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(Winnipeg Centre)
Indexed as: *Alvare v. St. Boniface Hospital Inc. et al.*
Cited as: 2021 MBQB 220

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COURT OF QUEEN'S BENCH OF MANITOBA

B E T W E E N:

	)	Appearances:
GORDON CLIFFORD ALVARE BY HIS	)	
POWER OF ATTORNEY, GRAHAM	)	Matthew T. Duffy,
GORDON MOLYNEUX ALVARE,	)	for the applicant
	)	
applicant,	)	Nicole M. Watson and
	)	Cheryl A. Frost,
- and -	)	for Gregg Matthew Eschun,
	)	Rhys Sharkey, Johann Strumpher,
ST. BONIFACE HOSPITAL INC.,	)	Shelly Zubert, Allan Schaffer and
DR. OWEN THOMAS MOONEY,	)	Aaron Guinn
DR. GREGG MATTHEW ESCHUN,	)	
DR. RHYS SHARKEY, DR. JOHANN	)	
STRUMPHER, DR. SHELLY ZUBERT,	)	Sacha R. Paul and Paula Ethans,
DR. ALLAN SCHAFFER, DR. AARON	)	for St. Boniface Hospital Inc.,
GUINN, DR. CHARLES SCOTT BRUDNEY,	)	Charles Scott Brudney,
CHIEF MEDICAL OFFICER, RHONDA	)	Rhonda Cairns and
CAIRNS, CHIEF NURSING OFFICER,	)	Martine Bouchard
MARTINE BOUCHARD, PRESIDENT AND	)	
CHIEF EXECUTIVE OFFICER,	)	
	)	JUDGMENT DELIVERED:
respondents.	)	October 25, 2021

SUCHE J.

[1] Gordon Alvare is a patient at St. Boniface Hospital ("the Hospital"). He is 84 years old and has end-stage Parkinson's disease and numerous comorbidities. He is bedridden, tube fed and suffers from dementia. Over the last several years

he has experienced respiratory failure on multiple occasions. This has required he be treated in the Intensive Care Medicine and Surgery unit ("ICU") where advanced cardiac life-support ("ACLS") measures including mechanical ventilation can be provided. From the outset of both this admission and during a prior admission at the Hospital, his ICU treating physicians have been of the view that further medical treatment for respiratory failure will not benefit Mr. Alvare, and he should not be resuscitated when this occurs. The common phrase for a patient with this status is "DNR", meaning, do not resuscitate.

[2] The physicians are of the view that Mr. Alvare's illness is terminal, and due to both the extent and degenerative nature of his disease, he will continue to experience respiratory failure, and likely with increasing frequency. Their medical judgment is that ACLS treatment will not provide him with any medical benefit, that is, while it might allow him to survive an immediate situation, it will not improve his condition and will actually cause him further pain and suffering. These procedures are invasive, painful and bring various risks including infection. They are intended to be temporary.

[3] The applicant is Mr. Alvare's son and substitute decision-maker. He is a recently licensed family physician. He disagrees with the physicians' assessment of his father's condition in most aspects. He wants all measures to be taken to prolong his father's life.

[4] These proceedings arise from a letter dated September 17, 2021 from Drs. Mooney and Eschun, being Mr. Alvare's treating ICU physician and the head

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of ICU at the Hospital, respectively. The letter advised that as of 5:00 p.m. on September 21, 2021, Mr. Alvare would not be readmitted to ICU. Thus, ACLS, mechanical ventilation and repeat bronchoscopy would not be offered. The letter stated its purpose was to advise of the decision and "to provide ample time to possibly find another treating physician in an Intensive Care Unit" to take over Mr. Alvare's care.

[5] While the letter, in effect, was the start of the court process, it came at the end of more than a month of Mr. Alvare's physicians attempting to engage the applicant in what they considered to be a medically appropriate care plan for Mr. Alvare. Throughout this time, Mr. Alvare remained on "resuscitate" status.

[6] This application was filed on September 24, 2021. It seeks:

- a declaration that the decision to place Mr. Alvare on DNR status and to refuse him further admission to ICU violates The College of Physicians & Surgeons of Manitoba Standard of Practice regarding withholding and withdrawing life-sustaining treatment ("the Standard"); and
- an injunction requiring the respondents to remove the DNR order and provide all life-sustaining care to Mr. Alvare.

