IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *De Châtillon v. Toma,*
2023 BCSC 1356

Date: 20230803
Docket: S234079
Registry: Vancouver

Between:

Evangeline De Châtillon and Elise Bikus

Plaintiffs

And

Dr. Mustafa Toma, Dr. MacRedmond, Camille Ciarnello and Saint Paul's Hospital

Defendants

Before: The Honourable Chief Justice Hinkson

Oral Reasons for Judgment

Appearing on her own behalf:	E. De Châtillon
Appearing on her own behalf:	E. Bikus
Counsel for the Defendant Providence Health Care Society:	M.L. Perry, L. McLeod E. McGoey, Articled Student
Place and Date of Hearing:	Vancouver, B.C. August 1, 2023
Place and Date of Judgment:	Vancouver, B.C. August 3, 2023

I. OVERVIEW

[1] The plaintiffs are daughters of Leo Edward Bikus, who was born on January 9, 1958. It is accepted that he is incapacitated from providing or refusing consent to his medical treatment, or to the termination thereof.

[2] Section 16 of the *Health Care (Consent) and Care Facility (Admission) Act,* R.S.B.C. 1996, c. 181 [*Act*], sets out the ordered list of persons that can be asked to give substitute consent. First on the list is the person's spouse, and second is the person's child: *Act* at s. 16(1)(a)–(b).

[3] The plaintiffs have indicated that Mr. Bikus has a spouse at the present time, but that they have been separated for over 20 years. As such, the defendants have been relying on Mr. Bikus' daughters to make health care decisions on his behalf. Given that Mr. Bikus is estranged from his spouse, his daughters are next on the list of those entitled to act as his temporary substitute decision makers. As such, they have the duty to refuse or give consent in accordance with Mr. Bikus' best interests with respect to his treatment: *Act* at s. 19(1).

[4] The defendant Saint Paul's Hospital is incorrectly named, and is properly described as Providence Health Care Society. I will refer to it as the defendant hospital.

[5] The plaintiffs contend that their father has shown intermittent increased movement and increasing positive trajectory of consciousness within stages of a coma.

[6] They seek an injunction ordering that the medical staff at the defendant hospital remove "Do Not Resuscitate" signage from their father's room at the defendant hospital, requiring that staff continue the provision of life support treatment of their father, and further testing of their father.

[7] The defendant hospital seeks an order directing that the active medical staff for the defendant hospital be at liberty to discontinue the provision of treatment or other health care services to Mr. Bikus within 24 hours of such order.

II. BACKGROUND

[8] Mr. Bikus experienced a cardiac arrest on May 18, 2023 that left him without a pulse for some 46 minutes. This caused a global anoxic injury resulting in electrocerebral inactivity. After the period without a pulse, he was placed on life support equipment where he remains to date.

[9] Mr. Bikus has had various neurologic assessments since May 18, 2023.

[10] Following the second of these assessments, the plaintiffs were advised that all of Mr. Bikus' clinical and investigational findings were indicative of a poor neurological process and that it was unlikely that their father would regain independent neurological function. The plaintiffs were also told that in the event of clinical deterioration, the defendant hospital would not give escalating care, and that no cardiac resuscitative procedures would be performed given that the harm to their father from such treatment would outweigh the potential benefits. The recommendation from the treating physicians to the plaintiffs was that life-sustaining therapies be withdrawn.

[11] The plaintiffs questioned the assessment of their father's condition, and on June 2, 2023, filed a notice of civil claim, seeking an order requiring the defendant hospital to continue life-sustaining treatments and allow a three-week time extension to enable them to obtain what they described as an unbiased and independent review of their father's circumstances from professional neurologists.

[12] On June 8, 2023, the plaintiffs filed a notice of application seeking the relief set out above: an injunction against the defendants to prevent physicians at the defendant hospital from withdrawing all life-sustaining therapies for their father.

