CITATION: McKitty v. Hayani, 2018 ONSC 4015
COURT FILE NO.: CV-17-4125
DATE: 2018 06 26

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:	)	
TAQUISHA DESEREE MCKITTY, BY HER SUBSTITUTED DECISION MAKERS, STANLEY STEWART AND ALYSON SELENA MCKITTY	)	Hugh Scher, counsel for the Applicant
Applicant	)	
– and –	)	
DR. OMAR HAYANI	)	
Respondent	)	Erica Baron and Leah Oslter, counsel for the Respondent
	)	**HEARD:** September 21, 28, October 17 – 20, November 6-7, 30, December 1, December 4-6, 2017

REASONS FOR DECISION

L. SHAW J.

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Overview

[1] This court is being asked to determine if Ms. Taquisha McKitty, a 27 year old woman who was declared dead by neurologic criteria on September 20, 2017, is in fact dead. This is a question of profound importance to Ms. McKitty's family who believe that she is alive and request an order that she be maintained on mechanical ventilation until such time as her heart stops beating. The applicant also asserts that Ms. McKitty's religious belief is that she is alive so long as her heart is beating and that belief ought to be protected in accordance with s. 2(a) of the *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c. 11 ("the *Charter*").

[2] The issues in dispute are also of significant importance to the respondent as the applicant is challenging the criteria for the determination of brain death that are used by physicians in all hospitals in Ontario and throughout Canada on a daily basis.

[3] At the outset it should be noted that this application was commenced naming Ms. McKitty's parents, Stanley Stewart and Alyson McKitty as her substitute decision makers as opposed to litigation guardians of Ms. McKitty or litigation guardians of her estate. This issue will be addressed in these reasons.

Medical History

[4] Ms. McKitty was found unconscious on a sidewalk in Brampton on September 14, 2017. Emergency Medical Services attended at the scene. Ms. McKitty was without a pulse and CPR was commenced. Circulation was restored after 20 minutes and she was then transported by ambulance to the William Osler Health Centre, Brampton Civic Hospital (the "Hospital"). Emergency medical treatment was provided to revive her as she suffered a further cardiac arrest in the emergency room. She was then admitted to the Intensive Care Unit ("ICU") where treatment was provided. She was on a ventilator but initially demonstrated her own respiratory effort.

[5] Dr. Moltayner, a critical care physician, met with Ms. McKitty's family on September 17, 2017 and informed them that her condition remained very poor from a neurological perspective. He informed them that imaging of her brain showed significant brain damage following a period of hypoxia, which is a lack of oxygen to her brain.

[6] This initial hypoxic injury was caused by a drug overdose. In high quantities, some drugs are respiratory suppressants resulting in hypoxia. Hypoxia affects the organs, damaging the most sensitive organs first beginning with the brain. The first hypoxic event seriously injured Ms. McKitty's brain but her brain

stem continued to function as she demonstrated spontaneous breathing efforts for her first days of hospitalization.

[7] While in the hospital, Ms. McKitty sustained a second hypoxic event, namely a raised intracranial pressure, which occurs when an individual's brain swells to the point where blood flow and oxygenation is prevented. This second hypoxic event caused further injury to her brain stem.

[8] Dr. Hayani is a critical care physician at the Hospital and was directly involved in caring for Ms. McKitty in his capacity as a physician at the Hospital. On September 20, 2017 he assessed Ms. McKitty and found that her condition was deteriorating as she had shown no signs of spontaneous breathing for 36 hours. As he suspected that she had progressed to death by neurologic criteria, he asked Dr. Patel, another critical physician at the Hospital, to assist with an assessment to determine if she was dead by those criteria. Death by neurologic criteria is commonly referred to as "brain death". The terms "death by neurologic criteria" and "brain death" will be used interchangeably throughout these reasons

[9] On September 20, 2017, Dr. Hayani met with Ms. McKitty's family to inform them that Ms. McKitty met the neurologic criteria for death and that mechanical ventilation would be removed. Without that support, he informed them that her heart would stop beating.

[10] After administering tests which are used by all physicians in Ontario who make declarations of death by neurologic criteria, Dr. Hayani declared Ms. McKitty dead on September 20, 2017. He completed a death certificate on September 21, 2017 certifying that she had died on September 20, 2017 from a drug overdose.

[11] On September 22, 2017, at the request of Ms. McKitty's family, Dr. Healey, a critical care physician at the Hospital and Division Head and Medical Director of Care for the William Osler Health System, repeated the testing administered by Dr. Hayani and Dr. Patel. He also found that Ms. McKitty met the criteria for brain death.

[12] Dr. Baker, a critical care physician at St. Michael's hospital, examined Ms. McKitty at the request of the respondent on September 30, 2017. He administered the same tests and found that Ms. McKitty met the criteria for brain death.

[13] On October 12, 2017, Dr. Baker ordered two ancillary tests after Ms. McKitty was declared brain dead since the family had questions about Ms. McKitty's movements and the determination of death by neurologic criteria. The first test was a Nuclear Brain Blood Flow Study which is a test to determine whether there is any blood flow to the brain over a period of time. This is done by injecting trackers into the patient's blood. Imagining is then conducted after approximately 30 minutes to see if any of the trackers make it to the brain. The results

demonstrated that no trackers made it to Ms. McKitty's brain, meaning that there was no blood flow and no perfusion of blood to her brain.

[14] The second test Dr. Baker ordered was a Somatosensory Evoked Potentials (SSEP) which is used to determine whether there are any electrical signals to the brain when the limbs are stimulated. According to the test results, there was no electrical activity in Ms. McKitty's brain when her limbs were stimulated.

[15] Dr. Carlen, a neurologist retained by the applicant, examined Ms. McKitty on November 15, 2017 and made the following findings:

- There was no response to voice or pain including sternal compression and nail compression in the upper and lower limbs
- Pupils were midsize and there was no reaction to light
- The right eye slightly deviated to the right and there was no ocular vestibular reflex in ice water caloric which was repeated bilaterally three times and showed no cold water induced movement of the eyes
- She had negative corneal reflexes and no response to nasal stimulation
- She had no responses to suction of the airway
- Her upper limbs were flaccid and the lower limbs showed variable tone in both sides

- She had right ankle clonus[1] which was transient
- On moving the lower limbs, she would develop writhing movements over several seconds which would include twisting of the upper body and flexing of the neck
- On repeatedly moving the upper limbs, she would develop similar writhing movements starting in the lower limbs
- The writhing movements were stereotypic i.e. they appeared similarly each time they occurred
- Her deep tendon reflexes were depressed diffusely and the plantar responses were equivocal bilaterally

[16] Based on his examination of Ms. McKitty, Dr. Carlen found that she met the criteria for neurologic brain death.

[17] Evidence was presented during this hearing regarding observations made of Ms. McKitty's movements since being declared brain dead. The movements will be described in more detail in these reasons as the applicant's position is that the movements are inconsistent with findings in the medical literature and expert medical opinion regarding the nature and duration of bodily movements of those who have been declared brain dead.

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[1] Involuntary rhythmic muscle contraction.

Procedural History

[18] The Hospital was initially a respondent. On consent, the application against the Hospital was withdrawn. The Fresh as Amended Notice of Application names Dr. Hayani as the only respondent.

[19] On September 21, 2017, the applicant, through her parents as substitute decisions makers, sought an interlocutory injunction restraining the respondent from withdrawing mechanical ventilation of Ms. McKitty who was in the intensive care unit of the Hospital, pending an application to the Consent and Capacity Board of Ontario ("CCB") pursuant to the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A ("HCCA").

[20] On a without-notice basis, the injunction was granted pending a return of the application on September 28, 2017. On that return date, a further two-week adjournment was granted so that the parties could arrange for further medical testing of Ms. McKitty.

[21] Given decisions from the CCB to decline jurisdiction where there had been a determination of brain death, the parties agreed that no application would be made to the CCB pending this court's ruling on the outstanding issues. It was also agreed that the application would proceed with the affidavits filed as evidence in chief subject to cross-examinations conducted in court.

[22] Following the initial order, evidence was heard over a number of days between September 21, 2017 and December 6, 2017.

[23] When the matter was before the court from October 17-20, 2017, I heard evidence from Dr. Paul Byrne, who had been retained by the applicant to provide an expert opinion regarding this matter. Pursuant to my decision dated October 21, 2017, I declined to qualify Dr. Byrne as an expert. Following release of the decision, I granted the applicant's request for a further adjournment to retain an expert. The matter was scheduled to be heard on November 6-7, 2017.

[24] Prior to the next return date, on consent, a Fresh as Amended Notice of Application was issued on November 4, 2017. The relief requested expanded to include a declaratory order that Ms. McKitty is not dead but alive according to the laws and precepts of her Christian faith. The applicant also sought an order that the CCB has jurisdiction to adjudicate and determine any disputes regarding Ms. McKitty's treatment and the dispute regarding her determination of death according to neurologic criteria. The amended application also included a claim that Ms. McKitty's *Charter* rights had been breached.

[25] The applicant requested additional time to retain an expert. In addition, as a Notice of Constitutional Question had not yet been served, I granted the applicant's request for a further adjournment to November 30, 2017.

[26] On consent, pursuant to s. 109 of the *Courts of Justice Act*, R.S.O. 1990, c. C.43, a Notice of Constitutional Question dated November 8, 2017 was served on the Attorney General of Ontario and Attorney General of Canada, both who declined to participate in these proceedings.

[27] Pursuant to the Notice of Constitutional Question, the applicant is challenging the constitutional validity of the *Vital Statistics Act*, R.S.O. 1990 c. V.4 (the "VSA") and its regulations with respect to the requirements to determine and certify death in Ontario. The applicant also challenges the failure of the respondent to take into consideration Ms. McKitty's religious beliefs as part of the legal process to determine and certify death pursuant to the guidelines used by physicians in Ontario and the *VSA*. The Notice alleges that Ms. McKitty's death was determined and certified in a manner contrary to sections 2(a), 7 and 15 of the *Charter* and that her death certificate must therefore be set aside.

[28] Final submissions were heard on December 6, 2017, at which time I ordered that the injunction maintaining the status quo medical support for Ms. McKitty would continue pending my final decision.

Issues

[29] As indicated above, the issues which were before the court evolved from the time the application was initially issued. I have identified the following five issues which now must be resolved by this court as follows:

(i) What is the common law definition of death in Ontario?

(ii) Does Ms. McKitty meet the criteria for a neurologic determination of death?

(iii) Does the *Charter* apply to the determination of brain death and if so, does it infringe on Ms. McKitty's s. 2(a), 7 and 15 *Charter* rights?

(iv) If the *Charter* does not apply, is the common law definition of death consistent with *Charter* values?

(v) Does the CCB have jurisdiction over this matter?

Position of the Parties

[30] The applicant's position can be summarized as follows:

(i) A body that is physiologically and biologically functioning represents life even if there is a determination of brain death;

(ii) As Ms. McKitty's heart is beating and her organs are functioning physiologically, she is alive and mechanical ventilation ought to be maintained until such time as her heart stops beating;

(iii) The determination and certification of death by physicians is a government function and/or done pursuant to a government program or policy and therefore subject to compliance with the *Charter*;

(iv) The existing process by which brain death is determined in accordance with the *VSA* and existing medical guidelines in Ontario violates Ms. McKitty's s 2(a), 7 and 15 *Charter* rights;

(v) Ms. McKitty is demonstrating bodily movements that are not consistent with the quality and duration of recognized spinal cord reflexes, which raises doubt that she meets the current criteria for the neurologic determination of death;

(vi) The determination of death requires an assessment of not only medical considerations but also the values, wishes and beliefs of the individual patient;

(vii) In order to be compliant with the *Charter*, the determination of brain death ought to include an accommodation of religious beliefs and

provide an exemption for those who hold a religious belief that death only occurs when there is a loss of cardiorespiratory function;

(viii) If the *Charter* does not apply, the common law definition of death must comply with values enshrined in the *Charter*;

(ix) Any dispute regarding whether a patient meets the criteria for the neurological determination of death or whether their values and/or religious beliefs ought to be accommodated should be dealt with by the CCB.

[31] The respondent's position can be summarized as follows:

(i) The common law recognizes brain death as death;

(ii) Ms. McKitty meets the criteria for death by neurologic criteria and is therefore medically and legally dead;

(iii) The medical guidelines used in Ontario to determine brain death are the established and accepted medical practice that are followed throughout Canada for the determination of death by neurologic criteria;

(iv) The determination of death is not a government function and therefore not subject to *Charter* scrutiny;

(v) The *Charter* does not apply to an individual doctor;

(vi) As Ms. McKitty is dead, her *Charter* rights have been extinguished;

(vii) If the *Charter* applies, there is no violation of Ms. McKitty's *Charter* rights;

(viii) The CCB does not have jurisdiction as Ms. McKitty is dead and there are therefore no treatment or capacity issues in dispute.

Issue One: What is the Common Law Definition of death?

[32] There is no legislative definition of death in Ontario. The respondent's position is that the common law does and should recognize brain death as death.

[33] The applicant's position is more complex. First, the applicant asserts that death has not occurred if the body is biologically and physiologically functioning, regardless of any brain function. The common law definition of death should, therefore, include a recognition that death has not occurred until there is cardiorespiratory failure, meaning the heart stops beating.

[34] The applicant submits that a determination of death requires not only an assessment of medical considerations but also of an individual's values and beliefs and that physicians have a duty to make inquiries of such values and beliefs before making a determination of death. If those values and beliefs include a belief that

biological functioning of the body is life, even in the presence of brain death, that belief ought to be accommodated in the determination of that individual's death.

[35] The applicant's position is that the current criteria by which brain death is determined as set out in medical guidelines, which will be reviewed in greater detail in these reasons, is based on subjective assessments and perspectives that place values on certain considerations over others. The applicant asserts that these medical guidelines are therefore arbitrary as reflected in the absence of any consideration of physiological or biological functioning as a criteria to determine death.

[36] In order to address these issues, it is necessary to review the following:

(i) The current legislation regarding death in Canada;

(ii) The relevant jurisprudence from Canada and other jurisdictions; and,

(iii) The current medical criteria by which brain death is determined by physicians in Ontario.

<u>How is Death Defined in Legislation in Canada?</u>

[37] The starting point, and upon which there is no disagreement, is that Ontario does not have a statutory definition of death.

[38] In Ontario, the *Trillium Gift of Life Network Act,* R.S.O. 1990, c. H.20 ("*Trillium Act*") is legislation dealing with organ and tissue donation both by way of inter-vivos and post-mortem gifts. Section 7 of the *Trillium Act* states as follows:

> 7. (1) For the purposes of a post mortem transplant, the fact of death shall be determined by at least two physicians in accordance with accepted medical practice. R.S.O. 1990, c. H.20, s. 7 (1).

