a minimally responsive state, barely above the vegetative state".

IV. POSITION OF COUNSEL FOR THE PLAINTIFF

[10] Counsel for the plaintiffs takes the position that the act of removal of the ventilator and other life supports requires the consent of the plaintiff, that the defendants threatened to remove the ventilator and life supports and this constitutes an assault, and if followed through, would constitute a battery on the plaintiff, which could cause, or at minimum hasten, his death. The refusal to consent and active opposition to the acts in question are based on a genuinely held religious belief. Further, the act of removal is analogous to the act of giving blood against the will of a Jehovah's Witness patient and materially different from writing a Do Not Resuscitate ("DNR") order. He relied on the ***Sawatzky*** case and ***Jin v. Calgary Health Region***, 2007 ABQB 593 to support the grant of the interlocutory injunction sought by the plaintiff.

V. POSITION OF COUNSEL FOR THE DEFENDANT HOSPITAL

[11] Counsel for the Hospital argued that members of the plaintiff's family have not adequately understood the seriousness of the plaintiff's condition; that the

conclusions reached by the doctors conform to reasonable standards of practice; that the withdrawing of medical treatment may be in the patient's best interest even if it means that he will succumb to the underlying illness; that the decision to withdraw medical treatment is that of the physician and not that of the patient or the courts; that the physicians used appropriate principles to be applied in making end-of-life decisions; that, in making "end-of-life" decisions, regard should be given to the dignity, quality of life and levels of pain being suffered by the patient; and that the plaintiff's failure to disclose to the court on November 30, 2007, the fact that they were given and availed themselves of the opportunity to obtain an independent medical opinion and that such opinion tended to support the conclusions reached by the defendants is a proper ground in itself for refusing to continue the injunction. He argued that the ***Charter*** has no application to the circumstances of this case and that, in any event, the plaintiff cannot succeed in a claim based on s. 2, s. 7 or s. 15 of the ***Charter***. He also argued that the role of the court in this case is very limited. The role is limited to determining whether the medical team has the right to make the decision and whether it has taken the appropriate investigative steps.

VI. POSITION OF COUNSEL FOR THE DIRECTOR OF THE ICU

[12] The director owes a duty of care to the plaintiff and not to his family. Throughout his conduct of this matter he has met the standard of care of a physician of like qualifications and experience. Having concluded that further treatment will not benefit the patient, he informed members of the family that he

intended to remove the plaintiff from the ventilator and life supports. The position of the director is that the decision belongs to the physician(s) and that they are entitled to carry it out inasmuch as he has carried out generally the following recommendation of Report No. 109 of the Law Reform Commission of Manitoba entitled, "Withholding or Withdrawing Life Sustaining Medical Treatment":

> - the attending physician should attempt to involve the family early on in the decision making process, providing full and complete information about the nature of the patient's condition, prognosis, and treatment options to provide an opportunity for considered and informed discussion.

Counsel stated that Mr. Golubchuk's family was consulted, advised of the diagnosis, treatment and prognosis from the time Mr. Golubchuk entered hospital and most specifically by both Dr. Kumar (on November 20, 2007) and by Dr. Paunovic (November 29, 2007).

> - a full and complete explanation why the withholding or withdrawal of medical treatment is medically appropriate.

Counsel stated that the evidence is clear that this explanation was provided by both Dr. Kumar and Dr. Paunovic.

> - the discussion should set out prognosis, alternate treatments and the like.

Counsel stated that this was done as above.

> - in the case of disagreement with the family, they should be offered other hospital resources to review the decision.

Counsel stated that the defendants made a consult to an ethicist (on November 15) to review the treatment plan, and advised the family they could discuss their position with the medical director of the hospital.

- The family should be given the opportunity to obtain a second medical opinion.

