**CITATION:** Morlani et al. v. Haddara, 2021 ONSC 7288
**COURT FILE NO.:** CV-21-00001843
**DATE:** 20211102

**SUPERIOR COURT OF JUSTICE – ONTARIO**



**RE:** Marco Morlani, By His Substitute Decision Maker and Litigation Guardian, Deborah Morlani, Applicant

**AND**

Dr. Wael Haddara, Respondent

**BEFORE:** Justice S. Nicholson

**COUNSEL:** H. Scher, for the Applicant

C. Brandow and J. Petrella, for the Respondent

F.W. Osunade, for Marco Morlani

**HEARD:** November 1, 2021

## REASONS

NICHOLSON J.:

[1] Mr. Marco Morlani, age 29, lies in a hospital bed. He has been there since October 19, 2021. He apparently attempted suicide by hanging. It is estimated that he had no oxygen supply to his brain for approximately 30 minutes. CT Scans during the second and third day in the Intensive Care Unit demonstrated swelling of his brain as well as areas of brain tissue death.

[2] Mr. Morlani was assessed by a neurologist on October 20, 2021, who concluded based on the lack of pupil reactivity to light and blink response, lack of response to central or peripheral stimulation, and fixed gaze, that he had "absent brainstem reflexes".

[3] On October 22, 2021, the same neurologist re-assessed Mr. Morlani and opined that he may have progressed to neurologic death due to a worsening of his condition. The neurologist recommended the completion of formal testing for neurological death determination.

[4] As of October 28, 2021, Mr. Morlani's situation had not improved. He was not arousable, his pupils were fixed and his corneal reflex was absent. His gag reflex was absent. He was fully reliant on a ventilator.

[5] Neurological death in Canada is defined as "irreversible loss of the capacity for consciousness combined with the irreversible loss of all brainstem functions, including the capacity to breath". Death will be pronounced if there has been a neurological determination of death.

[6] In Canada, there are standard steps in determining neurological death. Those steps include:

(a) Ascertaining an etiology or cause of brain injury capable of causing irreversible loss of capacity for consciousness and all brainstem functions,
(b) The absence of reversible causes of coma, or of confounding factors,
(c) Absences of brainstem reflexes, which are assessed clinically at the bedside, and
(d) Confirming that the patient has lost the ability to breathe spontaneously, determined by an "apnea test".

[7] It is the apnea test that is front and centre of this application. Mr. Morlani's current "most responsible physician", the Respondent, Dr. Wael Haddara, deposes in his affidavit that it is his judgment that if the standard steps to confirm neurological determination of death are completed, the outcome will be a neurological determination of death with a pronouncement of death being made. In short, it is his opinion that Mr. Morlani has already died. It is his further opinion that Mr. Morlani has experienced a significant neurological insult and will not recover, even if brain death has not occurred.

[8] Accordingly, the treating physicians propose to complete the standard steps including the apnea test on Mr. Morlani to determine whether he is neurologically dead.

[9] Mr. Morlani's mother, Deborah Morlani, and his father, Americo Morlani, are the substitute decision makers in respect of Mr. Morlani. They reportedly differ on how they wish to proceed. Mrs. Morlani has made comments to the physicians that indicate that she does not believe or trust that brain death equates with death. She believes that doctors can be wrong. She opposes the apnea test and has steadfastly refused to provide her consent for the test.

[10] Americo Morlani reportedly has advised the doctors that he wishes for the standard steps to be taken to confirm whether his son is still alive.

[11] Mrs. Morlani has commenced an application pursuant to the *Health Care Consent Act, 1996,* SO 1996, c 2, Sch A, (the "HCCA") to the Consent and Capacity Board (the "Board") in essence to determine if the apnea test is consistent with Mr. Morlani's wishes and in his best interests. At a preliminary case conference before the Board, the Respondent doctor took the position that the Board lacked jurisdiction to make those findings and indicated that he was going to proceed with the apnea test.

[12] Accordingly, Mrs. Morlani has brought this urgent application before me for an injunction to prevent the apnea test from proceeding and to allow the Board to review the matter. Dr.