[39] The *VSA* is legislation dealing with the registration of births, still-births, marriages, adoptions, change of names and deaths in Ontario. Section 21 of the *VSA* states as follows:

> 21 (1) The death of every person who dies in Ontario shall be registered in accordance with the regulations. 1994, c. 27, s. 102

[40] The regulation referred to in s. 21(1) is s. 35 of R.R.O. 1990, Regulation 1094, which states as follows:

> 35 (1) Upon the request of the funeral director, the applicable one of the following persons shall complete, certify and deliver to the funeral director a statement in the form approved by the Registrar General that contains personal particulars of the deceased:
>
> 1. The nearest relative present at the death or last illness, or any relative who may be available.
>
> 2. If no relative is available, the occupier of the premises in which the deceased died or, if the occupier is the deceased, any adult person residing in the premises who was present at the death or has knowledge of the personal particulars.
>
> 3. If the death occurred in unoccupied premises and no relative is available, any adult person who was present at the death or has knowledge of the personal particulars.

4. The coroner who has been notified of the death and who has made an investigation into the death, received a report of the results of an investigation into the death or held an inquest regarding the death.

(2) Subject to subsections (3) and (4), any legally qualified medical practitioner who has been in attendance during the last illness of a deceased person or who has sufficient knowledge of the last illness shall immediately after the death complete and sign a medical certificate of death in the form approved by the Registrar General, stating the cause of death according to the classification of diseases adopted by reference in section 70, and shall deliver the medical certificate to the funeral director.

[41] There is no other legislation in Ontario that deals with the definition or the determination of death. Accordingly, in Ontario, death, which is not defined, is determined by physicians in accordance with accepted medical practice.

[42] In all provinces and territories, any reference to the definition or determination of death is set out in legislation that deals with organ donation or the registration of death pursuant to vital statistics acts.

[43] Manitoba, Prince Edward Island, Nova Scotia and the Northwest Territories each have legislation that defines death.

[44] In Manitoba, death is defined in section 2 of the *Vital Statistics Act*, C.C.S.M c. V60 as follows:

> For all purposes within the legislative competence of the Legislature of Manitoba the death of a person takes place at the time at which irreversible cessation of all that person's brain function occurs.

[45] The determination of death in Manitoba is as set out in s. 8(1) of the *Human Tissue Gift Act*, C.C.S.M. c. H.180 which states as follows:

> Any determination of the occurrence of brain death within the meaning of the Vital Statistics Act, with circulation still intact, that may be necessary for the purposes of a successful transplant of tissue pursuant to this Act shall be made by at least two physicians and subject to subsections (2) and (3).

[46] In Nova Scotia, death is defined in s. 2(j) of the *Human Organ and Tissue Donation Act*, S.N.S. 2010, c. 36 as follows:

> "death" means the irreversible cessation of the functioning of the organism as a whole as determined by the irreversible loss of the brain's ability to control and co-ordinate all of the organism's critical functions.

[47] Sections 15 and 16 of the said Act addresses how death is to be determined as follows:

> 15 The specific medical tests to demonstrate that death has occurred are those established by the medical profession from time to time.
>
> 16(1) For the purposes of organs donated after death for transplantation, the fact of death must be determined by at least two physicians who have skill and knowledge in conducting the specific medical tests established by the medical profession for determining death.

[48] In Prince Edward Island, section 1(b) of the *Human Tissue Donation Act*, C. H-12.1 defines death as follows:

> "death" includes brain death as determined by generally accepted medical criteria

[49] Section 11(1) of the said Act states:

> The fact of death of a donor of tissue shall be determined by at least two medical practitioners in accordance with accepted medical practice.

[50] In the Northwest Territories, section 1 of the *Human Tissue Donation Act* S.N.W.T. 2014, c.30 includes a definition of death as follows:

> 1. In this Act,
>
> ...
>
> "death" includes brain death as determined by generally accepted medical criteria;
>
> 14. Determination of death
>
> (1) The fact of death of a donor of tissue shall be determined by at least two medical practitioners in accordance with accepted medical practice.

[51] The following can be concluded based on this review of the legislation in Canada regarding the definition and determination of death:

- The three provinces and one territory which define death do so as including brain death or loss of brain function;
- In all provinces, even where death is not defined, legislation states that death is determined by doctors in accordance with generally accepted medical criteria or practice;
- There is no legislation in any province that defines the medical criteria or practice that is to be used by physicians to determine death;
- There is no legislation in Canada that defines death as the cessation of cardiorespiratory function;

- There is no legislation that requires physicians to consider an individual's views, wishes or religious beliefs as factors to be considered in the determination of death.

What are the Medical Criteria Used to Establish Brain Death in Ontario?

[52] In Canada, physicians use one of two sets of criteria to make a determination of death. The first is the cardiorespiratory criteria (the heart ceases to function) and the second is based on neurologic (brain) criteria.

[53] The accepted medical practice used by all physicians in not only Ontario but throughout Canada to determine death based on neurologic criteria is set out in guidelines that were published in the *Canadian Medical Association Journal* in 2006 (the "CMAJ Guidelines").

[54] The CMAJ Guidelines were published following a forum held in 2003 and attended by 89 experts from various fields including emergency, trauma and critical care physicians, neurologists, neurosurgeons, nurses, advanced nurse practitioners, representatives of licensing colleges and donation-transplant agencies, health administrators, policy-makers, coroners, experts in end-of-life care, and ethicists from across the country.

[55] According to the CMAJ Guidelines, despite widespread national and international and legal acceptance of the concept of brain death, there existed

variation in the standards and medical practice used to determine brain death in Canada. As stated in the CMAJ Guidelines, one of the areas of focus of the forum was to therefore establish a Canadian definition, criteria, and minimum testing requirements for determining brain death.

[56] The forum started with the presumption that brain death was an accepted medical and legal concept of death in Canadian Society.

[57] According to the CMAJ Guidelines, the following are the minimum clinical criteria for brain death:

- Established etiology capable of causing neurological death in the absence of reversible conditions capable of mimicking neurological death
- Deep unresponsive coma with bilateral absence of motor responses, excluding spinal reflexes
- Absent brain stem reflexes as defined by absent gag and cough reflexes and the bilateral absence of
    - Corneal responses
    - Pupillary responses to light, with pupils at mid-size or greater
    - Vestibule-ocular responses
- Absent respiratory effort based on the apnea test
- Absent confounding factors

[58] The CMAJ Guidelines also sets out the testing that is to be conducted by physicians to determine if the criteria for brain death are met as follows:

> Testing for Death by Neurological Criteria
>
> 18. The absence of brain stem reflexes/absence of bilateral movements is determined with the following clinical tests:
>
> (a) **CNS-mediated motor response to pain:** Pain is applied to the eyebrow area, centrally (chest) and peripherally (fingers and toes). Motor responses (movement) in the head (including face) are evaluated. Spinal reflexes may be present and do not prevent diagnosis of death.
>
> (b) **Brain stem reflexes:** All reflexes must be tested bilaterally (except cough)"
>
> (i) **Pupillary response:** In a darkened room, shine light into each eye and observe change in pupil size. Absent reflex involves fixed dilated pupils that are unreactive to light. Intravenous drugs, including conventional does of atropine may influence pupil size, but the light response remains the same. Topical ocular instillation of drugs, however, may produce nonreactive pupils;
>
> (ii) **Corneal reflex:** Stimulate the cornea with a tissue and observe both eyelids for any response. If no response such as blinding is observed, the reflex is absent;
>
> (iii) **Gag reflex:** Stimulate the pharynx with a tongue blade/Yankauer. If it elicits no response, the reflex is absent;
>
> (iv) **Cough reflex:** If bronchial suctioning fails to initiate a cough, the reflex is absent; and
>
> (v) **Oculovestibular reflex (*cold calorics*):** With head of bed elevated 30 degrees, syringe about 120 cc of ice-cold water into each ear canal ensuring patient's eyes are open. *Any* movement of one or both eyes excludes the diagnosis of death. Prior to testing, a tympanic membrane assessment is required as testing of this reflex is contraindicated if there is impaired integrity of the tympanic membrane.
>
> (c) **Apnea testing:** Apnea testing is completed by allowing the rise of the partial pressure of carbon dioxide (PaCO2) in the blood to rise while maintaining oxygenation. This increases the PaCO2 levels which, in a person with even minimal brain function, would cause that person to make

> some respiratory effort (observed in chest or abdomen). If there is no respiratory effort together with blood gases after the testing of PaCO2 greater than or equal to 60 mmHg ***and*** PaCO2 greater than or equal to 20 mmHg rise above the baseline ***and*** a pH less than or equal to 7.28, the person does not have the capacity to breathe.

[59] In summary, according to the CMAJ Guidelines, brain death is declared when it is found, through the use of clinical testing described above, that there is a lack of capacity for consciousness, brain stem reflexes, and capacity to breathe.

[60] These tests were administered by five physicians (four critical care physicians and one neurologist) in the case at bar and each concluded that Ms. McKitty met the criteria for brain death as established in the CMAJ Guidelines.

<u>Is there a Common Law Definition of Death?</u>

[61] The respondent's position is that the absence of capacity for consciousness, brainstem reflexes, and capacity to breathe is the medical and legal definition of brain death in Canada. The respondent submits that this definition of brain death has been accepted by courts in Canada, the United Kingdom, and the United States.

[62] At this juncture it is important to note that there is a distinction between brain death and those who are minimally conscious or in persistent vegetative states. There have been decisions that deal with end-of-life situations which

involve those who are in the latter conditions. The evidence from Dr. Baker and Dr. Healey, who are critical care physicians, is that persons who are minimally conscious or in a persistent vegetative state still have brainstem function and are therefore not considered to be dead by neurologic criteria. The issue before the courts in those type of end-of-life cases often involve disputes when substitute decision-makers or family members disagree with the recommendation of a health care practitioner regarding the withdrawal of treatment.

[63] There is no evidence that Ms. McKitty is either minimally conscious or in a persistent vegetative state. She has been declared brain dead according to current medical criteria. Accordingly, the following review of the jurisprudence is limited to those cases, of which there are few, where there has been a similar medical finding of brain death.

Canada

[64] *Leclerc (Sucession) v. Turmel*, [2005] R.J.Q. 1165 (C.S.), is the only decision from Canada where the court has considered the legal definition of death. It was decided prior to the publication of the CMAJ Guidelines. There were no *Charter* claims advanced in *Leclerc*. The court was asked to determine whether a mother or her son, who were both involved in a car accident, had died first as that would have an impact on legal rights flowing from the estate. At the accident

scene, the mother was found not moving and not breathing with no sign of a heartbeat. No steps were taken to revive her. The son was found not moving but he was breathing. By the time the son arrived at the hospital, he was in complete cardio-respiratory arrest. Attempts to revive him were not successful and he was declared dead. The position taken by the defendant father was that the child survived his mother as he had autonomous cardio-respiratory activity at the accident scene which revealed that there was some activity in his brainstem.

[65] In his analysis, Bureau J. noted at para. 29 that over the years, a consensus had developed in both the legal and medical professions regarding the definition of death. He held that it was clearly established that death is determined on the basis of brain death.

[66] At para. 46, Bureau J. stated that it seemed clear that death is defined as brain death in Europe, the United States, and elsewhere. He noted that while there had been numerous legislative definitions adopted, they all accepted the concept of brain death.

[67] The court found that as the child still had brainstem activity demonstrated by his autonomous breathing and heartbeat, he was not dead at the accident scene.

[68] The court also referenced the report of the Law Reform Commission of Canada, *Criteria for the Determination of Death* (Ottawa: Law Reform Commission of Canada, 1981) which stated the following:

> Medical science since the late 1960's has developed an impressive series of precise and dependable scientific criteria for determination of death, of which those of the Harvard school were the first. Moreover, the public and medical science now accept the proposition that total disappearance of all brain functions is equivalent to the death of a person. Finally a good number of jurisdictions have experienced legislation on the subject and none of them has had the effect of elimination medical judgment.

[69] The court also noted that the Commission had made the following recommendation regarding a definition of death:

> The Parliament of Canada adopt the following amendment to the *Interpretation Act*, R.S.C. 1970, C. I-23:
>
> > Section 28A – Criteria of Death
> > For all purposes within the jurisdiction of the Parliament of Canada,
> > (1) a person is dead when an irreversible cessation of all that person's brain functions has occurred.
> > (2) the irreversible cessation of brain functions can be determined by the prolonged absence of spontaneous circulatory and respiratory functions.

[70] Despite the recommendations of the Law Reform Commission, this definition of death has not been adopted in Canada.

United Kingdom

[71] The common law of the United Kingdom ("UK") recognizes death by neurologic criteria, which is defined as death of the brainstem. Neurological determinations of death in the UK do not include a loss capacity for consciousness or capacity to breathe, both of which are criteria indicated in the CMAJ Guidelines.

[72] In *Re: A (A minor)*, [1992] 3 Med LR 303 (Fam. Div.), a 19 month old child was brought to the hospital and found to be brainstem dead. At para. 305, the Court found that it had jurisdiction to declare that the child was dead for all legal and medical purposes and the ventilator could be disconnected.

[73] In *Re: T.C. (A minor)*, [1994] 2 Med LR 376, the High Court of Justice of Northern Ireland (Family Division) found that a child who was brainstem dead was dead and could therefore be separated from the ventilator which "supported her existence and not life."

[74] In *Re: A (A child)*, [2015] EWCA 443 (Fam.), the father, who was a practicing Muslim, did not believe that brainstem death was equivalent to legal death. The English High Court of Justice found that brain death is death and declared the child dead.

[75] The judge accepted the evidence of a physician witness who explained the concept of brain-stem death as follows:

> [Dr. Playfor] "told me that brain-stem death, does not equate to death of the whole brain. There are studies that demonstrate that you can have electrical activity in some areas of the brain after brain-stem death is established. The key point, he said, is that no patient has ever regained consciousness or awareness following brain-stem death. Dr. Playfor went on to explain the reason for that in language which I found to be simple and accessible. The nerves which generate the breathing mechanism and maintain the integrity of the heart rate are all connected to the brain-stem. In simple terms, when the brain-stem dies, it is impossible for a patient to breath unassisted."

[76] The parents pointed to signs of twitching and retraction of the child's legs to undermine the determination of death. The judge accepted the evidence that these movements were spinal and not cerebral reactions.

United States

[77] Unlike in Canada, each state has a statutory definition of death. A number of states have adopted the *Uniform Determination of Death Act* (*UDDA*), which defines death as follows:

> An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brainstem, is dead. A determination of death must be made in accordance with accepted medical standards.

[78] Other states have adopted their own definition of death. Prior to a statutory definition, however, it was left to the courts to determine the common law definition of death.

[79] In the 1980 decision of *Re: the Welfare of William Matthew Bowman,* Wash. 617 P. 2d 731, the Supreme Court of Washington dealt with a case where a five year child was on a ventilator. The evidence was that there was neither blood flow nor electrical activity in the brain. The child's pupils were unresponsive, and there was no cornea reflex, no deep tendon reflexes, and no spontaneous breathing. The court had to determine if the child had died prior to the cessation of all bodily functions.

[80] In his decision, Chief Justice Utter held that death is both a legal and a medical question. He held that the law had adopted standards of death but had turned to physicians for the criteria by which the particular standard is met. The court found that the law's determination that brain death is the legal equivalent of death is because under current medical science, the capacity for life is irretrievably lost when the entire brain, including the brainstem, has ceased to function.

[81] The court found that it is the medical profession that must determine what acceptable diagnostic tests and medical procedures are necessary for determining that brain death has occurred.