[7] There are some questions regarding procedure followed in this application that made it unclear as to the relief requested. However, the parties argued the matter on the basis that an interim injunction was being requested.

[8] At the outset of the hearing, Mr. Duffy requested an adjournment to allow the applicant an opportunity to find a physician to treat his father and obtain expert

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opinion. This time was required, he argued, because the applicant did not receive his father's complete medical chart until September 29, 2021. Until then, the applicant had only received approximately 320 pages of the total 1,200 pages. He pointed out that since the chart was requested in early August, the Hospital violated its obligation under ***The Personal Health Information Act*** [1] to provide the chart within 30 days.

[9] I denied the request for an adjournment and dismissed the motion with very brief oral reasons. I told the parties I would provide more thorough reasons. I do so now. What I said at the hearing should be considered in conjunction with what I say below.

BACKGROUND

[10] Mr. Alvare was admitted to the Hospital on August 2, 2021. He was assessed as suffering from aspiration pneumonia. The applicant advised Dr. Guinn, the emergency room physician on duty, that he wanted his father to be resuscitated if he went into respiratory failure.

[11] This direction was contrary to an ICU assessment from 2019 when Mr. Alvare was a patient at the Hospital. At that time, the ICU treating physicians concluded he was not a candidate for further ICU admission as he would not benefit from ACLS measures. The applicant did not agree with this. However, his father recovered and was discharged in early 2020. A month later, he was

[1] ***The Personal Health Information Act***, C.C.S.M. c. P33.5.

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admitted to Grace Hospital, again with aspiration pneumonia. He was treated in the ICU and placed on a ventilator. He improved and was eventually discharged.

[12] Because the applicant's direction on this admission was contrary to the 2019 ICU assessment, Dr. Schaffer, an ICU physician, assessed Mr. Alvare. He concluded that given the extent of Mr. Alvare's comorbidities and his severe irreversible neurological disease, he would not benefit from an admission to the ICU.

[13] Mr. Alvare was then admitted to the medicine ward. Dr. Sharkey, the attending physician, told the applicant that ICU had assessed his father and determined he was not a candidate for admission. He advised that he too would not advocate for aggressive resuscitative measures. The applicant disagreed. He said he was planning to pursue legal action if this did not happen. He asked that the ICU team reassess his father.

[14] Acting on that request, the following day, ICU physicians Drs. Schaffer, Strumpher and Zubert assessed Mr. Alvare. They concluded he had an advanced non-curable disease and the aspiration events he had experienced were a natural part of the disease. They did not believe ICU care, that is ACLS measures, would benefit Mr. Alvare. They declined to offer these therapies.

[15] It is important to note that due to the lack of consensus with the applicant regarding the appropriate care for Mr. Alvare, he remained on "resuscitate" status, which would include full ICU response if needed.

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[16] On August 10, 2021, Mr. Alvare went into significant respiratory distress. A respiratory therapist provided deep suctioning, but raised concern that it was causing obvious pain to Mr. Alvare. After several unsuccessful attempts to reach the applicant, Dr. Astell had a discussion with him at the Hospital. Again, the applicant repeated his request to have his father admitted to ICU.

[17] Given the ongoing disagreement about the care plan for Mr. Alvare, Dr. Astell sought the opinion of Dr. Fultz, another ICU physician, and Katarina-Lee Amadurie, a clinical ethicist. Dr. Astell was of the view that intubation and mechanical ventilation would be unsuccessful and worried it may cause further suffering and pain to Mr. Alvare. The clinical ethicist told Dr. Astell that if the decision was made to withhold ICU care over the applicant's objections, the physicians would have to provide 96-hours' notice required by the Standard.

[18] Drs. Astell and Fultz had a two-hour discussion with the applicant at the Hospital that day. The applicant told them that in the past his father had made it clear he wanted all steps taken to prolong his life. He believed his father would be willing to receive life-support despite the risks.

[19] After listening to the applicant's view of his father's situation, Dr. Fultz, with great reluctance, agreed to provide ICU intervention to Mr. Alvare should he suffer further deterioration, but only for a trial of five to seven days. If there were no signs of improvement from the treatment, it would be clear that it was likely to cause greater harm than benefit. In that event, he told the applicant he would be notified in writing as required by the Standard.