Haddara has agreed to wait for my decision. In the meantime, Marco Morlani continues to be ventilated and to be infused with fluids and medications.

*Apnea Testing:*

[13] An apnea test assesses respiratory effort. If an apnea test demonstrates respiratory effort of any kind, then the test is aborted and the conclusion will be that the patient does not meet the criteria for neurological death.

[14] During an apnea test, an intact brainstem will react to rising levels of carbon dioxide in the blood by stimulating breathing. Accordingly, during the apnea test, the patient is monitored for any breathing efforts while the carbon dioxide levels are increased. Once a sufficient level of increase in carbon dioxide has been reached, with a concomitant rise in the blood's acidity level, if breathing has not been initiated, the apnea test has determined brainstem death.

[15] It is clear from the materials submitted on this application that the apnea test is not without its critics. Affidavits from two such critics were submitted by the Applicant. Dr. D. Alan Shewmon, a Professor Emeritus of Pediatrics and Neurology at the David Geffen School of Medicine at UCLA is of the opinion that there are significant risks of harm associated with apnea testing, including the serious prospect that the test itself may cause harm or neurological death for a patient who is not neurologically dead. He considers the apnea test to be an unethical procedure.

[16] Dr. Ari Joffe concurs in Dr. Shewmon's disdain for the apnea test. Dr. Joffe is a Pediatric Critical Care specialist at the Department of Pediatrics, John Dossetor Health Ethics Center, Stollery Children's Hospital at the University of Alberta in Edmonton. His research interests include ethics in critical care, specifically regarding brain death. He has published a number of articles about the use of apnea tests in declaring brain death. He describes that the apnea test fails to adequately account for two confounding factors that are usually present and not tested for, including a potentially reversible high cervical spinal cord injury resulting from brain herniation. Dr. Joffe is also of the view that the apnea test has the potential to cause harm to the individual undergoing the testing. In short, the apnea test may cause brain death itself in a person who had not yet suffered brain death.

[17] The Respondent argues that Dr. Joffe and Dr. Shewmon do not represent the mainstream of opinion with respect to apnea testing.

[18] The Respondent's expert is Dr. Andrew Baker, the Chief of the Department of Critical Care, Chief of the Department of Anaesthesia, and the Medical Director of the Surgery and Critical Care Program at St. Michael's Hospital, Unity Health Toronto, in Toronto, Ontario. Dr. Baker was one of the authors of the Canadian Medical Association Journal Guidelines ("CMAJ Guidelines") published in 2006 that established a Canadian definition, criteria, and minimum testing requirements for determining brain death. Dr. Baker was also one of the authors of a Special Communication published in the Journal of the American Medical

Association on the Determination of Brain Death/Death by Neurologic Criteria as part of the World Brain Death Project. Notably, Dr. Baker has also led the Ontario wide Critical Care COVID-19 Command Centre.

[19] Dr. Baker opines that it is the fundamental role of a physician to assess his or her patient. It is below the standard of care in respect of a patient with coma for a physician in Ontario not to assess the condition of the patient's brainstem. Similarly, a qualified physician must complete an assessment to assess for death using neurological criteria on any patient whom they believe may meet those criteria in order to meet the standard of care expected of a physician in Ontario.

[20] Dr. Baker states as follows in his affidavit:

> "The apnea test is a routine standard assessment for the determining of death by neurological criteria and endorsed uniformly by worldwide medical societies (see Exhibits "B" and "C"), with clear procedures for its safe conduct, and always performed under circumstances with high suspicion and likelihood of death (i.e. when all the other brainstem reflexes have ceased in the context of an irreversible underlying cause)."

[21] Dr. Baker deposes that the risks claimed to exist by Drs. Shewmon and Joffe are unproven.