[13] The defendant hospital's application was filed on June 20, 2023, and came on for hearing before Justice Ker on July 7, 2023. At that hearing the plaintiffs produced a video file of their father on July 4, 2023, which they asserted demonstrated "cortical responses", representing that he is in fact becoming conscious and has an upward trajectory of healing. Ker J. declined to interpret the video as proposed by the plaintiffs and adjourned the application to permit the plaintiffs to obtain a medical opinion to support their views.

[14] On July 17, 2023, the application again came on for hearing, this time before Justice MacNaughton, who again adjourned the defendant hospital's application to permit the plaintiffs to obtain a medical opinion to support their contentions. No such opinion has been produced.

[15] The parties came back before me on July 28, 2023. The plaintiffs indicated that they needed time for their chosen expert, neurologist Dr. Donald Cameron, to review Mr. Bikus' medical records and provide another opinion. I, again, adjourned

the hearing of the applications until August 1, 2023, to give the plaintiffs time to procure Dr. Cameron's opinion. This opinion was never secured.

[16] To facilitate his review of Mr. Bikus' condition, the defendant hospital gave Dr. Cameron hospital privileges which would allow him to attend at St. Paul's Hospital to review Mr. Bikus' records. Dr. Cameron neglected to do so. I understand that there were also issues in the defendant hospital's transfer of the records to Dr. Cameron; however, this does not excuse Dr. Cameron's failure to review the documents at the hospital and provide an opinion.

[17] The plaintiffs asked that I adjourn the hearing for a fourth time to allow them to secure an independent medical opinion. Given the circumstances, I am unwilling to grant this order. While it is regrettable that Dr. Cameron did not review the documents at the hospital for unknown reasons, I am satisfied that I can decide the applications based on the medical evidence before me.

III. MEDICAL EVIDENCE

[18] On May 18, 2023, Mr. Bikus collapsed while getting out of bed. His heart had stopped and he had to be resuscitated at the scene by paramedics. It was later determined that Mr. Bikus suffered a ST Elevation Myocardial Infraction type heart attack. Two of Mr. Bikus' heart vessels were occluded with clots. His heart muscle was also severely weak and it was unable to carry oxygen throughout his body. That same day Mr. Bikus underwent an angioplasty and was admitted into the Cardiac Intensive Care Unit at St. Paul's Hospital. Mr. Bikus has been unresponsive since he was admitted to the defendant hospital.

[19] Dr. Toma, a cardiologist that attended to Mr. Bikus, in his affidavit of June 8, 2023, indicated that two CT scans of Mr. Bikus' head were conducted:

a) the May 19, 2023 scan showed early anoxic brain injury; and

b) the May 21, 2023 scan showed progressive worsening of gray-white differentiation.

[20] Dr. Toma also deposed that it was his understanding that progressive worsening of gray-white differentiation is "predictive of a poor neurological outcome for patients who have experienced cardiac arrest."

[21] Dr. Toma also affirmed that Mr. Bikus was assessed on May 20, 2023, and showed minimal responsiveness. His pupils responded to light, but he had no cough, gag, or corneal reflexes and he showed no response to painful stimuli.

[22] Three doctors offered their neuroprognostication opinions regarding Mr. Bikus' likely prognosis:

a) On May 21, 2023 Dr. Morency, a neurology resident, wrote in her consultation note that the repeat CT scan was "not reassuring". However, it was too early to make a definitive prognosis. Dr. Morency recommended repeating the CT scan in 48 hours, considering an EEG test, and continuing to monitor Mr. Bikus.

b) Following an EEG on May 23, 2023 Dr. MacRedmond, an intensivist, wrote in a consultation note that the: "EEG showed global suppression with no discernible electrocerebral activity. This is a highly malignant pattern predictive of poor neurological recovery." She opined that Mr. Bikus' best prognosis was "profound neurological impairment" with no functional recovery or chance for independent living.

c) On May 24, 2023 Dr. Peets, offered a second opinion to Dr. MacRedmond's assessment. Dr. Peets' assessment was that Mr. Bikus' best case scenario was again one of "profound neurological impairment" meaning "completely dependent or persistently unconscious."