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[20] On August 12, 2021, Mr. Alvare suffered severe respiratory deterioration. He was admitted to ICU and intubated for aspiration pneumonia. A bronchoscopy was performed. Dr. Christianson, the respirologist, observed the airways were inflamed and recommended limiting deep suctioning as the area was prone to bleeding. He indicated that the accumulation of secretions, and thus the need for suctioning would continue. Mr. Alvare's community ENT specialist was consulted, and recommended a tracheostomy. This was performed on August 15, 2021.

[21] On August 19, 2021, Mr. Alvare was removed from the ventilator. He was assessed by Dr. Mooney the next day. Dr. Mooney concluded that further admission to ICU would not provide any benefit and would actually do harm to Mr. Alvare. Dr. Mooney was unable to reach the applicant to discuss the situation with him.

[22] Dr. Mooney assessed Mr. Alvare again on August 22, 2021. He remained of the opinion that a return to ICU level interventions would not benefit Mr. Alvare and would only serve to prolong his suffering. He was concerned that further deconditioning, a consequence of mechanical ventilation, would cause Mr. Alvare becoming dependent on the ventilator. As a result, he could not be discharged from ICU.

[23] On August 23, 2021, Dr. Eschun assessed Mr. Alvare and was of the view that recurrent respiratory failure and/or sepsis was inevitable and the trial in ICU had not improved Mr. Alvare's condition.

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[24] A narcotic had been prescribed for Mr. Alvare as those involved in his care observed him exhibiting signs of pain in different situations. It is usual for patients who are on a ventilator, and also following a bronchoscopy, to experience pain. The applicant told the attending nurse that his father was not expressing pain, but boredom.

[25] Dr. Eschun discussed the situation with the applicant on August 24th. He was not able to persuade the applicant that it was in his father's best interest to receive pain medication. The applicant maintained his father would not want analgesics. He withdrew consent to give narcotics, unless his father exhibited the specific expressions the applicant described, and questioned the need for Tylenol.

[26] Mr. Alvare was returned to the medicine ward on August 24th. On August 26, 2021, Dr. Hughes, a neurologist, assessed Mr. Alvare and concluded he had end-stage Parkinson's disease, severe rigidity and bradykinesia, and advanced dementia. His opinion was supportive care only should be provided, as Mr. Alvare's dementia was irreversible and his other symptoms could not be improved substantially. He consulted with Dr. Hobson, who had treated Mr. Alvare, about possible medication, but Dr. Hobson could not offer any suggestions.

[27] On September 10th, Mr. Alvare again experienced respiratory distress. An x-ray showed his right lower lung had collapsed. He received deep suctioning and chest physiotherapy, and improved somewhat. However, on September 13th, his

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left lower lung collapsed. He was admitted to ICU. A bronchoscopy was performed.

[28] Dr. Mooney assessed Mr. Alvare later that day, and concluded the lobar collapses were because of his loss of cough response, which functions to clear his lungs of secretions. While this was part of the disease process, it had significantly worsened after the trial on the ventilator in August.

[29] Dr. Mooney discussed Mr. Alvare's situation with the applicant and told him that therapeutic bronchoscopy would be of little benefit. The applicant disagreed and threatened malpractice and/or wrongful death claims. The applicant was quite upset and according to Dr. Mooney, belligerent. Dr. Mooney concluded he had exhausted all avenues to discuss a care plan for Mr. Alvare.

[30] Dr. Mooney assessed Mr. Alvare again on September 14th. He was unresponsive, and unable to communicate. He was not coughing spontaneously and required frequent suctioning.

[31] At Dr. Mooney's request, Dr. Eschun assessed Mr. Alvare later that day. He was of the opinion that it was inevitable that Mr. Alvare would continue to suffer respiratory failure and/or aspiration because of the advanced stage of his disease. Since the neurologist confirmed it was not realistic to expect any improvement and the trial in ICU did not improve his condition, Dr. Eschun concluded that Mr. Alvare's situation was utterly hopeless and his care plan should focus on comfort and dignity. In his view, Mr. Alvare's diagnosis and prognosis meant that

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providing advanced life-support was medically futile. The invasive nature of these procedures would also cause him unnecessary pain and suffering.