*The Scheme of the HCCA*:

[22] The purposes of the HCCA are set out in section 1 of the Act. The purposes include the following:

(a) To provide rules with respect to consent to treatment that apply consistently in all settings;
(b) To facilitate treatment, admission to care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters,
(c) To enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed and persons who are to receive personal assistance services by,
    (i) Allowing those who have been found to be incapable to apply to a tribunal for a review of the finding,
    (ii) Allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on their behalf concerning treatment, admission to a care facility or personal assistance services, and
    (iii) Requiring that wishes with respect to treatment, admission to a care facility or personal assistance services, expressed by persons while capable and after attaining 16 years of age, be adhered to.
(d) To promote communication and understanding between health practitioners and their patients or clients;

(e) To ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment, admission to a care facility or a personal assistance service; and
(f) To permit intervention by the Public Guardian and Trustee only as a last resort in decisions on behalf of incapable persons concerning treatment, admission to a care facility or personal assistance services.

[23] The threshold requirement for triggering the jurisdiction of the Board under the HCCA is found in the definition of "treatment" contained in section 2.

> "treatment" means anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include,
>
> (a) The assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the *Substitute Decisions Act, 1992* of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,
> (b) The assessment or examination of a person to determine the general nature of the person's condition,
> (c) The taking of a person's health history,
> (d) The communication of an assessment or diagnosis,
> (e) The admission of a person to a hospital or other facility,
> (f) A personal assistance service,
> (g) A treatment that in the circumstances poses little or no risk of harm to the person,
> (h) Anything prescribed by the regulations as not constituting treatment.

[24] The scheme of the HCCA, therefore, requires a health practitioner to obtain consent prior to performing "treatment". Treatment encompasses a broad swathe of medical procedures, ensuring that in the majority of procedures done for a health-related purpose, the HCCA requires a health practitioner to obtain consent of the patient. Under s. 10 of the HCCA,

> 10(1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,
>
> (a) He or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or
> (b) He or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act.

[25] As a result of the definition of "treatment", consent does not need to be obtained in relation to any of the items (a) through (h) that are not included in the definition of "treatment".

[26] Under the HCCA, a substitute decision-maker may give or refuse to give consent to a treatment on behalf of a person who is incapable with respect to the treatment.

[27] Section 18 of the HCCA prevents a health practitioner who proposes a treatment and finds that the person is incapable, from commencing the treatment if the practitioner is informed that the person intends to apply or has applied to the Board for a review of the finding of being incapable or if another person intends to apply to the Board to be appointed as a representative of the incapable person to give or refuse consent. Thus, the default procedure in relation to "treatment" is that the health practitioner must wait to proceed until the matter is brought before the Board. The section sets out time frames that must elapse once the health practitioner is informed of the application before they can commence treatment. This can include waiting until the Board has rendered a decision, and perhaps the final disposition of an appeal from the Board.

[28] Section 20 of the HCCA provides a list of persons who may give or refuse consent. This includes family members such as spouses, parents, children and siblings. These persons, or "substitute decision-makers" ("SDMs") are listed in order of who has priority. When two equally ranked persons disagree, the Public Guardian and Trustee shall make the decision concerning consent.

[29] The HCCA sets out a comprehensive set of "Principles for giving or refusing consent" in section 21. This includes if the SDM knows the incapable person's wishes applicable to the circumstances. Alternatively, the incapable person's best interests govern. Specific factors are enumerated to determine best interests. These include medical factors.

[30] Section 37 of the HCCA permits a health practitioner to apply to the Board if consent to treatment is given or refused by a SDM, and the health practitioner is of the opinion that the SDM did not comply with section 21. Importantly, the Board, in determining whether the SDM complied with section 21, may substitute its opinion for that of the SDM. In other words, the SDM does not make the ultimate decision. Instead, the Board makes the decision after having received input from the SDM and health practitioners.

[31] The Board has specific time frames by which it must complete its process. It must begin a hearing within seven days after receiving the application unless the parties agree to a postponement. It must render its decision within one day after the hearing ends. If requested, it must issue written reasons within four business days after a request for reasons.

[32] A party to a proceeding before the Board may appeal the decision to the Superior Court of Justice on a question of law or fact or both. The Court on appeal may exercise all the powers of the Board, substitute its own decision for that of a health practitioner, an evaluator, a substitute decision-maker or the Board, and may refer the matter back to the

Board. Thus, the HCCA has incorporated a role for the Court, but *after* the Board has made its determination.