Counsel stated that after the initial discussion with Dr. Kumar, a second opinion was sought from Dr. Paunovic. Thereafter, a physician of the family's own choosing - Dr. Chochinov - provided a further "second" opinion. She stated further that:

- the family was advised of additional recourse they could have should they continue to disagree, including approaching the College of Physicians & Surgeons of Manitoba and the WRHA;

- the defendants have tried to engage the family in discussion; and

- the defendants have tried to observe family's religious requests.

(motions brief of defendant Dr. Paunovic, pp. 16-17)

VII. THE ROLE OF THE COURT

[13] The role of the court in what is sometimes referred to as end-of-life decisions or cases, but which I prefer to refer to as "critically ill patient" cases, varies from jurisdiction to jurisdiction. In the United Kingdom, by court practice, court approval is required before the treatment can be withdrawn from a patient who is in a permanent vegetative state. In Manitoba, Beard J. stated in the ***Sawatzky*** case:

> 38 While courts and judges do not have any expertise in making medical decisions, they do have expertise in resolving factual disputes and in making legal decisions. In the case of non-consensual medical decisions, be they decisions to provide, withdraw or refuse care or treatment, there is a role for the courts to play in making factual determinations and advising of the legality or illegality of disputed decisions before the patient is dead. The very suggestion that there is the option of a claim in negligence raises the fact that doctors can and,

> on occasion, do make mistakes. Further, many of the decisions that they make are qualitative and there is much room for individual disagreement on the correctness of the decision. Such findings would surely guide the doctor as she/he makes these decisions.
>
> (motions brief of the plaintiff, tab 1)

I find that the court's role is broader than that argued by counsel for the defendant Hospital. I am content to fill the role described in ***Sawatzky***, although there may be cases in the future where our courts will have to consider whether to fill a broader role.

[14] There are two Manitoba court decisions to which counsel for the defendants have referred and which, they claim, support the proposition that the physicians have the right to unhook the ventilator and other life support without first obtaining the consent of the plaintiff or his family.

[15] The first case to be discussed is the decision of the Manitoba Court of Appeal in ***Child and Family Services of Manitoba v. R.L.***, [1997] M.J. No. 568. In that case, a three-month old infant was admitted to hospital after having been the victim of a savage attack. The injuries that he suffered reduced him to a vegetative state from which there was no hope of recovery. The doctors who cared for the infant recommended that a DNR order be placed on his file. The child caring agency that had apprehended the child consented to the order being made. The parents, who were suspects in the case, opposed the making of the order. One might wonder whether the provision in s. 227 of the ***Criminal Code***, which has since been repealed, might have coloured their

motives. The agency applied for an order under s. 25(3) of the ***Child and Family Services Act***, C.C.S.M., c. C80, "authorizing medical . . . treatment for an apprehended child where (i) the parents . . . of the child refuse to consent to such treatment . . .". The Court of Appeal set aside the order that had been granted by a Provincial Court judge on the ground that the word "treatment" as used in the statute means positive treatment and does not contemplate a refraining from intervening. Twaddle J.A. wrote:

> ¶9 The question for us, however, is not whether the infant should be allowed to die, but whether s. 25(3) of the Act permits a court to authorize the placement of a "Do Not Resuscitate" direction on a child's chart. To understand that question properly, one must understand why authority for medical treatment is necessary.
>
> ¶10 The treatment of a patient, whether surgically, with drugs or by other intrusive means, involves a touching of the patient's person. Unless done with the consent of the patient, such a touching would ordinarily amount to an assault. To avoid such a possible consequence, the patient's consent to treatment is usually sought. Such consent may be implicit in the patient's submission to the treatment, but is usually sought in writing for the more intrusive procedures.
>
> . . . . .
>
> ¶13 It follows, in my opinion, that the word "treatment" when used in s. 25(3) is used only in a positive sense. There is no need for consent from anyone for a doctor to refrain from intervening.
>
> . . . . .
>
> ¶15 The question is 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 . . . .
>
> (emphasis added)

After quoting from a Massachusetts decision, Twaddle J.A. concluded that:

> ¶17 . . . neither consent nor a court order in lieu is required for a medical doctor to issue a non-resuscitation direction where, in his or her judgment, the patient is in an irreversible vegetative state. Whether or not such a direction should be issued is a judgment call for the doctor to make having regard to the patient's history and condition and the

> doctor's evaluation of the hopelessness of the case. The wishes of the patient's family or guardians should be taken into account, but neither their consent nor the approval of the court is required.