[82] The court found that while modern medical technology could keep the child's heart beating and his blood circulating after brain death, it did not make him a living person in the eyes of the law.

[83] The issue of whether death by neurologic criteria is considered death at law was also addressed in the 1984 decision of *People v. EULO*, 63 N.Y. 2d. 341 (1984). In that case, the defendant shot his girlfriend in the head. She was pronounced dead by neurologic criteria and her organs were donated. The defendant appealed his conviction of manslaughter arguing that her death was caused by the intervening event of the removal of her organs, rather than the gunshot wound.

[84] Chief Judge Cook explored the common law definition of death and found that it had evolved from a traditional reliance on cardio-respiratory failure to one of brain death based on advancements in the medical community. He found that those medical standards must inform the common law. According to Chief Judge Cook, the question about when death occurs is one of fact and the criteria to be used are medical standards. Furthermore, those standards had evolved from one of irreversible cessation of cardiac and respiratory functions to cessation of brain activity. He found that "the movement in law towards recognizing cessation of brain functions as criteria for death followed this medical trend."

[85] At the time of this decision, New York State had not yet passed any legislation to define death. The court found that although there was a legislative void, it did not stop the court from fulfilling its obligation to construe laws of the state. The court found that it had a duty to instill certainty and uniformity.

[86] The court found that the legal definition of death was the irreversible and complete cessation of functioning of the entire brain, including the brainstem, consistent with the common-law concept of death. The court found that even when respiratory and circulatory functions are maintained by medical means, death may nonetheless be deemed to have occurred when, according to accepted medical practice, it is determined that the entire brain function has irreversibly ceased.

[87] In *Lovato v. District Court in & for Tenth Jud.*, 601 P. 2d 1072 (1979), the Supreme Court of Colorado heard an appeal from a decision where the court judicially recognized, for the first time in Colorado, the concept of brain death. The court upheld the decision and found that the child, who was the centre of the litigation, had died.

[88] The issue before the court was the definition of death. At the time of the decision, Colorado had not passed any legislation defining death. In reaching its decision, the court reviewed scientific views, judicial decisions, and recent legislation from other states.

[89] The court noted that prior to the development of resuscitative technology in recent decades, the medical profession had concluded that death occurs when one's heart stops beating and one stops breathing. With the advances in medical

technology, the medical community had developed a more complete definition of death which endorsed the concept of brain death.

[90] The court accepted the evidence of a neurologist who explained that the heart is an autonomous organ that does not depend on the integrity of the brain to maintain its own function. There can, therefore, be a complete destruction of the brain or brain function and yet the heart will continue to beat.

[91] The court found that the absence of legislative action to establish the statutory definition of death did not prevent it from resolving the legal issue of whether irretrievable loss of brain function can be used as a means to detect death. The court determined that it had a duty to deal with the issue as failure to do so would be to ignore the scientific and medical advances made throughout the world in the past two to three decades. The court therefore adopted the *Uniform Brain Death Act* definition which stated as follows:

> For legal and medical purposes, an individual who has sustained irreversible cessation of all function of the brain, including the brain stem, is dead. A determination under this section must be made in accordance with reasonable medical standards.

[92] The court stated that the recognition of brain death does not preclude the recognition of the standard of death as determined by the traditional criteria of cessation of respiration and circulation.

Summary from the Jurisprudence

[93] The following can be concluded from a review of the jurisprudence regarding the definition of death:

- Courts have made findings of death when cardiorespiratory function has been maintained by mechanical ventilation;
- Courts have accepted brain death as death;
- This definition of death has evolved from a traditional reliance on cardio-respiratory failure as a result of scientific and medical advancements;
- It is left to the medical community to determine the criteria or guidelines to establish brain death;
- There is no decision where the court has found that an individual's views, wishes and beliefs must be considered as part of the determination of death;
- There is no decision where the court has found that a body that may be physiologically and biologically functioning, in the presence of brain death, is alive.

Review of the Evidence

Dr. Truog

[94] The applicant relies on the opinion of Dr. Truog that brain death is not biological death and that those who meet the criteria for brain death continue to live for so long as they can maintain bodily functions through the aid of mechanical ventilation.

[95] Dr. Truog is a medical doctor and board-certified in the practices of paediatrics, anesthesiology and paediatric critical care medicine. He is also the director of Harvard University Medical School for Bioethics and the Frances Glessnar Lead Professor of Medical Ethics and anesthesiology and paediatrics at Harvard University Medical School. He has been on staff at Boston Children's Hospital where he has practiced paediatric intensive care medicine for more than 30 years, including 10 years as Chief of the division of Critical Care Medicine. He has published more than 300 articles in bioethics and related disciplines. He has written on the subject of brain death.

[96] He was retained by the applicant to provide an opinion regarding the neurologic determination of death. He filed an affidavit to which he attached an article he wrote and published in November 2014 in the American Journal of Bioethics, titled *Changing the Conversation about Brain Death.* He endorsed and adopted the contents of that article in his affidavit. Dr. Truog's qualifications to provide opinion evidence were not challenged, nor was he cross-examined on his affidavit. While the necessity of his evidence was challenged by the respondent, I found that his evidence would be of assistance to the court.

[97] It is Dr. Truog's opinion that brain death is not the same as biological death. His opinion is that so long as the body is functioning physiologically and biologically, even with the aid of mechanical ventilation, there is life.

[98] Dr. Truog's evidence is that there is an important and relevant distinction between brain death as a biological concept and brain death as a legal status. It is Dr. Truog's opinion that the clinical criteria for brain death do not coincide with a biological definition of death. His evidence is that over the past several decades there has been incontrovertible evidence developed that those individuals who meet the diagnostic criteria for brain death can continue to live and maintain integrated functions indefinitely with the aid of mechanical ventilation. These functions include circulation, digestion, excretion of waste products, temperature control, wound healing, fighting infections, and even configured growth and development. This array of organismic functioning in brain-dead patients is similar to the ventilator-dependent patients with high cervical quadriplegia, who can also live for years despite the near total physiological separation of the brain from the body.

[99] It is Dr. Truog's opinion that the legal definition of death in the United States, as defined by neurologic criteria, does not correspond with a biological definition of death. According to Dr. Truog, the criteria for determining death by both neurological and circulatory criteria have ignored biological reality in pursuit of fulfilling an important social function, which is being able to define people as dead while they are still physiologically in a state where their organs can be used

for transplantation; that is, a state where the organs are biologically alive and the body is deemed to be dead.

[100] It is Dr. Truog's opinion that patients diagnosed as brain dead are not biologically dead but for public policy reasons, they are considered legally dead. One of those public policy reasons is to maintain "organ procurement."

[101] According to Dr. Truog, there is no evidence to support the concerns expressed by some that substantial numbers of family members of neurologically dead individuals would seek significant hospital stays within ICU units at a significant cost if brain death is not recognized as biological death.

[102] Dr. Truog acknowledges that his views run against mainstream thought and bioethics.

Dr. Baker

[103] Dr. Baker was retained by the respondent to provide a second opinion, based on his own assessment, as to whether Ms. McKitty met the criteria for death by neurologic standards. He was qualified as an expert to give an opinion in that regard. He was also asked to provide an opinion regarding the scientific reliability and validly of the criteria in the CMAJ Guidelines. He was qualified as an expert to provide an opinion in that regard.

[104] Dr. Baker is a critical care physician at St. Michael's Hospital and holds the positions of Chief at the Department of Critical Care, Acting Chair of the Department of Anesthesia, and Medical Director of the Trauma and Neurosurgery Program at St. Michael's Hospital. He was a participant in the forum that led to the publication of the CMAJ Guidelines and also one of the authors.

[105] As a critical care physician, Dr. Baker is regularly involved in the care of individuals facing life threatening and life ending circumstances. He will typically make declarations of death as frequently as three times a week.

[106] According to Baker, in Ontario, a declaration that a person has died is a medical act. Physicians use one of two sets of criteria to make a declaration of death. The first is by cardiorespiratory criteria, which is the irreversible cessation of cardiorespiratory function, and the second is by neurologic criteria. Under both sets of criteria, there is an irreversible cessation of brain function based on the irreversible loss of blood profusion.

[107] Dr. Baker's evidence is that death by the cardiorespiratory mechanism occurs when the heart and lungs have irreversibly stopped working and cannot be restarted. This will lead, inevitably, to the death of the brain because of permanent loss of brain blood flow. When the heart and lungs stop initially, patients are not identified as dead immediately. This is because the brain can be supplied with

circulation temporarily through means such as CPR, and the heart can sometimes be restarted. If the heart cannot be restarted, or is not restarted, then the brain will suffer the absence of blood flow and die. Therefore, in Ontario and many other jurisdictions, the identification of the permanent loss of circulation meets the criteria for declaring that someone has died.

[108] According to Dr. Baker, identifying death using neurologic criteria is an accepted medical practice. It is the basis for the declaration of a significant number of deaths in Ontario. It is also the basis upon which post-mortem organ donation can proceed pursuant to the *Trillium Act.*

[109] It is Dr. Baker's evidence that the complete absence of capacity for consciousness, brainstem reflexes, and capacity to breathe constitutes the medical and legal determination of death in Canada, United States, United Kingdom, Australia, and the vast majority of countries with advanced health care systems in the world.

[110] Dr. Baker's evidence is that a practical difference between the identification of death by cardiorespiratory and neurologic criteria is that the neurologic criteria must be evaluated in the context of a functioning circulatory system with mechanical ventilator support. If a patient is declared dead, the ventilator is removed. This leads to hypoxia and cardiovascular failure. In the

context of organ donation, the ventilator will be maintained until the organs are retrieved.

[111] It is Dr. Baker's opinion that the concept of brain death in Canada is one of whole brain death. He explained that whole brain death means the loss of brainstem function. The brainstem is the most protected and the least vulnerable part of the brain. Therefore, when a cause capable of causing whole brain death is identified and it is sufficiently severe that it results in loss of brainstem function, this meets the concept of whole brain death because the rest of the brain will have died from the same cause which resulted in brainstem death.

[112] According to Dr. Baker, the medical standards for the neurologic determination of death in Ontario and throughout Canada, as set out in the CMAJ Guidelines, have been endorsed by the Canadian Critical Care Society, Canadian Association of Emergency Physicians, Canadian Neurological Society, Canadian Neurosurgical Society, Canadian Neurocritical Care Group, Conference of Chief Coroner and Medical Examiners of Canada, Canadian Association of Critical Care Nurses, Canadian Association of Transplantation, Canadian Society of Transplantation, Quebec Transplant, Trillium Gift of Life Network and its ICU Advisory Group, Alberta HOPE Programs, OPEN Program, Transplant Atlantic, New Brunswick Transplant, and the Canadian Council for Donation and Transplantation.

[113] It is Dr. Baker's evidence that death as determined by neurologic criteria is distinguishable from other states of severely impaired consciousness such as minimally conscious state, vegetative state, or coma. In these situations, there is some degree of capacity for consciousness and/or some brainstem function and/or some capacity to breathe. Persons in those conditions are not brain dead.

[114] According to Dr. Baker there is no recognized group of physicians in Canada who believe that death by neurologic criteria is not death. He is aware of a small number of individual physicians that question the philosophical or biological concept of brain death. They assert that even when an individual is brain dead, organs can continue to grow and a body can respond to infections and heal wounds. It is Dr. Baker's opinion that all of these biological functions are medically compatible with brain death.

[115] According to Dr. Baker, when an individual is dead by neurologic criteria, the heart can continue to pump for a period of time. This is unrelated to brain function. The heart, kidneys, liver, and most other organs have primary activities that are not initiated or stopped by the brain, but merely moderated by it. An exception to this is the lungs as respiratory drive is initiated by the brain. Individuals are sustained after brain death because they are kept on mechanical ventilators that initiate breathing on their behalf. This forced oxygen intake allows organs to continue to function at a biological level despite a lack of brain activity. Without the

ventilator, the lungs would not take in air and all of the functioning organs would subsequently die from lack of oxygen.

[116] Dr. Baker has never been involved in a case where a patient has been declared brain dead in accordance with the CMAJ Guidelines and subsequently found to have any brain function.

Dr. Healey

[117] Dr. Healey is a critical care physician at the Hospital and Division Head and Medical Director of Critical Care for the William Osler health System. He is also the Chief Medical Officer of the Trillium Gift of Life Network.

[118] His evidence is that since Ms. McKitty's hospitalization and the initial order of this court, she continues to be provided with nutrients and hydration through a nasal gastric tube. She has been treated with antibiotics to fight infection. His evidence is that this has been done in order to comply with the injunction granted by this court. Her body continues to urinate and defecate. She does not need any support for those bodily functions. Her heart, bowels, kidneys, and other organs are functioning. It is not disputed that there is physiological and biological functioning of her organs.

[119] According to Dr. Healey, no patient is declared brain dead unless the criteria in the CMAJ Guidelines have been met. He is unaware of any case where a patient has been declared brain dead on the basis of these criteria and then recovered. It is also his evidence that when there is no blood flow to the brain, it will die and death of the brain can never be reversed, even if blood flow could be reinstated.

Analysis

[120] There is no dispute that many of Ms. McKitty's organs are physiologically functioning and that her heart is beating. She is being provided with nutrients and hydration which is being absorbed by her body. She is excreting waste products through her bowel and kidney functions. Her blood is circulating throughout her body.

[121] Ms. McKitty does not have capacity to breathe of her own volition and her respiratory system is being maintained artificially through mechanical ventilation. At the cellular level, her body is performing the physiologic process of exchanging oxygen and carbon dioxide.

[122] It is not in dispute that if mechanical ventilation is not maintained her heart will not be supplied with oxygen and it will eventually stop beating. Blood will stop circulating throughout her body and her organs will also fail.

[123] The issue is whether or not this biological and physiological functioning of the body, including circulation, digestion, excretion of waste products, temperature control, wound healing and fighting infections constitutes life even when there is an absence of brain stem function, consciousness, and ability to breath.

[124] The applicant asserts that the *Lovato* decision supports the proposition that there are two means of determining death and that an individual may choose which method to determine their death based on their values and beliefs. That is not how I interpret that case. The *Lovato* decision, and all others reviewed above, have found that the concept of brain death has evolved and developed with medical advances. Originally, death was only determined when the heart stopped beating. The concept of brain death recognizes that death can occur before the heart stops beating. As explained by Dr. Baker, death can occur when there is a cessation of cardiorespiratory function *or* cessation of brain function. The determination of which criteria is used to establish death is not a choice made by the individual. Rather, it is a medical determination. Cessation of *either* cardiorespiratory or brain function constitutes death. The jurisprudence does not indicate that there is a choice between the two criteria but rather that the determination of death under one set of criteria is sufficient to establish death.

[125] If the definition of death is to be amended as proposed by the applicant, it would be contrary to the existing common law definition of death as found in

Canada (see *Leclerc*), United States, and the UK, which have all found that the legal definition of death includes brain death. There are no decisions known to this court where the definition of death does not include brain death or have found that an individual can choose not to be declared dead on the basis that physiological or biological function of a body constitutes life.

[126] The applicant is proposing a radical and significant change to the definition of death and, in essence, the concept of life. It is not the role of this court to engage in a social policy analysis that engages significant bioethical and philosophical considerations regarding the recognition of physiological functioning of the body as life.