<u>*Cuthbertson v. Rasouli*</u>:

[33] The Supreme Court of Canada had the opportunity to interpret the HCCA in *Cuthbertson v. Rasouli*, [2013] 3 S.C.R., in the context of whether or not consent was required to withdraw life support. McLachlin C.J.C. wrote the majority decision of the Court.

[34] Although not strictly analogous to the situation before me, there are obvious similarities. McLachlin C.J.C. described the issue in *Rasouli* as follows:

> [1] This case presents us with a tragic yet increasingly common conflict. A patient is unconscious. He is on life support—support that may keep him alive for a very long time, given the resources of modern medicine. His physicians, who see no prospect of recovery and only a long progression of complications as his body deteriorates, wish to withdraw life support. His wife, believing that he would wish to be kept alive, opposes withdrawal of life support. How should the impasse be resolved?

[35] It is important to understand how the *Rasouli* case made its way up to the Supreme Court. When the physicians and Mr. Rasouli's wife reached an impasse with respect to consent, the physicians agreed to postpone their plans to withdraw life support so that she could apply to the Ontario Superior Court of Justice for an order restraining the physicians from withdrawing life support and directing that any challenge to her refusal of consent be directed to the Board. The physicians cross-applied for a declaration that Mr. Rasouli was in a permanent vegetative state and that consent was not required to withdraw life support. The physicians submitted that the Board had no jurisdiction to decide these issues.

[36] Himel J. of the Superior Court, granted the wife's application and directed the matter to the Board. The physicians appealed. The Ontario Court of Appeal upheld the order. McLachlin C.J.C. for the Supreme Court of Canada held that the substance of the dispute must be determined by the Board.

[37] In so doing, McLachlin C.J.C. reviewed the common law requirement that medical caregivers must obtain a patient's consent to the administration of medical treatment. She noted that the patient's autonomy interest—the right to decide what happens to one's body and one's life—has historically been viewed as trumping all other interests, including what physicians may think is in the patient's best interests (at para. 19).

[38] In describing the statutory framework established by the HCCA, and other similar statutes enacted throughout Canada, McLachlin C.J.C. noted that the statutes, generally speaking, give effect to the patient's autonomy interest insofar as possible. If the patient's autonomy is compromised by lack of capacity, they seek to balance it against considerations related to the best interests of the patient. Some statutes even provide for resolution of disputes

by specialized tribunals instead of the courts. She concludes that the HCCA does all of these things (para. 23).

[39] After describing how the HCCA has been designed, McLachlin C.J.C. concluded that the HCCA gives the Board final responsibility to decide disputes over consent to treatment for incapable patients, based on an objective assessment of whether the substitute decision-maker complied with the requirements of the HCCA.

[40] Much like in the within case, *Rasouli* came down to the interpretation of "treatment". McLachlin C.J.C. noted that the basic rule of statutory interpretation is that "the words of an Act are to be read in their entire context, in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament". Every statute "shall be given such fair, large and liberal interpretation as best ensures the attainment of its objects".

[41] McLachlin C.J.C. contrasted, at paras. 36 and 37, the concept of "medical benefit" which has legal implications for the physician's standard of care with the concept of "health-related purpose", a legal term used in the HCCA to determine when the actions of health care practitioners require patient consent. She rejected that "treatment" should be defined with only a consideration of the medical community's perspective in mind concluding as follows at para.43:

> [43] Inclusion of life support in "treatment" is also generally supported by the objects of the HCCA. It provides consistency with respect to consent, protects autonomy through the requirement of consent, and provides a meaningful role in the consent process for family members. An interpretation of "treatment" that is confined to what the medical caregiver considers to be of medical benefit to the patient would give these statutory purposes short shrift. The legislature cannot have intended such a crabbed interpretation of "treatment".

[42] McLachlin C.J.C pointed out that the opening words of the definition of "treatment" could not be more expansive: "…anything that is done" for one of the enumerated health-related purposes or other health-related purpose is included in "treatment" (para. 46). In her view, the express exclusions in the definition strengthened the view that "treatment" was intended to have a very broad meaning (para. 47).