[16] In ***Sawatzky***, an adult patient who had Parkinson's disease, resided in Riverview Centre. When the patient's health deteriorated, the doctors placed a "Do Not Resuscitate" order on his file without consulting his family. The patient and his wife sued for an injunction restraining the doctors from implementing the order. Beard J. stated:

> 26 Based on the case law to date, the courts have stated that a decision not to provide treatment is exclusively within the purview of the doctor and is not a decision to be made by the courts. Thus, it appears that the courts would not interfere with a medical decision not to provide treatment. . . . There is only one case from a Canadian court, being the *L. (R)*, [*CFS v. R.L.*] decision and that case did not consider either effect of rights under the *Charter of Rights and Freedoms* (the *Charter*) or the Manitoba Human Rights Code, CCSM, c. H175.
>
> . . . . .
>
> 29 . . . I am satisfied that there are meritorious issues to be tried in this case and that the application is neither frivolous nor vexatious. It is, however, difficult to comment on the strength of that case, given that the plaintiffs and the MLPH are raising issues that have not been litigated before. It is true that, in many instances, the courts have recognized or developed new rights under the *Charter*. Whether this is one of those cases will have to be determined after a trial and a full examination of the law.

In the circumstances of the case, Beard J. granted the injunction.

[17] In 2002, the Manitoba Law Reform Commission, whose function is to inquire into and consider any matter relating to law in Manitoba with a view to making recommendations for the improvement, modernization and reform of law, published a discussion paper on the subject of "Withholding or Withdrawing Life-sustaining Treatment". The discussion paper drew a distinction between the

right to refuse life-sustaining treatment, which is firmly established in Canadian law, and "the right to demand life-sustaining treatment when health care workers have determined that it is no longer appropriate," which "is not recognized by either the medical profession or at law" (p. 1). Having said that the right is not recognized at law, the paper went on to state that, "In fact, there is much confusion in the law" in this area (p. 1) and that there is a lack of clarity in the law in Canada (p. 22). It said that the existence of the former right does not necessarily establish the existence of the latter right. It referred to the ***Sawatzky*** and ***R. L.*** cases to suggest that the right to demand treatment may not exist. Of the ***R. L.*** case, it stated (LRC Report 109, pp. 44-45):

> A number of commentators have relied upon *Lavallee* to support the proposition that a physician has the exclusive authority to make decisions to withhold or withdraw life-sustaining treatment. However, there are a number of reasons why the *Lavallee* decision cannot and should not be applied beyond the specific facts of this case.
>
> *Lavallee* involved a narrow set of facts: a very young child in a persistent vegetative state, who would certainly die and whose parents' reasons for resisting the DNR order were unclear. The Court did not consider either the *Charter* or *The Human Rights Code* (Manitoba) which are relevant to a broader application of the decision.

In a footnote, it referred to a critique of the judgment written by Prof. B. Sneiderman: "'A Do Not Resuscitate Order for an Infant Against Parental Wishes: A Comment on the Case of *Child and Family Services of Central Manitoba v. R.L. and S.L.H.,"* (1999), 7 Health L.J. 205".

[18] Prof. Sneiderman's commentary on the ***R. L.*** case is relevant here. At p. 207, he stated:

> The focus is thus not upon the patient's medical condition nor upon the treatment to be withheld or withdrawn. Rather it is upon the crucial circumstances requiring consent - treatment that involves physical contact with the patient's body. It follows that if there is no such contact, the physician can act unilaterally even if the patient is not vegetative and the treatment refrained from is not cardiopulmonary resuscitation (CPR).