[32] Mr. Alvare was transferred back to the medical ward on September 15th. The next day, Dr. Elise Crocker, the attending physician, met with the applicant to discuss his father's situation. She reviewed the findings and his history at length. The applicant told her his father had documented that he still wished to live. When she said that Mr. Alvare was not responsive, the applicant disagreed. He wanted an assessment conducted in the afternoon, when his father was more responsive.

[33] Later that day, a physiotherapist also assessed Mr. Alvare and concluded the chest physiotherapy treatment had shown no benefit to Mr. Alvare. Therefore, further physiotherapy would not be provided.

[34] Dr. Mooney received a letter from the applicant's lawyer on September 17th. It raised various concerns about Mr. Alvare's care and requested that he be transferred out of Dr. Mooney's care (Dr. Crocker was in fact the attending physician by that time). The letter went on to say that if Mr. Alvare's status was changed to DNR, the applicant would bring an application to this court requiring treatment be provided.

[35] The same day Drs. Mooney and Eschun sent their letter advising ICU treatment would no longer be provided to the applicant, the original was mailed to the applicant's home, and a copy was sent to his work e-mail address. His lawyer was also sent a copy by e-mail on September 19th.

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LEGAL PRINCIPLES

[36] It is long settled in common law that a person does not have the right to compel a physician to provide treatment that the physician believes is medically inappropriate or contrary to professional standards of care. Karakatsanis J. said it well in ***Cuthbertson v. Rasouli***[2] (at paras. 190-91):

> In my view, Canadian courts should assess whether the decision to withdraw life support accords with the physician's standard of care and her fiduciary duty, as well as considerations of patient autonomy and human dignity. In any review, the doctor's medical diagnosis and view of the implications of continued treatment feature prominently. The wishes, values, and beliefs of the patient should be considered; however, they cannot be determinative. A doctor cannot be required to act contrary to her standard of care.
>
> The common law protects the interests of Canadians in the medical realm — whether doctor or patient — by requiring physicians to act (1) in accordance with the conduct of a prudent practitioner of the same experience and standing in her field, including a duty to obtain informed consent (ter Neuzen v. Korn, 1995 CanLII 72 (SCC), [1995] 3 S.C.R. 674; Reibl, at pp. 899-900), and (2) in the best interests of their patients (Norberg v. Wynrib, 1992 CanLII 65 (SCC), [1992] 2 S.C.R. 226, at pp. 270-72). Typically, decisions to provide or to withdraw treatment are made on the basis of medical benefit to the patient. This approach will likely satisfy the standard of care and advance the patient's best interests where the patient's medical condition is the primary concern.

[37] The Standard does not change the common law, but sets out a physician's obligations if they conclude a patient should not be offered life-sustaining treatment, or if currently being given, that the treatment should be withdrawn. Because it is the basis for this proceeding, I quote the portion that applies to the present circumstances:

[2] ***Cuthbertson v. Rasouli***, 2013 SCC 53, [2013] 3 S.C.R. 341.

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3. No Consensus
The minimum [of achieving awareness of self-environment and experience their own existence] goal is achievable, but the physician concludes that life-sustaining treatment should be withheld or withdrawn, and the patient/proxy/representative does not agree and/or demands life-sustaining treatment.

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3.1 Clinical Assessment
There are no specific requirements; the general requirements apply.

3.2 Communication
In this situation, communication is particularly challenging and important. The physician should be aware that careful discussion above and beyond what is generally required may be necessary;

The concerns in these circumstances may not relate to clinical assessment or care and may involve subjective values and judgments regarding quality of life;

When confronted with such concerns, the physician should consider seeking assistance from other members of the health care team and/or religious authorities and/or ethics and/or other consultants.

3.3 Implementation
WHERE THE PHYSICIAN CONCLUDES THAT THE MINIMUM GOAL IS REALISTICALLY ACHIEVABLE BUT THAT TREATMENT SHOULD BE WITHHELD OR WITHDRAWN, that physician must consult with another physician.

1. Where the consultation supports the opposite conclusion, that treatment should not be withheld or withdrawn, the physician who sought the consultation must either provide the treatment or facilitate transfer of care to another physician who will provide the treatment.