[43] Chief Justice McLachlin also referred to the objects of the HCCA as informing the definition of "treatment". This includes the "values of autonomy—critical where life is at stake—and providing a meaningful role for family members support. A limited definition of "treatment" is antithetical to the purposes of the HCCA of providing incapable people some measure of autonomy in such important healthcare questions.

[44] I take from *Rasouli* that in order to meet the objectives of the HCCA, "treatment" should be broadly defined and the exclusions listed thereunder narrowly circumscribed. Thus, when one considers whether the apnea test is "a diagnostic" procedure falling within the

definition of "treatment" for which consent is required, or an "assessment or examination of a person to determine the general nature of the person's condition", for which no consent is required, the resolution which promotes the objectives of the HCCA may well be preferable.

[45] I note that McLachlin C.J.C. also addressed the argument that requiring a physician to obtain consent may place the physician in an untenable ethical situation, an argument raised in this case. As stated in paragraph 72, legally, a physician cannot be faulted for following the direction of the Board.

*Who Should Decide Jurisdiction—the Court or the Board*:

[46] The question that needs to be resolved is whether an apnea test is "diagnostic", in which case it is "treatment" or "an assessment or examination of a person to determine the general nature of the person's condition", in which case no consent is required.

[47] The Applicant frames her argument by stating that the question before me is "who should decide whether the apnea test is a diagnostic procedure or an assessment of a person to determine the general nature of the person's condition?" The Applicant argues that the Board has authority to determine its own jurisdiction. It has specialized expertise in making such determinations and it has the procedures in place to conduct a more thorough investigation into the nature of apnea testing than this Court does on an emergency motion for an injunction.

[48] In this case, I am presented with competing opinions about the risks associated with apnea testing and whether such a test should require consent prior to its occurrence. The experts, depending upon which side of the debate they fall on, have carefully chosen their description of the apnea test. The Applicant's experts refer to it as a diagnostic test, while the Respondent's experts frequently choose the word "assessment".

[49] Dr. Baker's qualifications are impeccable. Dr. Bosma and Dr. Haddara, the two "most responsible physicians" that have been involved with Mr. Morlani's care are also eminently qualified. I am asked to conclude, on a paper record, that the two experts put forth by the Respondents have inferior credentials or that their views are not reflective of the mainstream medical community. However, these experts too hold impressive qualifications, have attained positions of importance within hospitals and universities and have studied and written extensively on the subject at hand.

[50] Unlike the presentation before me on this motion, the Board has the ability to hear directly from the experts, and the treating physicians, who will also be subjected to cross-examination. The Board also has expertise to critically evaluate that evidence that the court may well lack. Finally, the Board has an appreciation of the mandate of the HCCA and the types of analogous procedures that it may or may not have been intended to encompass as requiring consent.

[51] It is clear that a court can determine whether or not it has jurisdiction to grant relief in any given proceeding. Likewise, the Applicant has submitted cases in which the Board has determined whether it properly had jurisdiction. *In the Matter of HC*, 2019 CanLII 47097 (ON CCB), the doctor, and an intervenor, took issue with the Board's jurisdiction with respect to the withdrawal of artificial nutrition and/or hydration.

[52] The Respondent in the case before me argues that in the *HC* decision, the Board simply accepted that it was bound by *Rasouli* and thus did not determine jurisdiction. I disagree. The Board in the *HC* decision devoted seven pages to determining whether the withdrawal of artificial nutrition and/or hydration was "treatment" and/or fell within one of the exclusions. Its analysis was thorough. Simply because the Board relied upon *Rasouli*, a decision from the SCC, does not mean that jurisdiction was not independently assessed. The Board clearly undertook that examination.

[53] The Respondent referred me to *E.B. (Re)*, 2005 CanLII 56655 (ON CCB) to suggest that the apnea test was akin to checking a patient's vital signs and that the Board in *E.B.* made it clear that checking a person's blood pressure was not "treatment". This decision of the Board makes it abundantly clear that the Board is prepared to make determinations of what does and does not constitute "treatment".