[127] There are also policy issues that would have to be considered which are beyond the role of this court. For example, according to Dr. Baker and Dr. Truog, given medical technology, a body can be maintained for an indefinite period of time after a declaration of brain death. That could have a significant financial impact on the health care system if a body that is biologically or physiologically functioning is to be maintained on mechanical ventilation until such time as the heart stops beating, at the request of the individual or their family, based on their personal values and beliefs. There could also be an indirect impact on those who require medical services or treatment if staffing and medical resources are required to maintain those who believe that a biologically functioning body is life. Lastly, there

could also be adverse consequences to the organ donation system in Canada. Although no evidence was led regarding any possible impact on the organ donation system, a reasonable conclusion is that if more individuals are maintained on mechanical ventilation beyond the determination of brain death, there could be fewer possible donors. This ripple effect of consequences flowing from a recognition of biological functioning as life requires careful consideration by the legislature.

[128] Furthermore, if a choice can be made that a physiologically functioning body must be maintained on mechanical ventilation, do medical services have to extend to providing other interventions to maintain that functioning body? For example, if Ms. McKitty's kidney function fails, will dialysis be required? Should she be treated with antibiotics to fight infection? If her bowels fail, should there be interventions to provide her with a colostomy for so long as her heart is beating? If her heart stops beating, is medical intervention required to attempt to restart the heart? What medical services and to what extent must those services be provided to maintain a physiologically functioning body if that is considered life? These are all issues that cannot be resolved by this court but are best dealt with by the government which is well-suited to address such policy issues. Unlike the court, legislatures are better able to determine questions with many diverse input factors that affect a variety of constituencies in the decision-making process.

[129] The evidence presented by the applicant to support her position that the biologic functioning of the body is life is the opinion of Dr. Truog, a bioethicist from the United States. Dr. Truog's opinion is that there is no evidence to support the fear that substantial numbers of families of brain dead patients would insist on continued treatment if brain death is not recognized as biological death. That opinion must be considered in the context of the very different health care systems in Canada and the United States. Accordingly, I do not place much weight on Dr. Truog's opinion in that regard as his opinion is based on his knowledge of the private health care system in the United States and not one that is publically-funded as in Canada.

[130] The opinion of one bioethicist, who acknowledges that his views are counter to mainstream thought and bioethics, is insufficient evidence to persuade this court that the medical practice and criteria by which death is determined in Canada should be set aside or amended to include a recognition of physiological or biological functioning as life.

[131] There is no basis for this court to deviate from the recognition in the jurisprudence and legislation from other jurisdictions that the medical and legal definition of death includes brain death. Furthermore, the medical determination of death cannot be subject to an individual's values and beliefs. Death, as in the diagnosis of any other medical condition, is a finding of fact. To import subjectivity

to the definition of death would result in a lack of objectivity, certainty and clarity. Such subjectivity could lead to an unacceptable level of medical, legal and societal uncertainty as well as potential adverse impacts on the health care and organ donation system.

[132] According to the jurisprudence and legislation in Ontario and throughout Canada, it falls to the medical profession to establish the medical guidelines or practice to determine death. The CMAJ Guidelines are used in all hospitals in Ontario and throughout Canada and have been endorsed by numerous medical associations across Canada. Dr. Baker's evidence is that Canada is considered a leader internationally for having a standard set of guidelines that are applied throughout the country. The CMAJ Guidelines were the result of a consultation process that resulted in a standardized practice used to determine if brain death has occurred. There is no evidentiary basis for this court to find that the CMAJ Guidelines are not the appropriate medical practice by which death by neurologic criteria is to be determined by physicians in Ontario. Physiological and biological functioning of a body are not criteria to consider in the determination of brain death. That does not result in medical guidelines that are arbitrary or overbroad in their application.

I find, therefore, that at common law, death includes brain death and brain death is to be determined based on medical criteria as set out in the CMAJ Guidelines.

It is important that the law keeps up with technological and medical advancements which, in turn, is consistent with permitting the medical community to establish the practice or guidelines to determine brain death.

Issue Two: Does Ms. McKitty Meet the Neurologic Determination of Death?

[133] Five physicians examined Ms. McKitty and found that she meets the criteria for the neurologic determination of death based on the CMAJ Guidelines. An issue that is very distressing for Ms. McKitty's family, however, is her movements which they assert are inconsistent with the nature and duration of movements that are typically observed after a declaration of brain death. The applicant's position is that since the movements are unexplained that ought to raise a doubt as to whether or not Ms. McKitty meets the criteria for neurologic death. Given that doubt and uncertainty, mechanical ventilation should be maintained until such time as there is a loss of cardiorespiratory function.

[134] The respondent's position is that Ms. McKitty's movements are consistent with spinal reflexes, which can be observed in those declared brain dead. They are not movements that are mediated by any brain activity. According to the respondent, Ms. McKitty's movements are not inconsistent with a determination of brain death.

[135] It is not in dispute that bodily movements can be observed after an individual has been declared brain dead. Spontaneous reflex movements originate in the spinal cord and not in the brain. They do not involve any brain activity. The presence of these movements does not preclude a diagnosis of death by neurologic criteria.

[136] The applicant asserts that not all of Ms. McKitty's movements originate in the spinal cord, but may be connected to brain activity. I will review in detail the evidence presented regarding these movements given that the applicant's position is that these movements are significant to the issue of whether Ms. McKitty is brain dead.

Review of the Evidence

Observations of Movements

[137] Mr. Stewart is Ms. McKitty' father. He was present each day of the hearing. He is a devoted father who believes that his daughter is still alive despite being declared brain dead.

[138] In his affidavit sworn October 11, 2017, Mr. Stewart described Ms. McKitty's movements that were recorded by cell phone video as follows:

(i) On September 25, 2017 at 8:56 am, in the presence my son Marquel Stewart and his girlfriend Kassandrah, Kassandrah took a cell phone video showing Taquisha moving her body in response to Marquel calling out Taquisha's name.

(ii) Marque states "Keesha, go, let's go Keesha.

(iii)Taquisha responded by moving her legs under the blanket.

(iv) On September 30, 2017 at 3:38 pm, in the presence of Marquel, Taquisha moves both of her feet, both of her knees, her upper body and her head.

(v) Marquel responds good girl Keesh. Marquel documents this by cell phone video

(vi) On October 2, 2017 at 3:03 pm, in the presence of Marquel, and his mother Alyson McKitty, Taquisha moves her legs, her upper body and her head. Marquel documents this by cell phone video.

(vii) On October 2, 2017 at 3:04 pm, in the presence of Marquel and his mother, Marquel calls Taquisha's name. Taquisha responds by moving her legs and her feet.

(viii) Marquel touches Taquisha's foot, and Taquisha subsequently crosses both of her feet. Marquel documents this by cell phone video.

(ix) On October 4, 2017 at 2:57 pm, in my presence, with a cell phone video taken by me, I state Keesha, can you move for me? There is no movement. I immediately restate Keesha, can you move?

(x) Taquisha moves her chest in response to the instruction. Subsequently, a nurse intervenes to conduct some cleaning and treatment to Taquisha's face.

(xi) Taquisha again moves her chest and leg.

(xii) On October 6, 2017 at 12:57 am, in the presence of Marquel and myself, Taquisha is viewed lifting her legs. A cell phone video is taken by Marquel. The movements are shown at point 4:33 of the video.

[139] Ms. Downey is Ms. McKitty's cousin. She visited Ms. McKitty daily from September 14, 2017 to September 29, 2017, and periodically thereafter. In her affidavit sworn October 11, 2017, she deposed the following with respect to Ms. McKitty's movements:

> 5.I would frequently speak into Taquisha's ear while at the bedside, and would say things like "do you feel me touching your fingers" and then I would rub her fingers and there wouldn't be movement. Then I would say "come on can you move your thumb for me, do you feel your

> thumb?" and Taquisha wiggled her thumb. She did this thumb movement several times in response to me speaking to her and asking her to move her thumb. The same is true in response to requests for Taquisha to squeeze my hand. My cousin Marquel Stewart captured some of these movements on cell phone video
>
> ....
>
> 8. I observed tears run down Taquisha's face when I would talk in her ear. Taquisha would respond the most when I would speak to her and try to encourage her to make certain movements like move her thumb, or squeeze my hand.
>
> 9. These movements and reactions to my instructions were apparent even after Taquisha was declared dead on September 20, 2017. I observed them at several different times, including from September 23, 2017 to September 25, 2017. Some of these were captured on cell phone video by my cousin Marquel.

Dr. Healey

[140] Dr. Healey has observed Ms. McKitty's bodily movements. He also viewed the cell phone video of her movements. His evidence is that all of Ms. McKitty's movements are spinal reflexes which do not represent brain function but rather spinal cord function. He explained that the commonly described triple flexion response (flexion of the hip, knee and ankle) was observed in response to pain to her foot. He also noted that ankle flexion alone was observed in response to painful stimuli. His evidence is that both responses are consistent with spinal reflexes and they do not negate the diagnosis of brain death. These movements occur because of the spinal cord and do not result in transmission of any message

to or from the brain. His evidence is that there were no movements observed in response to painful stimuli occurring in Ms. McKitty's upper extremities. He also noted that a fasciculation (brief muscle contraction) of the left thigh muscle had been observed, but this occurred spontaneously and did not signify any brain activity.

[141] According to Dr. Healey, the results of the Somatosensory Evoked Potentials (SSEP) test, which was one of the ancillary tests performed after the diagnosis of death, confirmed that there is no electrical activity in Ms. McKitty's brain when her limbs were stimulated. It is Dr. Healey's evidence that this also demonstrates that the movements in her limbs are spinal reflexes. If there was communication between the limbs and the brain, the brain would show signs of electrical activity when the limbs are stimulated.

[142] Dr. Healey agrees that if Ms. McKitty's movements are in response to commands, she is not brain dead. His evidence is, however, that given the lack of brainstem reflexes and capacity for consciousness that was found by more than one physician, it is impossible for her to go from that level of consciousness to one that is obeying commands.

[143] According to Dr. Healey, spinal reflexes occur spontaneously and in an unpredictable fashion. In some cases, people get the impression that there is a

following of commands such as asking someone to move a thumb, as occurred in this case. This can cause confusion. If Ms. McKitty is following commands, it would suggest a near normal level of consciousness.

[144] It is Dr. Healey's evidence that a patient cannot be in a deep unresponsive coma and all of a sudden, for a moment in the day, follow a command. It is impossible to follow commands for just one or two moments in a day and then have a medical examination consistent with brain death for the remainder of the day. It is Dr. Healey's evidence that if Ms. McKitty were in a minimally consciousness or vegetative state, she would demonstrate a brainstem reflex or some sign of consciousness.

[145] According to Dr. Healey, there is no physiological reason why spinal reflexes would stop at a certain point in time after death by neurologic criteria, assuming that mechanical ventilation continued.

Expert Opinions Regarding Movements

Dr. Shewmon

[146] Dr. Shewmon is a neurologist who gave evidence at the request of the applicant regarding the nature of Ms. McKitty's movements. Dr. Shewmon's

opinion is that the possibility of brain origin for some of Ms. McKitty's movements should be considered given the nature and duration of the movements.

[147] Dr. Shewmon has been an Academic Paediatric Neurologist since 1981 and is currently Professor Emeritus of Paediatrics in neurology at the David Geffen School of Medicine at University of California, Los Angeles ("UCLA"). He is board-certified in paediatrics, neurology (with special competence in child neurology), and clinical neurophysiology. He was Chief of Neurology at Olive View – UCLA Medical Centre, which is a county hospital affiliated with UCLA and Vice Chair of the Neurology Department at UCLA. His evidence is that he has diagnosed between 150 and 200 individuals as suffering from brain death. He has written a number of articles about brain death. In the mid 1980's he was a member of the Child Neurology Societies Ethics Committee, which had the task of drafting the first diagnostic guidelines for brain death in children. On consent, he was qualified as an expert to provide an opinion regarding the nature of Ms. McKitty's movements and the impact of the two ancillary tests which were performed after she was declared dead.

[148] In order to provide his opinion, he viewed the videos of Ms. McKitty's movement, the reports from the two ancillary tests, and her medical records up to September 30, 2017. He did not examine Ms. McKitty. He described the movements on the cell phone video as follows:

DE0-1046am.mp4 (duplicated under file name "IMG_0910 {l).MP4" and also "2017-09- 25-VIDE0-00000009.mp4"] {0:17)

Woman asking her to move "it" again. Woman's left hand is lightly stroking Taquisha's abdomen through a blanket. Only Taquisha's right hand is showing. Around 0:12 there is a quick twitch of the right thumb. It looks like a myoclonic jerk. The woman says "Good girl," implying that it was the requested movement (i.e., "it" referring to the right thumb).

2017-09-24-VIDE0-1059am.mp4 [duplicated under file name "2017-09-25-VIDE0-00000010. mp4"] {0:28)

Close up of right hand and forearm. Several myoclonic jerks of the thumb are interpreted by the woman speaking as responses to command to squeeze the woman's hand or to move Taquisha's thumb.

2017-09-25 at 8-56am -VIDE0-00000023. mp4 (0:25)

Legs move under blanket. Man at foot of bed is off camera at that point, but later we see his hands touching her feet. He could have been manipulating her legs off camera. Or at best, the movements are a reaction to his touch.

2017-09-30-3pm.mp4 {0:14)

The initial leg movement could have been induced by someone off camera. It looks as though the left leg is lifted slightly off the bed by someone off camera holding the foot. Subsequent leg and torso squirming is endogenous.

2017-10-10-.mp4 (5:19)

No reaction to man calling her name and talking to her (0:15-0:45). Otherwise, she is left alone and does not make any visible spontaneous movements (poor camera angle from foot of bed at her level, showing only her head, chest, and left knee anc! foot under a blanket), until 4:36-4:44 spontaneous squirming movements of legs and torso.

2017-10-25-VI DE0-00000027. mp4 (1:03)

View shows whole hospital bed; most of body is covered with a blanket. Arms are also under the blanket. Head is clearly visible. At 0:03 there is a movement under the blanket, probably of the right leg, along with a slight squirming movement of the torso and slight head turning (possibly passive from the torso movement). At 0:22 the left knee raises under the blanket and the head turns slightly to the left, then turns more slowly to the right, in association with slight elevation and then relaxation of the right shoulder. It is hard to tell whether the head movement is passive from the shoulder movement. At 0:29 there is a kind of stretching of the body and legs with extension of the neck, again possibly passively. At 0:44 there is sudden elevation of the knees under the blanket, then turning of the head to the right, which looks more active than passive from a shoulder movement (which is very slight if at all).

IMG_0915.MP4 .mov (0:14)

Most of body is covered with blankets, but head and bare feet are showing. There are squirming movements of both legs and feet at the ankles, also of the hips, judging from passive movements of the upper body.

Oct 2 303pm.MP4 (0:16)

Squirming movements of legs and torso under blanket. Feet are off camera, so can't tell whether anyone is manipulating the feet.

Oct 2 304pm.MP4 (0:17)

Squirming movements of legs under blanket. Brief glimpse of feet when blanket is lifted off them, but can't tell whether the man had just been touching the feet prior to that. At 0:11he touches the left foot and both feet move afterwards.