2. Where the consultation supports the conclusion that treatment should be withheld or withdrawn:

    a. The physician who sought the consultation must advise the patient/proxy/representative that the consultation supports the initial assessment that treatment should be withheld or withdrawn

    b. If there is still a demand or request for treatment, the physician must attempt to address the reasons directly and with a view to reaching consensus. The physician should consider resolving the conflict by:

i. offering a time-limited trial of treatment with a clearly defined outcome; and/or

ii. involving additional or alternative methods to facilitate a consensus, including, but not limited to, available resources such as a patient advocate, mediator or ethics or institutional review processes.

c. If consensus cannot be reached, the physician must give the patient/proxy/representative a reasonable opportunity to identify another physician who is willing to assume care of the patient and must facilitate the transfer of care and provide all relevant medical information to that physician.

d. Where, despite all reasonable efforts, consensus cannot be reached, the physician may withhold or withdraw life-sustaining treatment, but:

i. In the case of a patient/proxy who is still not in agreement with the decision to withhold or withdraw treatment, the physician must provide at least 96 hours advance notice to the patient or proxy as described below.

3.4 Written Notice

- the notice must be in writing, where possible, and must contain, at a minimum:
- name and location of the patient;
- name of the person to whom notice has been given;
- name, address and telephone number of the physician;
- diagnosis;
- description of the treatment(s) that will be withheld or withdrawn;
- date, time and location at which treatment will be withheld or withdrawn;
- date and time that notice was provided;
- name of the person who provided the notice.

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[38] The applicant argues that Drs. Mooney and Eschun violated the Standard in several respects: they did not consult with him after he received his father's chart, and without having the complete chart, any consultation was not meaningful; they failed to address the reasons for the disagreement, or find consensus in that they did not undertake ethics consultation to facilitate consensus; and, they did not give 96 hours' notice of their refusal to provide ACLS treatment. In this regard, the applicant says he did not see the September 17th letter until his lawyer forwarded it to him on September 19th.

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INTERIM INJUNCTION

[39] The test for an interim injunction is well known. A party seeking such relief must show that:

- there is a serious issue to be tried;
- irreparable harm will result if the injunction is not granted;
- the balance of convenience favours the applicant. That is, the applicant will suffer greater harm if the injunction is not granted, than the amount of harm the respondent will suffer if the injunction is granted.[3]

[40] If the relief sought requires a respondent to actively do something rather than refrain from doing something, the first requirement is more stringent. An applicant must demonstrate a strong *prima facie* case.[4]

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[3] ***RJR-MacDonald Inc. v. Canada (Attorney General)***, [1994] 1 S.C.R. 311.

[4] ***R. v. Canadian Broadcasting Corp.***, 2018 SCC 5, [2018] 1 S.C.R. 196.

[41] Although framed in part as a request to remove the DNR order, the substance of the order sought requires the respondent physicians to provide treatment they refuse to provide. Thus, the relief sought is a mandatory injunction.

[42] There is a line of authority, beginning with the English Court of Appeal decision in ***Re J. (a minor) (wardship: medical treatment)*** [5] that has concluded the standard test for an interim injunction is not appropriate.

[43] Ouellette J. in ***Sweiss v. Alberta Health Services*** [6] discussed this issue at length. Noting that the ***RJR*** test was based on the House of Lords decision in ***American Cyanamid Co. v. Ethicon Ltd.*** [7], he states:

> In *Hubbard v. Vosper* (1971), [1972] 2 Q.B. 84 (Eng. C.A.), at 96, Denning, L.J. stated that the remedy of injunction "must not be made the subject of strict rules." This position was adopted by McLachlin, J.A., as she then was, in *British Columbia (Attorney General) v. Wale* (1986), 9 B.C.L.R. (2d) 333 (B.C. C.A.), at 346, aff'd [1991] 1 S.C.R. 62 (S.C.C.). Writing for the majority, McLachlin J.A. noted the following:
>
> > Having set out the usual procedure to be followed in determining whether to grant an interlocutory injunction, it is important to emphasize that the judge must not allow himself to become the prisoner of a formula. The fundamental question in each case is whether the granting of an injunction is just and equitable in all of the circumstances of the case…
>
> McLachlin J.A.'s comments are particularly instructive on how the *RJR-MacDonald* test is to be applied. In my view, the case stands for the proposition that there need not be strict adherence to a formula, and further, that the fundamental consideration is whether the granting of an injunction is just and equitable in all the circumstances of the case. As a result of the above, I am satisfied that strict compliance with the tripartite test set out in *RJR-MacDonald* is not required in situations where an injunction is sought in the context of medical urgency or crisis.