[23] Following these various consultations, Dr. Toma and others met with Mr. Bikus' daughters to inform them of the results. Drs. Toma and MacRedmond recommended removing life-sustaining therapies on May 23, 2023. Dr. Toma again recommended the same on May 26. The plaintiffs opposed this recommendation.

[24] Throughout June 2023, Mr. Bikus continued to be assessed and monitored. This included a fourth neurological opinion by Dr. Sayao. In a consultation note of June 2, 2023, Dr. Sayao reported that Mr. Bikus showed no cortical responses and most of his brain stem reflexes remained absent. Dr. Sayao concluded that Mr. Bikus' neurological prognosis was "extremely poor" and that continuing of life-

sustaining treatment would be “futile” as it would merely prolong a “persistent vegetative state with no conscious awareness”.

[25] It is noteworthy that in an affidavit of July 13, 2023, Dr. Deyell deposed that he witnessed some movement of Mr. Bikus’ legs, but that it was not on command and likely reflexive. Therefore, Dr. Deyell did not find the movement significant and he explained that to the plaintiffs.

[26] Most recently, on July 19, 2023 there was a repeat CT scan conducted of Mr. Bikus’ head, and on July 21 there was a repeat EEG. Several physicians reviewed the results and the consensus was that there were no positive changes from the initial tests conducted in May 2023. For example, Dr. Tai, a neurologist who reviewed both tests, wrote in a prognosis note of July 25 that: “Given the lack of new findings in these investigations, I do not feel a repeat neurological opinion is indicated.”

[27] Mr. Bikus’ treating cardiologist, Dr. Ramanathan, affirmed an affidavit on July 4, 2023. Dr. Ramanathan reported that Mr. Bikus has developed a pressure ulcer. His wounds require consistent cleaning and treatment and are very painful (assuming that Mr. Bikus can still feel pain, which is unknown).

[28] Moreover, Mr. Bikus is unable to cough, which, according to Dr. Ramanathan, means that Mr. Bikus’ lungs slowly fill with mucus which impairs his breathing and puts him at risk of infection.

[29] Dr. Ramanathan, in his affidavit, also described Mr. Bikus’ present state and the life-sustaining treatments he is receiving:

> a) He remains intubated and ventilated (on a breathing machine) in the intensive care unit;
>
> b) He receives all of his nutrition through an orogastric feeding tube;
>
> c) He receives regular medications to support the ongoing function of his heart and kidneys;
>
> d) He exhibits occasional muscular movement in his limbs, but the movements are neither consistent nor reproducible; and
>
> e) His pupils are reactive to light, but he has no corneal, cough or gag reflex.

[30] I must also consider the plaintiffs' evidence which was tendered in various affidavits and was reiterated at the hearing of the application. The plaintiffs deposed that they witnessed Mr. Bikus move his feet or other limbs. As noted, these movements are recognized by various physicians, including Dr. Deyell and Dr. Ramanathan, who all believe the movements are reflexive and not conscious.

[31] The plaintiffs have also filed a number of affidavits, many of which contain accounts that are arguably hearsay, of what they say they were told by various nurses and physicians treating their father, and some of which append transcripts of discussions with some of the treating physicians.

[32] The transcripts do not support the plaintiffs' views of their father's condition, or any improvement therein.

[33] For example, in a transcript apparently from a May 30, 2023 discussion between Ms. De Châtillon and Drs. Kalia and Hsuing, the latter explained in part:

> Dr. Hsuing: So we have been involved since last week when we were called to review the patient and we've examine [sic] him over Friday, over the weekend, and the last two days and we did notice some of those reflexive movements on the weekend and there was more than just that hand movement. There was some slight movements in the leg but those where [sic] in response to pain. So these are more likely reflexes and reflexes have many different levels of function. As we explained to you last week, we do not think he has cortical response, that's the main cortex part of the brain but the brain stem is working…

[34] In the same transcript Dr. Kaila responded to Ms. De Châtillon's observation of what she believed to be her father's response, and said "it's not a response, it's a reflex".