Oct 4 257pm.MOV (0:52)

Man tells her to move at 0:02, then again at 0:07, and at 0:11she moves the left shoulder and chest, but camera shows only her head and chest. Can't tell whether anyone was stimulating her off camera. He says "move again" at 0:13, but she doesn't move until 0:45 (legs squirm). During that interval the man carries on a conversation with the nurse and does not coax Taquisha to move.

Oct 6 1257am .mp4 (0:50)

Man talks to her (can't understand from the muffled audio track), touches her around the right knee area at 0:14 and the right leg moves and torso squirms. Around 0:33-0:36 he touches the right leg again, and it moves at 0:38.

[149] According to Dr. Shewmon, with non-communicative and severely neurologically disabled persons, it can be difficult to deduce whether seemingly non-purposeful movements are spinal automatisms or volitional movements on their appearance alone. He noted that some of Ms. McKitty's movements in the

videos are quick jerks which have the appearance of spinal myoclonic.[2] He noted that there were, however, more complex squirming movements that involved multiple parts which could not be declared with any degree of certainty, on the basis of their appearance alone, to be of spinal origin. In particular, he noted Ms. McKitty's head turning, which he deposed has not been described in the literature of spinal movements in brain-dead patients.

[150] It is his evidence that although medical literature is unclear on the question of duration of spontaneous reflex movements associated with brain death, it suggests they do not last more than 72 hours. He referenced an article published by the Neurocritical Care Society in 2005 titled *Brain Death: Associated Reflexes and Automatisms,* authored by Samay Jain and Michael DeGeorgia. This article was a case report and review of the literature on movements seen after brain death. The article referred to a study which found that spinal reflexes were seen in the first 24 hours after brain death and remitted after 72 hours.

[151] According to Dr. Shewmon, Ms. McKitty's family believes that some of her movements are in response to command. His evidence is that the blood flow test

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[2] Sudden involuntary jerking of a muscle.

performed after the finding of brain death seems to indicate insufficient flow to support function in the cerebral hemispheres which would be necessary for Ms. McKitty to be responsive to command. His opinion is the test strongly implies that the movements are likely of spinal origin despite their atypical appearance and duration since the hypoxic event.

Dr. Carlen

[152] Dr. Carlen was retained by the applicant to provide opinion evidence with respect to whether Ms. McKitty met the criteria for a neurologic determination of death and to comment on her movements. He was qualified to give an opinion in that regard.

[153] Dr. Carlen has a specialty in clinical neurology. He is the Senior Scientist and Head of the Division of Fundamental Neurobiology at Toronto Western Research Institute. He has been on staff at Toronto Western Hospital as a neurologist since 1975. Since 2014, he has been the Tannenbaum Chair in Molecular Neuroscience at the Krembil Research Institute at the University of Toronto. He has also been a professor of neuroscience at the University of Toronto since 1988.

[154] Dr. Carlen examined Ms. McKitty for two hours on November 15, 2017. He also reviewed medical documentation and spoke with the family and attending

physicians in order to provide his opinion. Based on his examination of Ms. McKitty, Dr. Carlen's opinion is that Ms. McKitty meets the criteria for the neurologic determination of death as per the CMAJ Guidelines.

[155] With respect to her movements, his opinion is as follows:

> Because of the other signs of clinical brain death, the lack of cerebral blood flow, and the stereotypy of these movements, I attribute these movements to a higher spinal cord motor program initiation and not to intracranial activation of a motor program with the cerebrum. However, because these movements are persisting much long than is normally seen in patients diagnosed with brain death and because of their somewhat atypical and prolonged nature, I can understand the perception that they might represent the possibility of lack of brain death.

[156] It is Dr. Carlen's opinion that if there is no functioning brain stem, Ms. McKitty's movements come from the spinal cord. Once the lack of functioning of the brainstem is established clinically and the blood flow tests confirm there is no blood flow, then there is nothing happening above the brain stem. If there was evidence of cerebral blood flow then there could be some brain activity above the spinal cord, such that one would not be able to rule out brain activity.

[157] As there is no blood flow, no brain stem reflexes, and no response to pain, Dr. Carlen's opinion is that the movements he observed are attributable to a possibly higher spinal cord circuit. He noted, however, that there is no literature to support this opinion. His evidence is that as a general rule, spinal cord function lasts a few days. However, in the context of a functioning upper spinal cord, his

evidence is that there could be activity carried out on a sustained basis. It is his opinion that it is possible for the spinal cord to survive much longer.

[158] Despite the nature and duration of the movements, it is Dr. Carlen's opinion that Ms. McKitty is brain dead

Dr. Baker

[159] It is Dr. Baker's opinion that Ms. McKitty's movements are spinal reflexes and are not the result of any brain function. His evidence is that spinal reflexes are expected to occur following brain death and are inconsequential because they do not represent any activity in the brainstem or higher. Spinal reflexes do not change the definition of death.

[160] According to Dr. Baker, motor spinal reflex movements are present in approximately 40% to 50% of patients who meet the criteria for neurologic death. A significant range of motor movements have been observed in studies. These movements can include flexor/extension plantar responses (responses in the feet), triple flexion response (hip, knee, ankle flexion), abdominal reflex, extension and pronation of the arms (occasionally moving arms into a praying position on the chest before falling to the side, called the "lazarus sign"), flexion/extension of the fingers and toes, isolated jerks of the extremity and fingers, and leg movements when disconnected from the ventilator. Movements may occur spontaneously or

in response to touch. They cannot be elicited through verbal instruction because they are not purposeful reactions and are not instructed by the brain.

[161] Dr. Baker's evidence is that cranial nerves and spinal reflex nerves are distinct nerve groupings that originate in different parts of the body and function in different ways. Cranial nerves come from the brain stem, mostly serving the head. When the head is stimulated, such as pushing on the supraorbital nerve of the eyebrow, the pain will elicit a physical response. No response will occur after brain death because the brain stem no longer functions. Spontaneous reflex movements can be observed for a period of time after an individual has met the criteria for neurologic death. These movements originate in the spinal cord and not in the brain, and do not involve any brain activity.

[162] According to Dr. Baker, spinal reflex movements are restricted to stimuli in responses occurring below the neck. While cranial nerves cease to work because the brain is dead, spinal reflex movements continue to occur because the cells and the spinal cord are kept alive as a result of the continued mechanical ventilation.

[163] It is Dr. Baker's evidence that there are three types of nerves in the spinal cord: sensory, motor, and autonomic. None of these nerves rely on the brain for their function. Even without motor or sensory nerves, it is obvious the spinal cord

is alive because brain dead patients are able to maintain their blood pressure and have bowel movements, which are both functions of the autonomic spinal reflexes. The same phenomena is observed with individuals who are quadriplegic. Even though their spinal cord has been severed from their brain, the autonomic reflexes continue to occur.

[164] Dr. Baker was questioned about the article referred to above titled *Brain Death: Associated Reflexes and Automatisms.* This article referred to a study that found that spinal reflex movements remitted by 72 hours after a declaration of brain death. Dr. Baker's opinion is that the study is unreliable as there is no information about how many of the bodies were sustained by mechanical ventilation beyond 72 hours.

<u>Analysis</u>

[165] Ms. McKitty has been maintained on a mechanical ventilator since her admission to the Hospital. As reviewed above, a great deal of evidence was heard regarding her observed movements since she was declared brain dead on September 20, 2017 and what impact those movements have on whether Ms. McKitty meets the criteria for a neurologic determination of death. If the movements are not spinal cord reflexes then the movements must be the result of brain activity or function, meaning Ms. McKitty is not brain dead.

[166] Dr. Healey and Dr. Baker, who both care for critically ill patients and have a great deal of experience with brain death, observed Ms. McKitty personally and also viewed her movements recorded on cell phone video, as descried above. Both doctors gave evidence that Ms. McKitty's movements are consistent with spinal cord reflexes. This differs from the evidence of Dr. Shewmon and Dr. Carlen, who maintain that the movements are atypical in quality and duration.

[167] While Dr. Carlen's evidence is that he had never seen movements of this sort in someone declared brain dead, it is nonetheless his opinion that Ms. McKitty is brain dead. Given his clinical examination of Ms. McKitty and his review of the results of the ancillary test, which confirms that there is no blood flow to the brain, his opinion is that the atypical movements are the result of upper spinal cord function. His opinion does not support the applicant's position that Ms. McKitty's movements are inconsistent with a finding of brain death. He presented a theory that the movements were the result of the upper spinal cord's function, but he noted that there was no literature to support this opinion.

[168] Dr. Shewmon's opinion regarding Ms. McKitty's movements is equivocal as it relates to the source of the movements. While he opines that, given the nature and duration of the movements, the possibility of brain origin should be considered, he also states that the results of the blood flow test strongly imply that the movements are likely of spinal origin.

[169] Dr. Baker's opinion regarding the source of Ms. McKitty's movements is definitive. Unlike Dr. Shewmon, Dr. Baker examined Ms. McKitty and administered tests for the determination of death pursuant to the CMAJ Guidelines. I prefer Dr. Baker's opinion over Dr. Shewmon's more equivocal opinion. While Ms. McKitty's movements have continued beyond the time which is described in one article from the medical literature, Dr. Baker and Dr. Healey pointed out that there is little experience in maintaining mechanical ventilation beyond 72 hours after a declaration of death and almost no experience discussed in medical literature of maintaining support for this length of time. It is also Dr. Baker's evidence that there is no medical literature describing studies of chronic patients declared dead with mechanical ventilation.

[170] No evidence was presented that Ms. McKitty's situation of being maintained on mechanical ventilation for such an extended period of time after a declaration of brain death has been the subject of any medical study. It is, in essence, unchartered territory. As stated by Dr. Baker, however, cells and the spinal cord are kept alive as a result of the mechanical ventilation. Both Dr. Baker and Dr. Truog are of the opinion that bodies can be maintained for an extended period of time with the assistance of mechanical ventilation. According to Dr. Baker, there is no reason why movements would end at any particular point in time given the maintenance of mechanical ventilation.

[171] All physicians who have been involved with this matter feel empathy for the applicant and understand how the friends and family can be confused by a loved one's movements they observe after they have been declared brain dead. I accept the medical evidence that there is no blood flow to Ms. McKitty's brain which renders it medically impossible for Ms. McKitty's brain to be functioning in a manner that enables her to respond to commands as the family believes.

[172] While the expert opinions differ with respect to the nature of Ms. McKitty's movements, the one consistency is that each expert agrees that the test results do strongly suggest that the movements originate in the spinal cord and not the brain. Based on the totality of the medical evidence, including the results of the tests performed as part of the CMAJ Guidelines and the ancillary tests, I find that Ms. McKitty is brain dead despite the movements of her body.

Issue Three: Does the Charter Apply to the Determination of Death?

[173] The applicant's position is that a definition of death that does not violate the *Charter* is one that involves not only medical factors, but also considers the wishes, values and religious beliefs of the individual. Furthermore, accommodation of religious differences in the legal determination of death is consistent with rights protected by the *Charter*.

[174] The applicant's position is that the determination of death engages multiple fundamental constitutional rights and principles under sections 2(a), 7 and 15 of the *Charter*. To the extent that the CMAJ Guidelines and the legal process to determine death by neurologic criteria fail to accommodate Ms. McKitty's religious beliefs, the applicant asserts that the said guidelines and legal requirements are discriminatory and violate Ms. McKitty's fundamental constitutional and human rights to equality, religious freedom, liberty, security, and life itself.

[175] The applicant's position is that this court ought to adopt a definition and determination of death that provides for accommodation of those whose religious belief is that life is the beating heart rather than the capacity for consciousness, brain stem function, and an ability to breathe. The applicant urges the court to consider the *New Jersey Declaration of Death Act*, P.L. 1991, c. 90, which provides an exemption to the declaration of death on the basis of neurologic criteria for those whose religious beliefs are inconsistent with such a declaration. Section 26:6A-5 of the said Act states as follows:

> The death of an individual shall not be declared upon the basis of neurological criteria pursuant to sections 3 and 4 of this act when the licensed physician authorized to declare death, has reason to believe, on the basis of information in the individual's available medical records, or information provided by a member of the individual's family or any other person knowledgeable about the individual's personal religious beliefs that such a declaration would violate the personal religious beliefs of the individual. In these cases, death shall be declared, at the

> time of death fixed, solely upon the basis of cardio-respiratory criteria pursuant to section 2 of this act.

[176] The applicant's position is that the approach taken in New Jersey is an approach consistent with Canada's constitutional ideals, principles and values, including respect for religious beliefs, autonomy, liberty and equality.

[177] The respondent's position is that the *Charter* does not apply to the determination of death because the *Charter* does not apply to Ms. McKitty, who is brain dead, nor does it apply to Dr. Hayani, who is a physician.

[178] The relevant sections of the *Charter* are ss. 2(a), 7 and 15, which read as follows:

> 2. Everyone has the following fundamental freedoms:
> (a) freedom of conscience and religion;
>
> 7. Everyone has the right to life, liberty and security of the person and the right not be deprived thereof except in accordance with the principles of fundamental justice.
>
> 15. Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

[179] Before engaging in an analysis of whether the legal definition of death, which I have found includes brain death, violates Ms. McKitty's ss. 2(a), 7 or 15 *Charter* rights, there are two preliminary issues which must be addressed. The

first is standing to bring this application and the second is whether or not the *Charter* applies as this is a dispute involving two individuals.

Analysis

Who Has Standing to Bring this Application?

[180] I have found that at common law, the legal definition of death includes brain death and that Ms. McKitty meets the criteria in the CMAJ Guidelines for a neurologic determination of death. Given this finding, the question is: can Ms. McKitty, or anyone on her behalf, bring this application or have standing, given the finding of brain death?

[181] Following oral submissions, I requested further written submissions from counsel to address the following three cases; *Canada (Attorney General) v. Hislop* 2007 SCC 10, [2007] 1 S.C.R. 429; *Giacomelli Estate v. The Attorney General of Canada,* 2008 ONCA 346, 90 O.R. (3d) 669, leave to appeal to the Supreme Court of Canada refused, [2008] S.C.C.A. No. 278; and *Grant v. Winnipeg Regional Health*, 2015 MCBA 44, 319 Man. R. (2d) 67.

[182] In *Hislop,* the court was considering the constitutionality of various sections of the *Canada Pension Plan Act*, R.S.C. 1985, c. C-8. In that case, the

court found that an estate does not have standing to pursue relief under the *Charter.* At para. 73 the court found:

> In our opinion, the government's submissions have merit. In the context in which the claim is made here, an estate is just a collection of assets and liabilities of a person who has died. It is not an individual and it has no dignity that may be infringed. The use of the term "individual" in s. 15(1) was intentional. For those reasons, we conclude that estates do not have standing to commence s. 15(1) *Charter* claims. In this sense, it may be said that s. 15 rights die with the individual.

[183] *Hislop* was followed by the Ontario Court of Appeal's decision in *Giacomelli.* In that case, the issue was whether the government's refusal to compensate members of the Italian-Canadian community for their arrest and imprisonment during World War II was discriminatory and contrary to the freedoms and liberties of ss. 7 and 15 of the *Charter.* The appellant died before the matter was heard by the court.