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[5] ***Re J. (a minor) (wardship: medical treatment)***, [1992] 4 All E.R. 614 (C.A.).
[6] ***Sweiss v. Alberta Health Services***, 2009 ABQB 691, 15 Alta. L.R. (5th) 283.
[7] ***American Cyanamid Co. v. Ethicon Ltd.***, [1975] 1 All E.R. 504, [1975] A.C. 396 (H.L.).

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[44] In ***Re J.***, the lower court had issued an interim injunction requiring life-saving efforts be continued. The Court of Appeal reversed the decision stating as follows:

> Let me say at once that in a matter of this nature there is absolutely no room for the application of the principles governing the grant of interlocutory relief which were laid down by Lord Diplock in *American Cyanamid Co. v. Ethicon Ltd.*, [1975] A.C. 396 408. The proper approach is to consider what options are open to the Court in a proper exercise of its inherent powers and, within those limits, what orders would best serve the trust interests of the infant pending the final decision. There can be no question of "balance of convenience." There can be no question of seeking, simply as such, to preserve the status quo, although on particular facts that may well be the Court's objective as being in the best interests of the infant. There can be no question of, "preserving the subject matter of the action." Manifestly, there can be no question of considering whether damages would be an adequate remedy.
>
> The fundamental issue in this appeal is whether the Court in the exercise of its inherent power to protect the interests of minors should ever require a medical practitioner or a health authority acting by a medical practitioner to adopt a course of treatment which in the bona fide clinical judgment of the practitioner concerned is contra-indicated as not being in the bests interests of the patient.

[45] In ***C. (S.) v. Capital Health Authority*** [8] the court followed the conclusion in ***Re J.***, that the best interest of the patient was the proper approach.

[46] In ***Sweiss***, Ouellette J. agreed with this. He states:

> In my opinion, the proper test to be applied in this type of case in what is in the patient's best interest. This inquiry requires that several matters be considered and weighed. Some of the pertinent considerations include: (i) the medical condition of the patient; (ii) the recommended medical treatment, including doing something, nothing or very little; (iii) the wishes and beliefs of the patient, if they are known; and (iv) what is just and equitable in all of the circumstances of the case. This list does not exhaust the factors which may be[sic] considered in such applications, but rather reflects some of the issues to be considered in determining what is in a patient's best interest. In addition, I wish to emphasize that no factor

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[8] ***C. (S.) v. Capital Health Authority***, 2008 ABQB 250, 90 Alta. L.R. (4th) 322 (ABQB) (sub nom. *I.H.V. (Re))*.

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> should be considered paramount and all considerations ought to receive equal weight.

[47] I agree with this line of authority for the reasons articulated. The appropriate test for an injunction is the best interests of the patient.

DECISION

Adjournment

[48] Before addressing the substance of the request, I wish to elaborate on my decision to refuse an adjournment.

[49] Typically, a request by an applicant for a brief adjournment of their proceeding would be granted. Here, however, the circumstances and history of this situation and the consequences of even a brief adjournment require careful consideration, and also the reason for the request and the value of what might be achieved by same. The lack of evidence regarding these issues caused me to direct the applicant to appear and give viva voce testimony, which he did.

[50] One of the reasons an adjournment was said to be necessary was to allow the applicant to engage an expert to provide an opinion regarding the Standard and whether it was followed. In my view, expert evidence is neither required nor admissible on this issue. The Standard sets forth actions a physician must take. Whether this occurred is a question of fact that the court is capable of determining without the assistance of specialized knowledge. An adjournment for this reason is unnecessary.

[51] As for other experts, the applicant testified that he had not yet consulted anyone. Those he was thinking of consulting were three gerontologists and his

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father's ENT specialist, not critical care physicians. I fail to see the relevance of their expertise and therefore their opinions to the issues before me. Accordingly, an adjournment for this purpose would be of no value.

[52] The most compelling aspect of the applicant's request was his assertion that he wanted time to find an ICU physician in another facility to take over his father's care.