[35] Later in the same transcript, the following exchange between Ms. De Châtillon and Dr. Hsuing occurred:

> Ms. De Châtillon: I understand that but how do you state minimal consciousness states when they come in and out of coma. You can't expect that to be a consistent response.
>
> Dr. Hsuing: Well, we look at, as I explained, one of the things that we look at is brain stem response and the fact that his breathing is getting worse. His eye light reflex is getting worse. Those are not a good sign of brain responses…

[36] In a transcript of a discussion between Ms. De Châtillon and Dr. Deyell from July 4, 2023, the two said, in part:

> Dr. Deyell: Except this isn't a long term. This is a critical care sort of situation, unfortunately. The longer he's in this state, he's going to accumulate complication after complication after complication. Just like today he's more septic. He's probably getting an infection from somewhere.
>
> …
>
> Ms. De Châtillon: We're not acting like an emergency but they've never ever witnessed a cortical response.
>
> Dr. Dreyell: But if it's a cortical response it should be easy to reproduce.

[37] Unfortunately, the plaintiffs were unable to secure an additional opinion from Dr. Cameron. However, I am confident that the medical evidence before me from the various physicians that attended Mr. Bikus is reliable and credible.

[38] In summary, although I have not referred to all of the medical evidence tendered, it is clear that there is no medical opinion before me that suggests that Mr. Bikus' neurological prognosis is anything other than extremely poor. There appears to be a consensus that Mr. Bikus will never make a functional recovery and that continuing life supporting treatment will merely continue his vegetative state. There is evidence that continuing treatment would be harmful as it puts Mr. Bikus at risk of infections, ulcers, sepsis, and further complications.

IV. DISCUSSION

[39] The competing applications are really corollaries of each other and can be dealt with at the same time. The defendant hospital wishes to remove life sustaining treatments, and the plaintiffs seek an injunction to stop this.

[40] The legal basis advanced by the defendant hospital for its application is twofold: that the *parens patriae* jurisdiction of the Court permits the relief sought, and in the alternative that the relief sought is available pursuant to s. 33.4 of the *Act*, on the basis that the plaintiffs are not acting in Mr. Bikus' best interests by requiring the defendant hospital's staff to continue the provision of life support treatment to him.

A. *Parens Patriae* Jurisdiction

[41] The Court's *parens patriae* jurisdiction was discussed by Justice La Forest, for a unanimous Court in *E. (Mrs.) v. Eve*, [1986] 2 S.C.R. 388, 1986 CanLII 36 [*Eve*]. At para. 73, La Forest J. explained:

> 73 The *parens patriae* jurisdiction is, as I have said, founded on necessity, namely the need to act for the protection of those who cannot care for themselves. The courts have frequently stated that it is to be exercised in the "best interest" of the protected person, or again, for his or her "benefit" or "welfare".

[42] The scope of the jurisdiction is broad and the categories of situations in which it can be exercised are not closed. It is also clear that it can be exercised in the health care context: *Eve* at paras. 74, 76. However, this jurisdiction is bounded by the court's discretion "to do what is necessary for the protection of the person for whose benefit it is exercised": *Eve* at para. 77.

[43] *Parens patriae* jurisdiction has been used in situations where family members of a patient were refusing to consent to treatment for an incompetent patient. For example, in *British Columbia (Superintendent of Family and Child Service) v. Dawson*, 145 D.L.R. (3d) 610, 1983 CanLII 472 (B.C.S.C.) [*Dawson*], the parents of a profoundly disabled child refused their consent to an operation on their son to correct blockage of a shunt implanted to drain excess fluid from the child's head. Justice McKenzie considered the evidence of the child's doctors, who were in favour of the operation as being in the child's best interest (paras. 15, 22). Ultimately, McKenzie J. ordered that the treatment be carried out (para. 42).