[184] The court found that *Hislop* was determinative and that rights guaranteed by s. 15(1) of the *Charter* cannot be asserted by an estate because those rights are personal and, therefore, end with the death of the affected individual. The court found that while the appellant commenced his *Charter* claims during his lifetime, the claims had not been adjudicated or argued at the time of his death. As a matter of law, the *Charter* claims did not survive his death. The court also found that the reasoning in *Hislop* applied equally to claims involving s. 7 of the *Charter.*

[185] *Hislop* was considered by the Manitoba Court of Appeal in *Grant.* In that case, the plaintiff, who was the sister of the deceased and the administrator of his estate, commenced an action over the alleged disregard of the deceased after a prolonged stay in the emergency waiting room. One of the allegations was the deceased's ss. 7, 12 and 15 *Charter* rights were violated while he was alive and waiting for medical care. The claim was that the breaches of the deceased's rights contributed to his death. The motion judge found that the plaintiff lacked standing to advance the *Charter* claim as death extinguished the right to seek redress for a violation of the *Charter*, even where the violation allegedly contributed to the death.

[186] The Manitoba Court of Appeal found both *Hislop* and *Giacomelli* distinguishable. In *Grant*, the deceased did not die before the alleged breach of his *Charter* rights occurred. Furthermore, it was alleged in *Grant* that the *Charter* breaches contributed to the deceased's death – an allegation not made in either *Hislop* or *Giacomelli.* The court declined to strike the pleading. The court found that the plaintiff should be granted public interest standing to advance the *Charter* claim to clarify the serious issue of whether redress for a *Charter* violation ends on death when the alleged breach contributed to the death.

[187] In this matter, Ms. McKitty has been found to meet the criteria for brain death by five doctors. I have also found that the common law definition of death includes brain death. Ms. McKitty was declared dead in accordance with

neurologic criteria before this application was commenced. There were no *Charter* breaches that contributed to her death. Based on *Hislop, Giacomelli* and *Grant* therefore, had this action been framed as an action commenced by Ms. McKitty's estate, the application could not proceed because an estate does not have standing to commence ss. 7 and 15 *Charter* claims. As in *Giacomelli*, I see no reason why the same reasoning would not apply to other sections of the *Charter* including s. 2.

[188] This action was not, however, commenced as a claim by Ms. McKitty's estate. Her family, including her mother and father who are named in the pleading as her substitute decision makers, do not believe that she is dead and this is therefore Ms. McKitty's personal action and not that of her estate.

[189] Counsel for the respondent had indicated in her closing submissions that even if Ms. McKitty is not dead, the claim ought to have been commenced by a Litigation Guardian on her behalf in accordance with Rule 7 of the *Rules of Civil Procedure*, R.R.O. 1990, O. Reg. 194. The respondent, however, did not seek a stay of the application for the purpose of correcting the title of proceedings. Furthermore, the unique circumstances required a timely adjudication of the issues.

[190] Given the important issues raised in this case and the fundamental question of whether the legal definition of death violates the *Charter,* I am not prepared to strike the application on the basis that Ms. McKitty's estate cannot assert *Charter* rights. If I am to find that the legal definition of death violates the *Charter,* then Ms. McKitty may not be dead and, therefore, this would not be an application by her estate. Rather, it would be her personal application commenced by her Litigation Guardian.

Does the *Charter* Apply to Ms. McKitty, Who is Brain Dead?

[191] The applicant's position is that even if there has been finding of death by neurologic criteria, Ms. McKitty's religious beliefs ought to be accommodated such that her death will only occur at law when there is a loss of cardiorespiratory functioning, meaning her heart has stopped beating.

[192] The respondent's position is the *Charter* only applies to living persons. The respondent relies upon the finding in *Tremblay v. Daigle*, [1989] 2 S.C.R. 530, where the Supreme Court of Canada found that the Quebec *Charter of Human Rights and Freedoms,* R.S.Q., c. C-12 ("Quebec *Charter*") did not confer legal personhood upon a fetus. By analogy, the respondent asserts that the *Charter* does not confer legal personhood upon someone who is brain dead.

[193] It is useful to review *Daigle* and the analytical approach taken by the court to reach its conclusion that neither the Quebec *Charter* nor the legislature conferred legal personhood upon a fetus.

[194] In *Daigle*, the court was asked to consider whether a fetus had a right to life under the Quebec *Charter*, the *Civil Code of Lower Canada*, and the *Charter*. The court found that the applicant's argument had to be viewed in the context of the legislation in question. At pp. 552-553, the Court stated:

> The court is not required to enter the philosophical and theological debates about whether or not a foetus is a person, but, rather, to answer the legal questions of whether the Quebec legislature has accorded the foetus personhood...Nor are scientific arguments about the biological status of a foetus determinative for our inquiry....Ascribing personhood to a foetus in law is essentially a normative task. It results in the recognition of rights and duties – a matter which falls outside the concerns of scientific classification. In short, this Court's task is a legal one. Decisions based on broad social, political, moral and economic choices are more appropriately left to the legislature.

[195] The court examined the text of the Quebec *Charter* and other sources in order to interpret the Quebec *Charter*. The court noted that no cases were before it which dealt with the issue of fetal rights under the Quebec *Charter*. The court also noted that the Quebec *Charter* was framed in general terms and made no reference to fetal rights or defined the term "human being".

[196] The court considered the meaning of the words "human being" and "person" and found that the Quebec *Charter*, considered as a whole, did not

display any clear intention of the part of the framers to consider the status of a fetus.

[197] The court also engaged in an analysis of the wording of the *Civil Code* and found that a fetus is not a juridical person under the *Civil Code*.

[198] The court considered jurisprudence involving fetal rights and noted that a number of Anglo-Canadian courts have considered the status of a fetus and had consistently reached the conclusion that to enjoy rights, a fetus must be born alive. The court referred to *Dehler v. Ottawa Civic Hospital* (1979), 101 D.L.R. (3d) 686 (Ont. H.C.), aff'd (1980) 117 D.L.T. (3d) 512 (Ont. C.A.) wherein the Ontario High Court concluded that "the law has selected birth as the point at which the foetus becomes a person with full and independent rights." In *Medhurst v. Medhurst* (1984), 9 D.L.R. (4th) 252 (Ont. H.C.), the court stated that it did not consider a foetus as a person.

[199] Given the treatment of fetal rights in civil law and the consistency found in common law jurisdictions, the court found that it would be wrong to interpret the vague provisions of the Quebec *Charter* as conferring legal personhood upon the foetus. The court therefore found that birth is the point at which a fetus becomes a person and then has full and independent rights.

[200] Ms. McKitty has been declared brain dead. Given that status, the question is whether or not she is a person to whom the *Charter* applies. If so, she would be entitled to the rights and freedoms as set out in the *Charter*, including the right to freedom of religion, life, liberty, security of the person and equality.

[201] As stated in *Daigle*, this court should not enter into a philosophical and theological debate about whether Ms. McKitty, having been declared brain dead, is a person. Rather, this court's task is a legal one. The issue is whether the *Charter* confers personhood upon someone declared brain dead.

[202] As in *Daigle*, this analysis must consider the words used in the *Charter*. Sections 2, 7, 8, 9, 10, 12 and 17 of the *Charter* open with the phrase, "Everyone has the right..." In s. 15, the term "every individual" is used. In ss. 11 and 19, the term "any person" is used. Section 20 uses the term "any member of the public" and s. 24 uses "anyone." These terms are not defined.

[203] The *Charter* guarantees a number of rights and freedoms including, amongst others, the freedom of thought, conscience, belief, opinion, expression, voting, mobility, life, liberty, security of the person, the right not to be arbitrarily detained, the right to be informed promptly of the reasons for arrest, the right to be tried within a reasonable time, equality before and under the law without discrimination, and language rights. Ms. McKitty, having met the criteria for brain

death, which includes the lack of capacity for consciousness, lack of capacity to breath and no brain stem function, is not able to exercise any of these rights and freedoms.

[204] The plain and ordinary meaning of the term "everyone" in ss. 2 and 7 and "every individual" in s. 15 suggests that the *Charter* does not extend to include those declared brain dead but whose body is physiologically functioning as a result of external supports such as mechanical ventilation. Furthermore, a reading of the *Charter* as a whole does not display any intention of the part of the framers to consider the status of persons declared brain dead.

[205] By analogy to and relying on the analytical approach from *Daigle*, I find that brain death extinguishes personhood, and with it, the right to assert *Charter* protection. Whether personhood extends beyond brain death and is to include physiological or biological function as life is engaging in a philosophical and theological discussion – a discussion that is beyond the role of this court. Just as the courts have not engaged in a theological debate on when life begins, so too should the court not become involved in a debate about when life ends. Decisions that involve social, political, moral, bioethical, and philosophical considerations are appropriately left to the legislature.

[206] Support for this finding can also be found in *Hislop* and *Giacomelli* where the court found that *Charter* claims that had not been adjudicated upon at the time of death did not survive the individual's death.

[207] As Ms. McKitty is brain dead, she is not a person and it would be incorrect to interpret the provisions of the *Charter* as conferring legal personhood upon Ms. McKitty.

Does the Charter Apply to Dr. Hayani?

[208] Dr. Hayani, who determined that Ms. McKitty was dead on September 20, 2017, is the only respondent in this application. As this is an action involving two private litigants, the issue to be determined is whether the *Charter* applies to Dr. Hayani.

[209] According to s. 32 of the *Charter*, the *Charter* applies to the Parliament and government of Canada and the legislature and government of each province. In one of the earliest decisions from the Supreme Court of Canada dealing with s. 32, the court found the *Charter* only applies to government action (*RWDSU v. Dolphin Delivery Ltd*, [1986] 2 S.C.R. 573).

[210] Since then, however, there have been decisions expanding the application of the *Charter* beyond just government action to include hospitals when

they deliver publically-funded medical services (*Eldridge v. British Columbia (Attorney General)* [1997] 3 S.C.R. 624), but not when they manage their internal affairs (*Stoffman* v. *Vancouver General Hospital*, [1990] 3 S.C.R. 483).

[211] Relying upon *Eldridge*, the applicant asserts that the legislation governing the process of determining and then certifying death is as set out in the *VSA* and regulations. The applicant's position is that Dr. Hayani, in determining and certifying death pursuant to the *VSA,* is serving as a state actor in carrying out that legal duty. The applicant acknowledges that a physician's actions would not be subject to *Charter* scrutiny in every element of their functions but only for those in which they are engaging in a fundamentally public function. The applicant's position is that the determination and certification of death is such a function. The applicant also asserts that the process of determining and certifying death is done pursuant to statutory authority and that the nature of the act engages *Charter* scrutiny.

[212] The respondent's position is that the *determination* of death is not a governmental function. The *registration* of death, which is done after death has occurred, is done pursuant to the *VSA* and that may be a government function since there are many legal consequences that flow from such registration. The determination of death, however, is an action that involves a medical assessment, much like the diagnosis of other medical conditions. To find that the *Charter*

applies, the respondent submits that the court would have to find that Dr. Hayani's action in determining death was done either at the direction of the government or mandated by statute.

Analysis

[213] *Eldridge* involved a *Charter* challenge brought as a result of the Vancouver General Hospital's failure to provide sign language interpretation to its deaf patients. The Supreme Court of Canada found that the *Charter* applied in that case and the lack of sign language interpretation unjustifiably breached s. 15 of the *Charter*.

[214] At para. 51 of *Eldridge,* the court found that there was a direct and precisely-defined connection between a specific government policy, being the medical service delivery system, and the hospital's impugned conduct, which was the failure to provide sign language interpretation. The court found that the provision of the services was not just a matter of internal policy management but was an expression of government policy.

[215] According to *Eldridge*, there are two ways in which a party, other than the government, may be subject to *Charter* scrutiny. The first is determining if the party is, in fact, an apparatus of the government. The second is determining

whether the party, while not a government actor, is engaging in a government function or activity.

[216] In certain limited circumstances, it has been found that doctors can be subject to *Charter* scrutiny where they are acting as an agent of the government. In *R. v. Dersch*, [1993] 3 S.C.R. 768, the court gave the example of doctor who takes a blood sample illegally at the request of the police. In that scenario, the doctor would be acting as an agent of the government and his/her actions subject to *Charter* scrutiny.

[217] When Dr. Hayani administered tests and determined that Ms. McKitty was brain dead according to the CMAJ Guidelines, he was not acting as an agent of the government. He was performing his medical duty in diagnosing brain death.

[218] While Dr. Hayani was not an agent of the government when he determined death, the nature of this activity must still be considered to assess if it can, in some way, be ascribed to government. If the determination of death is the implementation of a statutory scheme or government program, then Dr. Hayani may be subject to the *Charter* when performing that activity. This "government activity" test was applied by the court in *Eldridge* where La Forest J. found, at para 44:

> Second, an entity may be found to attract Charter scrutiny with respect to a particular activity that can be ascribed to government. This demands an investigation not into the nature of the entity whose activity is impugned but rather into the nature of the activity itself. In such cases, in other words, one must scrutinize the quality of the act at issue rather than the quality of the actor. If the act is truly governmental in nature – for example, the implementation of a specific statutory scheme or government program – the entity performing it will be subject to review under the Charter only in respect of that act and not its other private activities.

[219] The *VSA* does not govern the determination of death in Ontario. Rather, it sets out the process by which acts such as birth, still-births, marriage, adoption, change of names and death are to be registered by the Registrar General, after the act has occurred. On an annual basis, the Registrar General then provides a report to the Lieutenant Governor in Council as to the numbers of these events. This is not legislation that provides any statutory authority for the determination of death but only authority for the registration of the event with the government, *after* the determination has been made. The registration of death, pursuant to the *VSA*, may be an act to further a government program or policy of maintaining a record of these events, perhaps to gather statistical information that is useful to the government for various purposes. This is not, however, the statutory authority pursuant to which Dr. Hayani was acting to determine that Ms. McKitty was brain dead.

[220] The accepted medical practice to determine death by neurological criteria that is used by physicians are the CMAJ Guidelines. There is no legislation that

either defines death or the process by which it is determined. It is left to the medical community to make those determinations.

[221] There is no direct and precisely-defined connection between a specific government policy and the respondent's conduct in determining death. There is no dispute that the determination of death has a number of legal consequences that result once an individual is declared dead. That does not, however, render the act of determining death an act of the government. The determination of death is a medical act that is carried out on a daily basis in hospitals throughout Canada. That medical determination is not connected to any government program or policy. Death is a diagnosis, similar to the diagnosis of many other medical conditions, which requires the application of medical tests, practices and guidelines. The determination of death is grounded in clinical assessments and made for medical purposes, not for the purpose of implementing the *VSA*.

[222] If I am not correct and the determination of death itself is subject to *Charter* scrutiny, the *Charter* would nonetheless not apply to Dr. Hayani, the only named respondent in this action.

[223] The issue of whether an individual doctor's actions can be subject to the *Charter* was not dealt with by the court in either *Eldridge* or *Stoffman*. It was, however, specifically considered by Himel, J. in the trial decision of *Rasouli* v.