[53] The applicant said he had not yet taken any steps to this end. He agreed that both the September 17th letter and an e-mail from Dr. Mooney on September 21st raised this possibility. However, he thought the suggestion was that he could find another physician at the Hospital, because he believed his father was not medically fit to be transferred. He explained that he wanted to have his father transferred to Grace Hospital. He spoke to Dr. Sharkey, the attending physician, who told him his father was not sufficiently stable. As a result, he did not know his father could be transferred until he read Dr. Mooney's affidavit two days before the hearing. He hadn't had time to make any inquires since then.

[54] In cross-examination, he agreed that, as a physician, he was aware that a patient's condition can change over time, and in fact this was so with his father. Nonetheless, after that conversation with Dr. Sharkey, he never again inquired if his father was well enough to be transferred - even as recently as the night before the hearing when he spoke to his father's attending physician.

[55] The other part of the applicant's explanation for not pursuing the possibility of another physician providing care is that a facility would want to have his father's

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entire chart before accepting a transfer there. He acknowledged, however, that physicians working within the Winnipeg Regional Health Authority have access to a patient's electronic charts and can access them for the purposes of providing care.

[56] That the applicant has not taken any steps towards finding another physician to take over his father's care, particularly given that Mr. Alvare was treated in ICU at Grace Hospital in 2020, is most puzzling. I have to conclude that if the applicant did not realize his father was fit to be transferred until recently it is because he did not want to pursue that possibility. I find his assertion that he wants more time to do this to be unpersuasive.

[57] All of these considerations are relevant because of the consequences of an order, even if for a few days, that Mr. Alvare be provided ACLS treatment should he go into respiratory failure. For the same reasons detailed further on in this decision, I am of the view that it is not in Mr. Alvare's best interests that this happen.

[58] In the end, my conclusion, regrettably, is that an adjournment would not serve any purpose. The evidence sought would not bolster the applicant's case and could not overcome the overwhelming evidence that it is not in Mr. Alvare's best interests to be provided ACLS treatment if he goes into respiratory failure. I turn then to the issues raised on the motion.

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Was the Standard Violated?

[59] As referred to earlier, the Standard creates a process to be followed by a physician when there is disagreement regarding the provision of life-sustaining treatment. Clearly, the primary goal of the Standard is to try and find consensus about the patient's care plan. However, if that cannot be achieved, the Standard sets out the nature, purpose and details of the notice to be given to the patient or their decision-maker.

[60] The Standard does not mandate the steps a physician must take to try to find consensus. It offers suggestions for a course of action. This includes a trial of treatment, which occurred here.

[61] The Standard emphasizes the importance of communication including the need for careful discussion, the fact that subjective values and judgments about quality of life may be present. It suggests consultation with other members of the health care team, or religious authorities or ethics or other consultants.

[62] In this regard, it is worth saying that the physicians involved in Mr. Alvare's care repeatedly attempted to engage the applicant in conversations about the reality of his father's situation. The applicant was usually not available. They left messages on his cellphone, sent messages through Mr. Alvare's caregiver, Michael, who was frequently at the hospital, and had nurses make follow-up calls when he did not call back. On September 10th when Dr. Christianson was trying to reach the applicant because Mr. Alvare was in respiratory distress, Michael told him the applicant was screening his calls, thus in order to speak with him, it would be best

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to use Michael's cellphone. Dr. Christianson asked Michael to convey the message to the applicant that he should return Dr. Christianson's previous call.

[63] I pause to say that this last reference is hearsay, and I must treat it carefully. However, I note it was neither disputed nor was an objection raised during the hearing. As a result, I give it some weight.

[64] My conclusion based on all of what went on in this respect is that the applicant did not want to discuss his father's situation with the physicians, and was actively avoiding them.

[65] It is also the case that, from the outset, and repeatedly, when various physicians (and nurses) did engage the applicant in conversation about his father's condition, he usually threatened to take legal action if his direction was not followed. And to the extent he did discuss his father's care, he often disagreed with the opinions and clinical judgments of the physicians.

[66] It is also worth saying that the evidence shows that the the physicians did not take the decision to refuse ACLS treatment precipitously. As noted previously, despite the assessment of the ICU team on August 2nd and only because the applicant disagreed with it, Mr. Alvare continued on "resuscitate" status for approximately seven weeks. During that time, he was admitted to ICU on two occasions.