[44] In making this order, McKenzie J. wrote the following at para. 32:

> [32] I am satisfied that the laws of our society are structured to preserve, protect and maintain human life and that in the exercise of its inherent jurisdiction this court could not sanction the termination of a life except for the most coercive reasons. The presumption must be in favour of life. Neither could this court sanction the wilful withholding; of surgical therapy where such withholding could result not necessarily in death but in a prolongation of life for an indeterminate time but in a more impoverished and more agonizing form.

[45] While Canadian law has developed a great deal in the matter of assisted dying, McKenzie J. clearly contemplated *parens patriae* jurisdiction being used in the best interests of the patient to prevent suffering and in the unfortunate circumstances when a family member might disagree with the physicians on the correct course of action. In a sense, *Dawson* is the opposite of the present case; the physicians in this case opine that the best course of action is to stop a treatment while the family wishes it to continue.

[46] I find that *parens patriae* jurisdiction allows the Court to make an order to further Mr. Bikus' best interests in this case, given his incapacity.

B. The *Health Care (Consent) and Care Facility (Admission) Act*

[47] The general rule is that health care cannot be provided without an adult patient's consent: *Act* at s. 5(2). As explained above, when the patient is incapable, then the health care provider must seek consent from the temporary substitute decision makers listed in s. 16(1). This person must act in the best interests of the patient: *Act* at s. 19(1)

[48] Health care is defined broadly as "anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health" including some more specific treatments: *Act* at s. 1.

[49] Section 33.4 of the *Act* provides, in part, that:

> 33.4 (1)The following people may apply to the court for an order under subsection (2):
>
> > (a) a health care provider responsible for the care of an adult who is incapable of giving or refusing consent to health care;
>
> ...
>
> (2) On application by a person described in subsection (1), the court may do one or more of the following:
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> ...
>
> > (c) confirm, reverse or vary a decision by
> >
> > > (i) an adult's representative or personal guardian,
> >
> > …
> >
> > to give or refuse consent to health care or admission to a care facility;
> >
> > (d) make any decision that a person chosen to provide substitute consent under this Act could make.
>
> ...
>
> (4) Nothing in this Act
>
> > (a) limits the inherent jurisdiction of the Supreme Court to act in a *parens patriae* capacity, or
> >
> > (b) deprives a person of the right to ask the Supreme Court to exercise that jurisdiction.

[50] I am satisfied that the defendant hospital is a health care provider responsible for the care of an adult who is incapable of giving or refusing consent to health care as defined by s. 33.4(1)(a) of the *Act*.

[51] However, the defendant hospital argues that s. 33.4 should not apply since it is not expressly set out in the *Act* that it applies to the withdrawal of life support. Rather, I should rely on this Court's *parens patriae* jurisdiction.

[52] In my view this Court can supersede a temporary substitute decision maker's choice to withhold consent to health care under s. 33.4(2)(c).

[53] The defendant hospital referred me to *Cuthbertson v. Rasouli*, 2013 SCC 53 [*Cuthbertson*], where the Court discussed the *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sch. A [*HCCA*], Ontario's equivalent to the *Act*. In *Cuthbertson*, the Court found that the *HCCA* did apply to decisions to remove life support. The *HCCA* is materially different to the *Act*, as it designates that an administrative tribunal is to resolve disputes between substitute decision makers and doctors.

[54] The Court found that specifically, with regard to the decision to withdraw life support, a health care practitioner could apply under s. 37 of the *HCCA* to the tribunal and challenge a temporary substitute decision maker's refusal to consent to the withdrawal of life support. This application would be brought on the basis that the temporary substitute decision maker was not acting in the patient's best interests: *Cuthbertson* at para. 97.