Sunnybrook Health Sciences Centre, 2011 ONSC 1500, 105 O.R. (3d) 761. In that decision, Himel, J. found that the reasoning in *Eldridge* should not be extended to apply to the decisions of doctors. At para. 90, Himel, J. found:

> A doctor's status as an independent contractor owing an individual duty of care to a patient is such that the doctor may not be considered a government agent in the same manner as a hospital as determined in *Eldridge*. Furthermore, the fact that hospitals cannot be held vicariously liable for the actions of doctors puts into question the argument that doctors' decisions are subject to the *Charter* because they are being made on behalf of the hospital. The current common law relationship between hospitals and doctors, as well as between doctors and patients, provides a basis for the assertion that the decisions of doctors are not subject to the *Charter* in the same manner as those of hospitals.

[224] This finding was not considered by either the Court of Appeal or Supreme Court of Canada in either of each court's subsequent decisions. I nonetheless find it to be persuasive authority to find that the *Charter* does not apply to Dr. Hayani.

Issue Four: Is the Common Law Definition of Death Inconsistent with *Charter* Values?

[225] The applicant asserts that if the *Charter* does not apply, the common law should nonetheless be interpreted and applied in a manner consistent with *Charter* values.

[226] While the *Charter* does not apply directly to the common law where no governmental actor is involved, the *Charter* does have an indirect effect on the common law. In *Dolphin Delivery*, the Supreme Court of Canada found that the

judiciary ought to apply and develop the principles of common law in a matter consistent with the fundamental values enshrined in Canada's Constitution.

[227] The applicant's position is that the common law definition of death by neurologic criteria does not respect the constitutional values of freedom of religion, life, security of the person, and/or equality. The focus of the applicant's submissions was on religious freedom. The applicant asserts that the accommodation of religious differences in the legal determination of death is essential and consistent with these values. Specifically, the religious belief that death only occurs when there is a loss of cardiorespiratory function ought to be accommodated in the legal definition of death to protect persons who hold that belief. The applicant argues that support for this position is found in the State of New Jersey, which has included in its statutory definition of death an accommodation for those individuals whose religious beliefs are violated by the neurologic criteria to determine death.

[228] While evidence was heard regarding Ms. McKitty's religious beliefs, the issue in this case is not if there has been a breach of individual *Charter* rights but rather whether or not the common law definition of death is inconsistent with *Charter* values generally. Accordingly, these reasons will not involve a review or any finding regarding Mr. Stewart's evidence of Ms. McKitty's religious beliefs or

whether there was sufficient evidence that Ms. McKitty held a sincere religious belief that life ends only when the heart stops beating.

Analysis

[229] The analytical framework for a *Charter* values claim was fully explored in *Hill v. Church of Scientology of Toronto*, [1995] 2 S.C.R. 1130, where the Supreme Court of Canada found that in the context of civil litigation, the *Charter* will apply to the common law only to the extent that the common law is found to be inconsistent with *Charter* values. The court set out the following analysis:

> 98. Private parties owe each other no constitutional duties and cannot found their cause of action upon a *Charter* right. The party challenging the common law cannot allege that the common law violates a *Charter right* because, quite simply, *Charter* rights do not exist in the absence of State action. The most that the private litigant can do is argue that the common law is inconsistent with *Charter* values. It is very important to draw this distinction between *Charter* rights and *Charter* values. Care must be taken not to expand the application of the *Charter* beyond that established by s. 32(1), either by creating new causes of action or by subjecting all court orders to charter scrutiny. Therefore, in the context of civil litigation involving only private parties, the *Charter* will "apply" to the common law only to the extent that the common law is found to be inconsistent with *Charter* values.
>
> 99. Courts have traditionally been cautious regarding the extent to which they will amend the common law. Similarly, they must not go further than is necessary when taking *Charter* values into account. Far-reaching changes to the common law must be left to the legislation.
>
> 100. When the common law is in conflict with *Charter* values, how should the competing principles be balanced? In my view, a traditional s. 1 framework for justification is not appropriate. It must be remembered that the *Charter* "challenge" in a case involving private litigants does not allege the violation of a *Charter* right. It addresses a conflict between principles. Therefore, the balancing must be more flexible than the traditional s. 1 analysis undertaken in cases involving

> governmental action cases. *Charter* values, framed in general terms, should be weighed against the principles which underlie the common law. The *Charter* values will then provide the guidelines for any modification to the common law which the court feels is necessary.
>
> 101. Finally, the division of onus which normally operates in a *Charter* challenge to government action should not be applicable in a private litigation *Charter* "challenge" to the common law. This is not a situation in which one party must prove a prima facie violation of a right while the other bears the onus of defending it. Rather, the party who is alleging that the common law is inconsistent with the *Charter* should bear the onus of proving both that the common law fails to comply with *Charter* values and that, when these values are balanced, the common law should be modified. In the ordinary situation, where government action is said to violate a *Charter* right, it is appropriate that the government undertake the justification for the impugned statute or common law rule. However, the situation is very different where two private parties are involved in a civil suit. One party will have brought the action on the basis of the prevailing common law which may have a long history of acceptance in the community. That party should be able to rely upon that law and should not be placed in the position of having to defend it. It is up to the party challenging the common law to bear the burden of proving not only that the common law is inconsistent with *Charter* values but also that its provisions cannot be justified.

[230] This approach was followed in *Dore v. Quebec (Tribunal des professions)*, 2012 SCC 12, [2012] 1 S.C.R. 395, where the court found, at para. 40, that when interpreting a common law rule, there is no violation of a *Charter* right but a conflict between principles, so "the balancing must be more flexible than the traditional s. 1 analysis with *Charter* values providing the guidelines for any modifications to the common law."

[231] In *Law Society of British Columbia v. Trinity Western University and Brayden Volkenant*, 2018 SCC 32, 2018 CarswellBC 1510, Rowe J. noted at para.

167 that the concept of *Charter* values first appeared in cases where the *Charter* had no direct application. Rowe J. noted that the Supreme Court of Canada has had regard to *Charter* values in the development of common law principles in a number of cases: *R. v. Salituro,* [1991] 3 S.C.R. 654; *Dagenais v. Canadian Broadcasting Corp*., [1994] 3 S.C.R. 835; *Hill v. Church of Scientology of Toronto*; *M. (A.) v. Ryan* [1997] 1 S.C.R. 157; *WIC Radio Ltd. v. Simpson*, 2008 SCC 40, [2008] 2 S.C.R. 420; *Grant v. Torstar Corp.*, 2009 SCC 61, [2009] 3 S.C.R. 640.

[232] At para. 168, Rowe J. commented that this approach makes good sense in cases where the *Charter* has no direct application since, rather than subject common law rules to a s. 1 analysis, "the concept of *Charter* values allows the courts to move the common law toward coherence with the *Charter*."

[233] A starting point in determining whether the common law definition of death, which includes brain death, is inconsistent with *Charter* values is to consider the specific *Charter* values in issue and the principles which underlie the common law. The applicant primarily asserts that the *Charter* value at issue is freedom of religion. Although submissions were also made regarding the values of life, liberty and security of the person and equality, the bulk of the submissions focused on Ms. McKitty's religious beliefs.

[234] This is the first instance where the court has been asked to consider the values associated with the common law definition of death. I find that the values that underlie the common law is a definition of death that provides predictability, objectivity, and certainty for those who provide medical services but also for patients and family members.

[235] Section 2 of the *Charter* constitutionally protects freedom of conscience, religion, thought, and belief. The nature of the *Charter* protection of freedom of religion was described in *R. v. Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295, at paras. 94-95, as follows:

> The essence of the concept of freedom of religion is the right to entertain such religious beliefs as a person chooses, the right to declare religious beliefs openly without fear of hindrance or reprisal, and the right to manifest belief by worship or practice or by teach and dissemination. But the concept means more than that.
>
> Freedom can primarily be characterized by the absence of coercion or constraint... Coercion includes not only such blatant forms of compulsion as direct commands to act or refrain from acting on pain of sanction, coercion includes indirect forms of control which determine or limit alternative courses of conduct available to others. Freedom in a broad sense embraces both the absence of coercion and constraint, and the right to manifest beliefs and practices.

[236] The value protected by s. 2(a) is the right to hold religious beliefs and manifest those beliefs without fear or coercion.

[237] The Supreme Court of Canada recently considered s. 2(a) of the *Charter* in *Ktunaxa Nation v. Minister of Forests*, 2017 SCC 54, [2017] 2 S.C.R. 386. In that case, the applicant's position was that the Minister's decision to approve the construction of a ski resort would destroy the Grizzly Bear Spirit, which was central to the applicant's religious beliefs. It was not disputed that the Ktunaxa sincerely believed in the existence and importance of Grizzly Bear Spirit. They also sincerely believed that the ski development would drive the sprit from that place.

[238] The court found that the freedom to manifest the belief required an objective analysis of the interference caused by the impugned state action. The Minister's decision to approve the development did not interfere with the applicant's freedom to believe in the Grizzly Bear Spirit or their freedom to manifest that belief. At para. 71, the court found:

> Rather, the state's duty is to protect everyone's freedom to hold such beliefs and to manifest them in worship and practice or by teaching and dissemination. In short, the *Charter* protects the freedom to worship but does not protect the spiritual focal point of worship... Section 2(a) protects the freedom to pursue practices, like the wearing of a kirpan or *Multani* or refusing to be photographed in *Hutterian Brethren of Wilson Colony v. Alberta*... In this case, however, the appellants are not seeking protection for the freedom to believe in Grizzly bear Spirit or to pursue practices related to it. Rather, they seek to protect Grizzly Bear Spirit itself and the subjective spiritual meaning they derive from it. That claim is beyond the scope of s. 2(a).

[239] It is Mr. Stewart's evidence that Ms. McKitty's religious belief is that life ends when the heart stops beating as that is when the soul leaves the body. In

essence, the applicant is seeking to protect not just her belief, but to protect the soul which she believes does not leave the body until the heart stops beating. Applying the analysis of *Ktunaxa,* this would be beyond the scope of s. 2(a).

[240] The neurologic determination of death does not inhibit or prevent persons from holding the belief that death occurs when the heart stops beating. As set out in *Ktunaxa,* the state's duty is to protect the freedom to hold that religious belief and to manifest it in worship and practice or by teaching or dissemination. While the freedom to worship is protected, the spiritual focal point of worship is not protected. The common law definition of death as including brain death is not inconsistent with the *Charter* value of religious belief to believe in the soul and to manifest that belief. This is because the *Charter* value of religious freedom does not extend to protecting the object of the belief which, in this case, is the soul.

[241] If I am not correct and the common law definition of death as including brain death does violate the *Charter* value of religious freedom, the competing value which must be considered is that of a need for certainty, predictability and clarity in the law regarding the determination of death.

[242] A uniform definition, based on medical and secular criteria, avoids favouring one religion over another. If Ms. McKitty's Christian religious beliefs must be accommodated to comply with *Charter* values, so too must all religious

beliefs regarding the determination of death. That would lead to a lack of certainty and predictability in the provision of medical treatment following a declaration of death in accordance with the CMAJ Guidelines. Physicians would be required to determine if the individual had any religious belief that would necessitate ongoing mechanical support of the body. That could lead to the potential for disputes among family members regarding interpretation of their loved one's religious beliefs and/or disputes regarding the type, extent, and duration of medical services to be provided.

[243] Families of persons declared brain dead also need certainty and predictability in the determination of death, particularly during times of emotional distress and trauma. A clear, uniform and objective definition of death will provide clarity and certainty to families.

[244] A definition of death that provides exemptions for those whose religious beliefs would be violated by a neurologic determination of death could also lead to uncertainty and unpredictability in other areas of legal significance. For example, in *People v. EULO* discussed above, the defendant argued that it was the act of organ removal that killed his girlfriend after there was a neurologic determination of death, and not his act of shooting her. It is possible that if his girlfriend's religious belief was that she was alive for so long as her heart was beating and that belief was accommodated, the accused's argument might have to be considered by the

court. The lack of an objective definition of death could lead to this kind of nonsensical result, further underscoring the importance of certainty, clarity and predictability. In a similar vein, a common definition of death without exemptions provides certainty and clarity in other areas of the law, such as determining the date of death in wills and estates cases, family law cases, etc.

[245] The applicant urges this court to the approach taken by the state of New Jersey, which specifically accommodates those whose religious belief would be violated by a neurologic determination of death. In those instances, death should be declared on the basis of cardio-respiratory criteria. The New Jersey legislation (i.e. *New Jersey Declaration of Death Act*, cited above) is of limited assistance as it does not address some significant policy considerations such as what, if any, medical intervention is required to maintain the cardio-respiratory system and if it extends beyond mechanical ventilation.

[246] It is also worth noting that it was legislation that carved out this exemption in New Jersey and not the common law. It is open to the government in Ontario to take a similar approach.

[247] At this time, Ms. McKitty is in the ICU unit at the Hospital. She is being provided with nutrients, hydration, and mechanical ventilation. She has been provided with antibiotics to fight infections. Evidence was heard about cancellation

of surgeries and a lack of ICU beds for post-operative care as a result of Ms. McKitty being maintained in the ICU at the Hospital. There was also evidence that patients requiring ICU beds were being managed in other non-specialized areas of the hospital which cannot provide the same level of specialized care available in the ICU.

[248] Although no evidence was led regarding the cost of such services, it is reasonable to conclude that there would be significant costs to provide medical support for someone whose religious belief is that death only occurs when there is a cessation of cardiorespiratory function. Those costs could escalate if additional medical intervention is needed to maintain the body and/or as other organs fail and arguably must be maintained so long as the heart is beating.

[249] In addition, the possibility of adverse impacts on the organ donation system would have to be contemplated. Although there were no submissions made in this regard, this is one of the many policy considerations that are beyond the scope of this court to consider but must be addressed if there is to be an accommodation of religious beliefs in the determination of death.

[250] I therefore find that the common law definition of death as including brain death is consistent with *Charter* values.

Section 7 and 15

[251] While I have found that the *Charter* does not apply, I should comment on Section 7 of the *Charter* which states that everyone has the right to life, liberty and security of the person and the right not be deprived thereof except in accordance with the principles of fundamental justice. In *Carter v. Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331, the court found at para. 72 that laws that impinge on life, liberty and security of the persons must not be arbitrary, overbroad or have consequences that are grossly disproportionate to their object.

[252] In *Carter*, the court noted at para. 62 that the case law suggests that the right to life is engaged where the law or state action imposes death or an increased risk of death on a person either directly or indirectly. At para. 60 of *Carter*, the court referenced the dissent decision at the Court of Appeal by Finch C.J.B.C. where he stated; "The point at which the meaning of life is lost, when life's positive attributes are so diminished as to render life valueless... is an intensely personal decision which "everyone" has the right to make for him or herself."

[253] The matter before this court is not about state action that imposes death or an increased risk of death. It is not about the right to determine when to die. Rather, the issue before this court is the very definition of death and the medical criteria used to make that determination.

[254] The determination of death is made by physicians. The CMAJ Guidelines set out the criteria to be used to make the determination of brain death. Those guidelines were established in 2006 and are used on a daily basis in hospitals throughout Canada.