He stated at p. 214:

> . . . In other words, if there is no touching, then consent is not required. If however, a sedating dose of morphine were indicated because the patient might otherwise gasp for breath, then consent would be required. It is true that if the physician did nothing and allowed the patient to suffer needlessly before dying of respiratory failure, then the family could sue for negligence. Still, this scenario sure illustrates the peculiar nature of a ruling that takes the overall treatment plan for a patient and bisects it into treatment, which requires consent, and refraining from treatment, which does not.
>
> (emphasis added)

[19] The discussion paper went on to consider the applicability of the ***Charter*** to this issue. After discussing the cases pro and con whether the ***Charter*** might apply to hospitals when they are engaged in the administration and delivery of health services, it stated (LRC Report 109, pp. 49-50):

> . . . Conversely, in *Eldridge v. British Columbia (Attorney General)*, [[1997] 3 S.C.R. 624], the Supreme Court held that the *Charter* does apply to hospitals when they are engaged in the administration and delivery of health services.
>
> In Manitoba, the publicly funded health insurance plan covers "all services rendered by a medical practitioner that are medically required and which are not specifically excluded by regulation." There is no definition of the term "medically required" and no requirement that health care providers obtain Manitoba Health's approval before undertaking a treatment. Health care providers decide which services are medically required for any given patient which means that they control the patient's access to the publicly funded health care system. As suggested above, health care providers are bound by the *Charter* in exercising this public function.
>
> The *Charter* rights which are most relevant to the provisions of health care services are the right to life, liberty and security of the person (Section 7) and the right to equality before and under the law and to equal protection of the law (Section 15(1)).

> Section 7 protects the right of self-determination in health care and has been described as a fundamental right at common law. This right of self-determination is part of the right to security of the person and encompasses the right to determine what medical procedures will be accepted and the extent to which they will be accepted. The right to decide what is to be done to one's own body includes the right to be free from medical treatment to which the individual does not consent. Section 15(1) of the *Charter* prohibits discrimination on both the listed and any analogous grounds.
>
> *Charter* rights are subject to some limits to ensure that the exercise of rights by one person does not infringe on the rights of another. Accordingly, under section 1, all *Charter* rights are subject to reasonable limits which are "demonstrably justified in a free and democratic society." Section 7 rights are also subject to limits in accordance with "principles of fundamental justice". Limits on the rights of self-determination in health care have been recognized or proposed in the following situations:
>
> - where refusing treatment might endanger the life or health of another person;
> - where the exercise of autonomy might offend public policy; for example, the sale or donation of one's organs while living;
> - consenting to have death "inflicted" (euthanasia or assisted suicide).
>
> Withholding or withdrawing life-sustaining treatment without the patient's consent will violate the patient's right to life and security of the person because the patient may die and is deprived of control over their bodily integrity. The next question to consider is whether the deprivation of this right is in accordance with principles of fundamental justice.
>
> In *Rodriguez*, Justice Sopinka described principles of fundamental justice as those which are vital to our societal notion of justice. The difficulty with recognizing a right to treatment is that it creates a positive obligation on the health care provider. It requires the health care provider to do something that may go against his or her professional judgment. Is a health care provider's right of professional integrity protected by the *Charter*? If there is such a right, then any right to treatment would have to be balanced against it.

[20] The Law Reform Commission circulated the discussion paper and sought input from all segments of the community on a number of pertinent issues. After receiving and analyzing a significant number of responses, the Commission published its report. It referred to the fact that the Winnipeg Regional Health Authority's Principles Related to End of Life Decisions provides that physicians

will consider mediation services if agreement between physician and patient about such decisions cannot be reached. It made five recommendations in order "to provide advice to those bodies and institutions who are formulating end of life policies. . . ." (LRC Report 109, p. 32). Among those recommendations was (p. 33):