[55] Notably, s. 37 of the *HCCA*, generally allows a health care practitioner to challenge a substitute decision maker's refusal to consent to a "treatment", not just specifically the withdrawal of life support. The Court found that the broad definition of "treatment" in the *HCCA* would usually include the removal of life sustaining treatments: *Cuthbertson* at paras. 60–61, 68, 70.

[56] It is not necessary for me to decide whether the *Act* applies to the circumstances of this case, given that I found that the court has *parens patriae* jurisdiction to resolve what is in the patient's best interests in this case. Moreover, s. 33.4(4) of the *Act*, clearly states that the *Act* does not limit the Court's *parens patriae* jurisdiction.

[57] To be clear, I am not making any final determination regarding whether the withdrawal of life support should be considered “health care” for purposes of the *Act*. Nor am I making a finding that a physician would be entitled to withdraw life support unilaterally against the wishes of the temporary substitute decision maker.

[58] Even if, in the event that the *Act* did apply to this application, the interpretation of the *HCCA* in *Cuthbertson* is persuasive as to what the task of the reviewing tribunal is when considering a refusal to remove life support by a substitute decision maker.

[59] The text of s. 33.4 of the *Act*, is far broader than s. 37 of the *HCCA*, and affords this Court greater discretion than the tribunal created under the *HCCA*. Yet, on the question of whether the Court should disturb the substitute decision maker’s choice to withhold consent to ending life support, the ultimate issue is determining what is in the best interests of the patient. When a substitute decision maker has failed to fulfill their statutory duty to act in the best interests of the patient, then there is a clear basis for the Court to intervene. This is consistent with the limits to the Court’s discretion under its *parens patriae* jurisdiction described by La Forest J. in *Eve*.

[60] Therefore, regardless of whether the defendant hospital relies on s. 33.4 of the *Act*, or *parens patriae* jurisdiction as the legal basis for its application, the legal test is the same: what is in the best interests of Mr. Bikus?

C. Injunction Stopping Withdrawal of Life Support

[61] The usual test for an injunction is well known and set out in *British Columbia (Attorney General) v. Wale*, 9 B.C.L.R. (2d) 333, 1986 CanLII 171 (C.A.), and *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1994] 1 S.C.R. 311, 1994 CanLII 117.

[62] However, there is some caselaw suggesting that the usual test for an injunction should not apply in the context of this application.

[63] In *Rotaru v. Vancouver General Hospital Intensive Care Unit*, 2008 BCSC 318, the petitioner sought a court order for a physician to return to a course of treatment that was determined to be harmful (paras. 15, 18). At para. 12, Justice

Burnyeat quoted the English Court of Appeal decision in *Re J (a minor) (wardship: medical treatment)*, [1992] 4 All E.R. 614 (C.A.), which addressed similar issues.

[64] In *Re J*, Lord Justice Donaldson wrote that the usual injunction test was inappropriate for determining whether to order that an infant receive artificial ventilation; there was no place for considerations such as the "balance of convenience". Instead, Donaldson L.J. wrote that "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 true interests of the infant pending a final decision." See *Rotaru* at para. 12.

[65] Burnyeat J. appears to have accepted the test in *Re J*, and refused to grant the order as there was no evidence that resuming the treatment would be beneficial. To the opposite, the doctors opined resuming the treatment program would be harmful and "potentially toxic": *Rotaru* at para. 18.

[66] I was also referred to *Sweiss v. Alberta Health Services*, 2009 ABQB 691. The facts in *Sweiss* are analogous to this case. The patient, Mr. Sweiss, suffered a heart attack leading to severe brain damage and him being placed on life support. Mr. Sweiss' family also opposed removing life-supporting therapies and applied for an injunction. The question before Justice Ouellette was what was the correct legal test for the order the family sought.