[255] As I have found above, the determination of death is not governed by statutory authority nor is it an act done in furtherance of a government policy or program. As such, there is no law to review to determine if it is arbitrary, overbroad or have consequences that are grossly disproportionate to their object. If there was such a challenge to legislation, the appropriate responding party would be the government and not Dr. Hayani.

[256] If I am not correct and the CMAJ Guidelines are subject to *Charter* scrutiny, the guidelines are not arbitrary for failing to consider a person's wishes and beliefs in determining if they are dead. The CMAJ Guidelines are not overbroad for failing to carve out a religious exemption or for failing to recognize that physiological function of the body should be considered life if that is the person's personal value and belief.

[257] The CMAJ Guidelines were developed in accordance with years of scientific and medical research and testing. Further, the criteria used in the said guidelines are intended to provide objective criteria and testing for medical

practitioners to apply in order to determine brain death and in that vein, they do not go too far to interfere with conduct that bears no connection to its objective. They do not risk putting individuals, who have the capacity for life, at risk of improperly being declared dead.

[258] Section 15 of the *Charter* is the equality provision. While I have found that the *Charter* does not apply, I will briefly address the applicant's submission. The applicant's position is that Ms. McKitty is brain injured and is a vulnerable person with a disability. As such, in order to preserve autonomy and equality, those most vulnerable must be protected.

[259] Ms. McKitty is not, however, suffering from a brain injury. The uncontroverted medical evidence is that there is no blood flow to her brain. Her brain is dead. The medical evidence is that a brain cannot recover after being declared dead. She is not in a vegetative state nor is she minimally conscious. The criteria used to determine brain death do not have an adverse effect on her because she is disabled as she is not disabled.

Issue Five: Does the CCB have jurisdiction in situations where the person has been declared dead?

[260] The CCB is an administrative tribunal tasked with hearing disputes involving determinations of incapacity of individuals and medical treatment disputes involving those who are found incapable.

[261] The applicant's position is that any dispute regarding whether or not Ms. McKitty meets the criteria for brain death should be dealt with by way of an application to the CCB for two reasons. The first is that the withdrawal of mechanical ventilation is treatment since mechanical ventilation enables Ms. McKitty to continue to physiologically function. If it is treatment, then the respondent requires consent from the substitute decision maker before it can be withdrawn. Relying upon *Rasouli (Litigation Guardian of) v. Sunnybrook Health Sciences Centre*, 2013 SCC 53, [2013] 3 S.C.R. 341, the applicant's position is that any dispute regarding treatment modalities is to be dealt with by way of application to the CCB pursuant to the *HCCA*.

[262] The second reason is that the applicant asserts that Ms. McKitty's views, wishes, and religious beliefs should be considered as part of the assessment to determine whether she is dead by neurologic criteria and the CCB is best-suited to hear such determinations in a timely and cost-effective manner. The applicant

submits that the CCB regularly assesses questions about consent to the withdrawal of treatment, including the withdrawal of mechanical ventilation that may result in the death of a patient. The Board does so based upon factors set out in s. 21 of the *HCCA* which includes both medical considerations and also the individual's wishes, values and beliefs in assessing the best interest of the individual. The applicant's position is that those same factors should be considered in the determination of whether an individual is brain dead if a dispute arises.

[263] The respondent's position is that the CCB does not have jurisdiction as Ms. McKitty has been declared brain dead and is therefore, at law, not a person. Furthermore, *Rasouli* is distinguishable as Mr. Rasouli was not declared brain dead and, accordingly, withdrawal of life support was considered a form of treatment. The respondent asserts that because Ms. McKitty is brain dead, the withdrawal of mechanical ventilation is not treatment that requires consent of the substitute decision maker and/or application by the respondent to the CCB to resolve any dispute as it is not providing a therapeutic, preventive, palliative, diagnostic, cosmetic, or other health-related purpose.

Analysis

[264] In 1996 the Ontario Legislature passed the *HCCA*, which provides a statutory framework governing consent to treatment for capable and incapable patients. The general premise of the *HCCA* is that medical treatment cannot be administered unless the person is capable with respect to the treatment and has given consent or the person is not capable and the person's substitute decision-maker has given consent. If the patient is incapable, the *HCCA* sets out the process governing consent to treatment and who can be appointed as substitute decision-makers. In determining whether or not to grant or refuse consent, the substitute decision-maker must respect prior applicable wishes of the patient expressed while the patient was capable. If there are no such wishes, the substitute decision-maker must take into consideration a series of factors set out in s. 21(2) in determining the best interests of the patient. If there is a dispute, an application is made to the CCB.

[265] In *Rasouli*, the court described the general purpose of the *HCCA* at para. 28 as follows:

> In summary, the HCCA contemplates disputes between physicians and substitute decision-makers over the care of incapable patients, and provides for their resolution by the Board, an independent, quasi-judicial body with specialized jurisdiction over matters of consent to medical treatment.

[266] In *Rasouli*, Mr. Rasouli was initially found to be in a persistent vegetative state and then, after further assessment, minimally conscious. He still had brain stem function and therefore was not brain dead. The hospital intended to withdraw life support as the physicians concluded that life support no longer offered a medical benefit to Mr. Rasouli, given his unconscious state and the extreme unlikelihood of his recovery. The hospital's position was that withdrawal of life support (mechanical ventilation) was not treatment and therefore it did not need to apply to the CCB when the substitute decision maker did not agree with its decision.

[267] The court found that withdrawal of life support was treatment. In reaching that decision, it considered the definition of "treatment" in s. 2 of the *HCCA*, which states as follows:

> "Treatment" means anything that is done for therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan ...

[268] The court found that this definition covered the provision of life support as effective in keeping the patient alive and forestalling death. It found that life support fell within the terms "therapeutic and preventative" purposes.

[269] The court also found that treatment extended to the withdrawal of treatment, which included the withdrawal of life support. At para. 68, the court found as follows:

> "Withdrawal of life support is inextricably bound up with care that serves health-related purposes and is tied to the objects of the act. By removing medical services that are keeping a patient alive, withdrawal of life support impacts a patient's autonomy in the most fundamental way. The physicians attempt to exclude withdrawal of life support from the definition of "treatment" under s. 2(1) of the HCCA cannot succeed."

[270] In reaching its conclusion, the court noted that the practice of the CCB, although not determinative, reinforced the conclusion that treatment under s. 2(1) includes withdrawal of life support. The court noted that the CCB had regularly exercised its jurisdiction in cases where physicians proposed to withdraw life support, consistent with the view that withdrawal of life support constituted "treatment" under the *HCCA*.

[271] There have been three recent decisions from the CCB wherein the Board declined jurisdiction to hear matters involving individuals who had been declared brain dead. These decisions, while not binding, are persuasive authority for this court to consider in the case at bar.

[272] In each of the decisions there had been a determination of death by neurologic criteria and the doctor had informed the patient's family that mechanical ventilation would be removed. In each of the cases, an application was made to

the CCB pursuant to section 35 of the *HCCA* as the substitute decision-maker was disputing the determination of death and opposed the withdrawal of mechanical ventilation.

[273] *In EI*, a decision released on September 30, 2016, after the application had been made to the CCB and before a determination of the jurisdiction issue, the patient's heart stopped beating. The CCB accepted the applicant's withdrawal of the application but agreed that the issue was of importance and so released its decision. At page 10, Vice Chair Patton held as follows:

> I am also uncertain as to whether this is an issue best determined by legislation. Other provinces have chosen to set out in legislation a legal definition of death. Ontario has not done so. While it may be within the role of the Board to delineate its jurisdiction, the determination of such a question has much more expansive policy implication than could be considered in an application before this Board.

[274] Vice Chair Patton considered the question about whether the *HCCA* applies and whether the Board has jurisdiction to hear applications about a person for whom a death certificate is issued. At page 10, she found that the Board does not have jurisdiction to hear an application relevant to treatment of a person where a medical certificate of death has issued in respect to that person. Vice Chair Patton described the process that is followed for a physician to declare death by neurological criteria. She noted that such a declaration is significantly different from declaring a patient to be in a "persistent vegetative state" or "minimally conscious

state." In those cases, some brain stem function remains, even if limited, and those persons will not meet all of the criteria required to declare death by neurological testing.

[275] At page 12, Vice Chair Patton found that the primary issue to be resolved is whether or not there is a role for the CCB to play in questioning a determination of death by a physician. She concluded that if there is a role for a legal review of such a determination, it must lay with the courts. She specifically found that once a declaration of death by neurological criteria is made, the *HCCA* can have no application.

[276] That decision was followed by *H. (U.), Re,* 2016 CarswellOnt 21402, released on October 20, 2016. Again, the CCB was asked to determine whether or not it had jurisdiction to hear an application with respect to a dispute regarding the removal of ventilation when there had been a neurologic determination of death. The position of the hospital was that the neurologic definition of death is the legal definition of death. At page 8, the Board found that it accepted the doctor's evidence that UH experienced neurologic death and therefore death according to the law of Ontario.

[277] In *H. (U.),* the panel noted that whether or not EI was a "person" under the *HCCA* was not determined by Vice Chair Patton. The Board found that death terminates the person. At page 10 the Board found as follows:

> Thus, when death occurs, there is no longer a "person" who is subject to "treatment" under the *HCCA*. Since section 35 of the *HCCA* contemplates that an application for directions under this section relates to treatment of a person, where there is no person to treat, neither the substitute decision-maker nor the attending physician may apply under that section for directions. That is because the preconditions for an application are absent. Therefore, the *HCCA* can have no application and there is no role for the Board in circumstances such as these.

[278] The Board found that the application of mechanical ventilation to the dead body of UH did not fall within the definition of "treatment" as set out in section 2 of the *HCCA*. Specifically, the Board found that the application of mechanical ventilation was neither therapeutic nor preventative because UH had experienced neurologic death and thus was legally dead. It was found that mechanical ventilation could not prevent death as UH had already died. Similarly, mechanical ventilation could not be considered therapeutic meaning beneficial or remedial or restorative or corrective because there was no condition to correct.

[279] The CCB released its decision in *TP, Re*, 2017 CarswellOnt 20410, on September 22, 2017. In *TP*, the substitute decision-maker was challenging the finding of death and requested that the Board prevent discontinuance of

mechanical ventilation. The hospital's position was that the individual was no longer alive, mechanical ventilation was not treatment, and that the CCB had no jurisdiction to consider the application. At page 6, the Board found as follows:

> The Board is a statutory tribunal and only has authority that is granted by legislation. There is nothing in the law that would indicate that the Board can proceed with an application about treatment when the patient has been declared dead. The application before me was a "Form G" application, filed by SP; this is an application to determine whether a substitute decision-maker has complied with the law when making a decision about treatment (s.37, *HCCA*). That application may only be brought by a health practitioner who is proposing treatment and SP had no standing to initiate the application. The application could be amended to one that SP could initiate although I found it unnecessary in the circumstances as no application would result in the Board having jurisdiction to proceed.

[280] At page 8, the Board found as follows:

> Following a declaration of death, a body can no longer be said to be subject to "treatment" (as defined in s.1, *HCCA* "anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan"). There would be no longer any treatment at issue. Removal of mechanical ventilation in the case of a deceased person could not be considered treatment. I find that the determination of death in this case was made in accordance with law and the Board had no jurisdiction to review that determination or to further consider this or any other application with respect to TP.

[281] Based on these decisions, the CCB has clearly stated that it does not have jurisdiction to deal with disputes regarding persons declared dead by neurologic criteria.

[282] I have found that physiological functioning of a body, maintained through artificial means, is not a criterion to consider for the purpose of determining brain death. I have also found that the legal definition of death includes brain death and that the criteria used to determine brain death are as set out in the CMAJ Guidelines. I have also found that Ms. McKitty meets these criteria for brain death.

[283] It flows from these findings that Ms. McKitty would not be a person for whom any dispute regarding treatment can be heard by the CCB. Having been declared brain dead, she is not an incapable person for whom consent must be obtained from a substitute decision-maker to provide consent to treatment.

[284] The next issue is whether the withdrawal of mechanical ventilation is treatment. According to s. 2 of the *HCCA*, "treatment" means anything done for therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose.

[285] At this time, mechanical ventilation is maintaining Ms. McKitty's physiological functioning. With that support, her heart is pumping, her blood is circulating, she is able to process hydration and nutrients, her kidneys and bowels function, as do other organs such as her liver. This is not, however, treatment for a therapeutic or other health-related purpose. Ms. McKitty is brain dead. The

evidence from the physicians is that brain death is irreversible. A brain that has died cannot be treated and recover.

[286] The use of mechanical ventilation to maintain physiological function of a body after a declaration of brain death is not treatment as defined in the *HCCA*.

[287] Treatment is for persons, even those with impaired levels of consciousness as Mr. Rasouli. As Ms. McKitty is not a person medically or at law, there are no medical services that can be provided to her that would be considered treatment. This includes mechanical ventilation.

[288] As I have found that a declaration of death by neurologic criteria is legal death, the CCB does not have jurisdiction. The focus of the CCB is on disputes with respect to treatment of incapable persons. An individual declared brain dead would not be a person for whom any treatment is required as that person would be dead and not incapable.

[289] My findings are consistent with the findings of the CCB in its three decisions cited above, each of which involved applications to the board involving persons who had been declared dead by neurologic criteria.

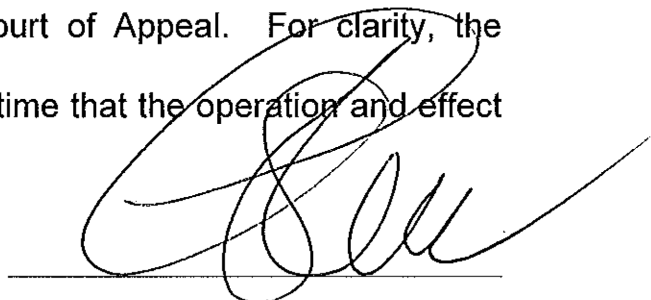
[290] I will comment on the applicant's position that the CCB is best able to consider an individual's values, wishes and beliefs as it is has a legislative

requirement to do so. As I have found above, death is determined by medical criteria. The determination is not subject to an individual's values, wishes or beliefs and, as such, the CCB has no distinct or specialized skills that are would make it best-suited to deal with such issues.

Conclusion

[291] Based on my findings herein, the application is dismissed and the injunction is vacated.

[292] The operation and effect of this decision is suspended until either the 30 day deadline to file the notice of appeal expires or, if an appeal is filed within the deadline, until further order of the Ontario Court of Appeal. For clarity, the injunction remains in place during the period of time that the operation and effect of this decision is suspended.



L. Shaw J.

Released: June 26, 2018

CITATION: McKitty v. Hayani, 2018 ONSC 4015
COURT FILE NO.: CV-17-4125
DATE: 2018 06 26

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

MS. MCKITTY DESEREE MCKITTY, BY HER SUBSTITUTED DECISION MAKERS, STANLEY STEWART AND ALYSON SELENA MCKITTY, Applicant

AND:

DR. OMAR HAYANI AND WILLIAM OSLER HEALTH CENTRE, BRAMPTON CIVIL HOSPITAL, Respondent

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REASONS FOR DECISION

L. Shaw J.

Released: June 26, 2018