> *RECOMMENDATION 4*
>
> *That health care institutions, agencies and organizations across the province assume special responsibility to provide, at their expense, information, advice and assistance to patients or substitute decision makers in respect of all reasonable mediation and conciliation dispute resolution measures, the securing of independent second medical opinions or the transfer of care to other physicians. The dispute resolution measures should include institutional and external mediation and conciliation procedures. The institutions and the most responsible physicians should cooperatively accommodate all reasonable requests by patients or the substitute decision makers for such measures. We are reluctant to stipulate more definitively the nature of the mediation procedures to be used because of the differences in the size, nature and resources of health care institutions across the province.*
>
> (emphasis added)

[21] The Commission concluded its report stating (pp. 33-34):

> It may be argued that even if our recommendations are accepted there is still no legal certainty. There will be no authoritative judicial or legislative ruling and dissatisfied patients and substitute decision makers will continue to litigate disputes that have not been resolved by the contemplated measures. It is our view, however, that the implementation of a transparent and accountable system of end of life medical decision making that is consistent with the recommendations contained herein is likely to be accepted and validated by the courts.
>
> (emphasis added)

[22] In response to a question from this court, an affidavit was filed of the director of the ICU, detailing what steps would be taken if the Hospital were

permitted to discontinue the life support for the plaintiff. The director deposed as follows:

> 3. In the event the ventilator is withdrawn, the process specifically for Mr. Golubchuk and in consideration of Mr. Golubchuk's medical condition, would involve one of two scenarios which could be followed. . . :
>
> a. Either (a physician) or myself would make adjustment on the ventilator to slowly reduce the ventilatory support being received by the patient in order to test whether Mr. Golubchuk would exhibit any discomfort (to the extent he feels any discomfort). Discomfort would be determined by his demonstrating erratic breathing and/or an increase in his heart rate and/or sweating. If that occurred, the patient would normally be given narcotics to ensure his comfort and the ventilator tubing would be disconnected from his tracheostomy tube.
>
> b. In the alternative, if the patient did not exhibit any discomfort when the ventilatory support was turned down, one of us would simply disconnect the ventilator as above and the patient would pass away.
>
> (emphasis added)

[23] Given the facts that the removal of the ventilator probably involves some interaction with the plaintiff's body; that it involves the providing of narcotics over the plaintiff's objection in the sense that, if the ventilator is not disconnected, it will not be necessary to give it; and that removal will lead to the passing of the plaintiff sooner in time than if he remained on the ventilator, what is this court's appraisal of the strength of the plaintiff's case? Is there an issue of law that is material and not frivolous?

VIII. THE STRENGTH OF THE PLAINTIFF'S CASE: ARE THERE ISSUES OF LAW OR FACT FOR TRIAL THAT ARE MATERIAL AND ARE NOT FRIVOLOUS?

[24] A discussion of the legal issue of who has the final say in the event of an impasse between doctors and patient or the patient's authorized representative often turns on a discussion of whether the proposed next step is an act or commission, for example, the giving of a blood transfusion over the objection of a patient, or an omission, for example, the making of a DNR order. Counsel for the plaintiff argued in his brief:

> 2. . . . In the "Do Not Resuscitate" cases, the Defendants propose doing nothing (omission) but this case involves the Defendants actually committing an act that ultimately will end the life of the Plaintiff (commission). . . .

In the context of a critically ill patient case, the categorization in this manner has proved to be nebulous and unhelpful, elusive and hair-splitting (Physician-assisted Suicide: Rights and Risks to Vulnerable Communities: Physician-assisted Suicide: A Common Law Roadmap for State Courts" (1997), 24 Fordham Urb. L.J. 817 at 829-30) and has led courts to perform mental gymnastics to fit whatever is being proposed into one category or the other (***Airedale N.H.S Trust v. Bland***, [1993] 1 All E.R. 821 at 867-68). Some authorities have abandoned this categorization, recognizing that virtually all treatment given to a patient consists of both acts or commissions and omissions. The LRC report refers to treatment, life-sustaining treatment, withholding life-sustaining treatment and withdrawing life-sustaining treatment.