[67] Ouellette J. reviewed *Re J* and found that the usual injunction test was inappropriate for the circumstances: *Sweiss* at para. 61. Instead, at para. 65, he found:

> [65] In summary, I am of the view that the proper test to be applied is what is in the best interest of the patient. In determining the best interest of the patient there are several factors and considerations which should be taken into account. Although not exhaustive, they include:
>
> (i) the patient's actual condition;
>
> (ii) the medical treatment that is recommended;
>
> (iii) the wishes and directions of the patient; and
>
> (iv) what is just and equitable in the circumstances.
>
> All of these factors and considerations must be weighed and balanced and no one factor should be considered determinative.

[68] Briefly, the defendant hospital argued that this Court lacked the jurisdiction to grant the injunction sought by the plaintiffs on the basis that the Court could not

order a physician to act against what they believed to be the best interests of the patient. The defendant hospital cited *Rotaru* for this proposition.

[69] While *Rotaru* certainly considered this issue, and ultimately accepted the doctors' evidence that continuing treatment would be harmful, I am skeptical of reading *Rotaru* as broadly as the defendant hospital proposes. Burnyeat J. was also careful to distinguish the facts in *Rotaru* from a situation where there were conflicting medical opinions or where a doctor sought an order to compel a treatment that the patient's family opposed (para. 19). It is also clear that the scope of *parens patriae* jurisdiction is broad. Thus, I am hesitant to place limits on what orders the Court can make under this jurisdiction given the Supreme Court's comments in *Eve*.

[70] Ultimately, given my findings in this case, it is unnecessary to decide the issue raised by the defendant hospital.

[71] I agree with the authorities referred to above, and I prefer to determine the question of the injunction sought by the plaintiffs using the test of what is in the best interests of the patient.

D. Best Interests of Mr. Bikus

[72] Following from the discussion above, the essential question is: what course of action is in Mr. Bikus' best interests? This is the appropriate legal test to resolve the injunction and how to exercise the Court's *parens patriae* jurisdiction.

[73] In this case, Mr. Bikus' condition is deteriorating, and the uncontradicted medical evidence before me is it will continue to do so.

[74] As I have stated above, the unanimous and uncontradicted views of Mr. Bikus' treating physicians is that it is in his best interests for the life-sustaining treatment to be terminated, as such care would simply prolong his life and be futile, leading to a persistent vegetative state, with no conscious awareness, and would likely result in further harm including bed sores, infection and other complications.

[75] Where a treatment is recommended in the patient's best interest and is proposed by uncontradicted medical professionals, it is inappropriate for the Court

to interfere with the clinical judgment of those medical professionals: *Rotaru* at paras. 11–14.

[76] Understandably, there is no evidence of Mr. Bikus' wishes and directions, except that attributed to the plaintiffs who are said to have indicated that he would not wish to live in a vegetative state.

[77] There is no basis for a finding that it would be unjust or inequitable to terminate Mr. Bikus' present treatment.

[78] Notwithstanding the views of the plaintiffs, I find that their opposition to the withdrawal of treatment for Mr. Bikus is not in his best interests. For this reason, I must reject their application for an injunction. On the evidence before me, I allow the defendant hospital's application pursuant to this Court's *parens patriae* jurisdiction.

V. CONCLUSION & ORDER

[79] For the reasons above, I grant the following order:

> The acting medical staff of Providence Health Care Society are at liberty to transition Leo Edward Bikus to a comfort care treatment plan and may discontinue any life-sustaining treatment or health care services which, in their opinion, are not in his best interests within 24 hours of this order.

[80] Given the circumstances of these applications, the parties will bear their own costs, including the costs of preparing for and attending the hearings before me, Justice Ker, and Justice McNaughton.

[81] Counsel for the defendant hospital will draw the order arising from my decision. I will dispense with the plaintiffs' approval as to form of the order so long as the order is directed to me for my review and signature through the Registry. The order must not be acted upon until I sign it.

"The Honourable Chief Justice Hinkson"