[67] I turn to the specific breaches the applicant alleges. I reject the assertion that without having the *entirety* of the chart in his possession, he could not have meaningful discussions with his father's physicians. Aside from the fact this was

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never raised by him in his communication with Dr. Mooney or others, I consider it, if not irrelevant, at least unnecessary to the issues then at hand.

[68] The applicant says he was not given 96 hours' notice, because he did not see the September 17th letter until September 19th. While I accept that this happened, I disagree that it amounts to a breach of the Standard.

[69] In this respect, I observe that the requirement to provide the notice implements a physician's obligation to give reasonable opportunity for the patient to identify another physician to provide care. The wording of the Standard makes it clear that the obligation is to provide notice, not that the patient receive notice. If it were the latter, this could prove to be impossible if the patient decided they did not want to receive notice. Given the circumstances here, one can see how that might happen.

[70] I am satisfied that sending the notice to the applicant at his work e-mail address was reasonable and complied with the Standard. I am also satisfied that the applicant has had a reasonable opportunity to find a physician in an ICU at another facility.

<u>Is an injunction in Mr. Alvare's best interest?</u>

[71] The basis for the application is essentially twofold: the respondent physicians have not met their ethical obligations when implementing a decision to refuse life-sustaining treatment; and Mr. Alvare's condition "does not warrant giving up on his life in the event he requires life-sustaining intervention".

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[72] The plaintiff relies on the decision in ***Sawatzky v. Riverview*** [9] where this court granted an interim injunction requiring the attending physician to return a patient to resuscitate status. However, the facts of that case were very different. There, the attending physician had concluded just ten days or so before the hearing that Mr. Sawatzky's status should be DNR. The decision had not been discussed with his wife, the applicant, at any length in advance. Further, the court found the evidence as to Mr. Sawatzky's diagnosis and prognosis was contradictory and "cried out for some clarification". Beard J. (as she then was) concluded an injunction for a period of weeks was just and equitable in the circumstances.

[73] It is important to note as well that ***Sawatzky*** was decided before the Standard was in place. I was told that in fact, the Standard was developed in direct response to the ***Sawatzky*** and ***Golubchuk v. Salvation Army Grace General Hospital et al.***[10] decided in 2008. Had the procedure in the Standard been followed in ***Sawatzky***, the injunction likely would not have been granted.

[74] Here, evidence that Mr. Alvare will not benefit from the treatment sought is simply overwhelming. Both Drs. Mooney and Eschun attest to this, but it is also clear from the chart that all of the ICU physicians who have treated or assessed Mr. Alvare are of the same view. It is also clear that administering these procedures will cause pain and suffering to Mr. Alvare. I accept that this was the case when Mr. Alvare was treated in ICU. The applicant does not agree that what

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[9] ***Sawatzky v. Riverview Health Centre Inc.***, 1998 CanLII 19469, 132 Man. R. (2d) 222 (MBQB).

[10] ***Golubchuk v. Salvation Army Grace General Hospital et al.***, 2008 MBQB 49, 227 Man. R. (2d) 274.

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the nurses and other treating professionals observed were expressions of pain. I conclude he is simply wrong. The fact that he will not allow his father to receive the narcotics prescribed for pain relief adds to the likely extent of the pain and suffering his father will suffer if these measures are taken.

[75] Dr. Mooney states emphatically that requiring him to provide the requested treatment would force him to violate his primary ethical obligation to do no harm. Given the consensus about the appropriate treatment for Mr. Alvare among the ICU physicians involved in his care, I easily infer that they share this view.

[76] There is no basis in law to require a physician to provide treatment contrary to their medical judgment. The respondents, I am satisfied, have met their ethical obligations in implementing their decision not to provide this treatment. I am satisfied the treatment sought is medically futile and undoubtedly will cause Mr. Alvare further pain and suffering. I do accept, as the applicant has stated on several occasions, that it was and perhaps still is his father's wish to have his life prolonged through any available treatment. However, this is but one consideration and does not override all the others.

[77] All this leads me to conclude that it is not in Mr. Alvare's best interests to receive the treatment requested. In the result, it would not be just and equitable to grant an injunction.

[78] For these reasons, the motion is dismissed.

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Suche J.

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