[25] Contrary to the assertion of the defendants, it is not settled law that, in the event of disagreement between a physician and his patient as to withdrawal of life supports, the physician has the final say. In ***Sawatzky***, the court held that there was an untested triable issue relating to the applicability of the ***Charter*** to the actions of the doctors or the Hospital. Even if the ***Charter*** does not apply, common law principles must develop in keeping with ***Charter*** values, which include respect for religious freedom (s. 2(a)) and respect for life and personal autonomy (s. 7), (***Hill v. Church of Scientology of Toronto***, [1995] S.C.J No. 64 at ¶91). Even if ***R. L.*** settles the law with respect to decisions to refrain from treating a patient, it is open to a trial judge to find that the action contemplated in ¶22 of these reasons is a positive act that requires the patient's consent. The decision in ***R. L.*** is distinguishable from the facts of this case. It does not resolve the issue of who has the right to decide whether to withdraw a ventilator that has been put in place. Should this issue be resolved by whether the treatment in question is an act of commission or omission? Should withholding of treatment and withdrawal of treatment be treated the same? Are there are other criteria or factors to be considered? Does the plaintiff have a right to continuation of the treatment that is in place, either at common law or under the ***Charter***? In my view, the resolution of these questions is wide open. They may be decided for the defendants. They may be decided for the plaintiff. The legal questions are not frivolous, and it is also important that they be

decided for the good of the parties and in the public interest, and the sooner the better.

[26] There is also an issue of fact that is relevant and not frivolous. In ¶7-9, I have referred to the differences in the evidence adduced by the parties. Legal issues cannot be decided in a vacuum, and there is an important issue of fact that must be addressed at trial as to the plaintiff's level of cognition and consciousness, and the issue is not frivolous. Having assessed the merits of this case, I must consider and balance the five other factors referred to in ¶3 hereof.

IX. THE EXTENT TO WHICH DAMAGES ARE INADEQUATE AS A REMEDY FOR THE PLAINTIFF, ASSUMING ULTIMATE SUCCESS

X. THE EXTENT TO WHICH DAMAGES, ON THE PLAINTIFF'S UNDERTAKING TO PAY THEM IF UNSUCCESSFUL AT TRIAL, WOULD BE AN ADEQUATE REMEDY FOR THE DEFENDANTS

I find that damages would not be an adequate remedy for the plaintiff in this case. If the plaintiff dies when the ventilator is disconnected and life support cut off, no relief at trial could adequately compensate him or his family for the loss. Further, no mention has been made by counsel for the defendants of damages as a factor in the defendants' position.

XI. THE BALANCE OF CONVENIENCE

[27] If the injunction is continued, it would mean that the physicians might be compelled to continue to treat the plaintiff despite their ethical concerns. If the injunction is continued, the plaintiff may, during his lifetime, be afforded an opportunity to be heard fully on his legal, religious and ***Charter*** positions. In

Sawatzky, Beard J. granted such an injunction, as did Martin J. in the ***Jin*** case. I conclude that the balance of convenience favours the plaintiff. Further, I think that most reasonably informed members of the public would support my finding on the questions of irreparable harm and balance of convenience.

XII. THE DESIRABILITY OF MAINTAINING THE STATUS QUO

[28] The situation today is that the plaintiff is on a ventilator. That is the status quo. The physicians placed the plaintiff in the ICU and on the ventilator, although they complain now that they were talked into it. We must assume that their doing so squared with their ethical obligations at the time. Further, although the physicians now say that their position to withdraw the support is mandated by their ethical obligations, as Beard J. observed in ***Sawatzky*** at ¶31(v): "The treatment does not, in and of itself, raise the same type of ethical problems for the doctor that could be associated with controversial procedures like abortions." The status quo favours the plaintiff's position.

XIII. ANY SPECIAL CIRCUMSTANCES

[29] I find that there is a special circumstance that should be addressed in this case. It concerns what I would call the right that should be afforded to patients who disagree with their doctors to be provided with a written outline of the procedures available to them and an opportunity to have the disagreement addressed with the help of a knowledgeable, trained and objective mediator, who would, in appropriate cases, be chosen from outside the hospital environment, and in an appropriate case, from outside of Winnipeg. Mediation

was strongly recommended by the LRC in its report and, if offered, might have avoided litigation if used in this case.

[30] Counsel for the Hospital filed the following additional materials on this subject: firstly, an article entitled "Withholding or Withdrawal of Life Support: the Canadian Critical Care Society Position Paper," which has a section entitled "Consensus Building". The section concludes with a subsection, "If an impasse remains between the family and the ICU team, there should be recourse to either mediation or adjudication". In addition, the Canadian Medical Association's policy in para. 11-9 states that, "If it is . . . disputed who has the right or responsibility to make the decision, seek mediation, arbitration or adjudication".

[31] It is clear on the evidence that communication broke down between the plaintiff and the physicians. That is not surprising in light of the emotional issue involved. If it were important to assess fault, that could be done at trial. However, based on the experience of judges of this court, mediation of emotion-charged issues can be successful, and the providing of a written outline of the options should be done as a matter of course. There is no evidence to suggest that mediation was available or, if available, was offered as an option in this case. As mediation has not been considered, adjudication by a judge in this court could be appropriate.

[32] I have reviewed all the considerations that were mentioned by Twaddle J.A. in ***Pereira v. Smith*** to be relevant in a motion of this kind. I have found in favour of the plaintiff on each consideration. I have therefore concluded that it is just and convenient to make an order continuing the injunction until a decision is rendered at the trial of this action. This action should proceed to trial as quickly as possible. To ensure that end, I make an order for case management and will make myself available as early as possible to assist the parties in getting the case ready for trial.

[33] At the hearing of this motion for an interim injunction, the plaintiff failed to disclose to the court the fact that the family had called in a physician with experience in emergency room medicine to assess Mr. Golubchuk's condition and to inform the court of his findings. Those facts should have been disclosed, although if disclosed, I doubt that I would have refused the injunction. Courts often dissolve an injunction, on motion by a defendant, for failure to disclose a material fact. In doing so, courts underscore the need, on a without notice hearing, to make a disclosure of all material facts known to the party, and it is intended as a punitive response to the failure to make the required disclosure. In this case, the defendants did not move to set aside the interim injunction. Moreover, an order dissolving the injunction would be disproportionate to the wrong. I am satisfied that this court can satisfactorily deal with the matter when the parties address the costs of the proceeding.

[34] When we reconvened the hearing of this motion on January 11, 2008, in order to permit counsel to make submissions about the admissibility of two affidavits, which were tendered by counsel for the plaintiff, counsel for the defendants drew the court's attention to the fact that the defendant physicians may at some point cease to be involved in the care of the plaintiff and that other physicians may take over. I suggested to counsel for the defendants that they propose a suitable amendment to the injunction to cover the situation. Having heard nothing from them, I make the following orders:

1. that the defendants, Grace General Hospital Facilities Limited, Dr. Anand Kumar, Dr. Bojan Paunovic and Dr. Elizabeth Cowden, are hereby restrained from removing the plaintiff, Samuel Golubchuk, from life support care, ventilation, tube feeding and medication and that, if one or more of the defendants has removed Samuel Golubchuk from such support they are to immediately place him back on life support;
2. that this order is to continue in effect until a decision is rendered after a trial of this action unless, in the meantime, the plaintiff's committee consents to a variation of the order; and
3. that the defendant Hospital take measures to ensure that any physician or other medical personnel involved in care of the plaintiff be aware of the existence of this order, including, without

restricting the generality of the order, that the Hospital attach a copy of this order to the plaintiff's medical chart.

This court has no information as to the names of physicians who may be providing care to the plaintiff at this time or about who may provide the care until the trial of this action. While I cannot make an order against individuals who are not parties to this action, I expect that any physicians and medical personnel who provide care to the plaintiff will comply with the spirit and intent of this order.

J.