[54] I also note the cases of *TP*, 2017 CanLII 86545 (ON CCB) and *UH*, 2016 CanLII 98580 (ON CBB), two cases in which the Board determined whether or not it had jurisdiction where the incapable person had been determined to be dead with an issued certificate of death.

[55] In my view, the Board is well equipped to determine its own jurisdiction. If it errs on an issue of jurisdiction, there is an appeal route to the Court. The Court then exercises the appropriate standard of review with respect to jurisdiction. In my opinion, the Court ought not to lightly enter the fray at first instance when there is a statutorily empowered tribunal that has expertise in the area and interprets the legislation in question as part of its mandate.

[56] While the Respondent complains of the time required to complete the procedure before the Board, the timelines set out in the HCCA are designed to promote a quick resolution, including an expedited appeal route. Indeed, had the parties proceeded down that route initially, they would be much farther along than the route they have chosen via the court. I agree with the Applicant that the Board can tailor the proceedings to deal with jurisdictional issues at the outset of a hearing or the end, depending on its preference.

[57] I concur with the Court of Appeal's description of the process in *M. (A.) v. Benes*, 1999 CanLII 3807 (ON CA), at para. 46, as follows:

> [46] A case will come before the Board only when the health practitioner disagrees with the S.D.M.'s application of the best interests test under s. 21(2). The Board will then have before it two parties who disagree about the application of s. 21: the S.D.M., who may have better knowledge than the health practitioner about

> the incapable person's values, beliefs and non-binding wishes; and the health practitioner, who is the expert on the likely medical outcomes of the proposed treatment. The disagreement between the S.D.M. and the health practitioner potentially creates tension and the Act recognizes this by providing for a neutral expert board to resolve the disagreement. Indeed, after hearing submissions from all parties, the Board is likely better placed than either the S.D.M. or the health practitioner to decide what is in the incapable person's best interests. Thus, the Board should not be required to accord any deference to the S.D.M.'s decision.

[58] In my view, that same reasoning applies with respect to the issue of jurisdiction. The Board is well suited to determine its own jurisdiction. There remains a role for the Court during the appeal process. If the Board declines jurisdiction when it ought not to, or acts without jurisdiction, the Court may review that determination on appeal.

[59] I return to *Rasouli*, where McLachlin C.J.C. concluded as follows at para. 103:

> [103] Bringing its expertise to the issue, the Board's decisions may be expected to bring consistency and certainty to the application of the statute, thereby providing essential guidance to both substitute decision-makers and health care providers in this difficult area of law.

[60] In my view, it is preferable to keep cases under the HCCA in the hands of the Board and have the Court take on an appellate role, as opposed to having the Court deal with issues of jurisdiction by way of urgent motion for an injunction to enjoin a medical procedure.

[61] The alternative would be for this Court, on a documentary record, to perhaps set a wide-sweeping precedent with respect to apnea testing that would authorize health care practitioners to make such decisions without consent and unchecked by the Board. The Board is in a much better position to appreciate the consequences of such a decision.

[62] I am bolstered in my belief that the Board is the body best equipped to address this issue by the Supreme Court of Canada decision in *Canada (Minister of Citizenship and Immigration) v. Vavilov,* 2019 SCC 65. In "charting a new course forward" for determining the standard of review that applies when a court reviews the merits of an administrative decision, the Court stated as follows in para. 24;

> [24] Parliament and the provincial legislatures are constitutionally empowered to create administrative bodies and to endow them with broad statutory powers: *Dunsmuir*, at para. 27. Where a legislature has created an administrative decision maker for the specific purpose of administering a statutory scheme, it must be presumed that the legislature also intended that decision maker to be able to fulfill its mandate and interpret the law as applicable to all issues that come before it. Where a legislature has not explicitly prescribed that a court is to have a role in reviewing the decisions of that decision maker, it can safely be assumed that the legislature intended the administrative decision maker to function with a minimum

> of judicial interference. However, because judicial review is protected by s. 96 of the *Constitutions Act, 1867*, legislatures cannot shield administrative decision making from curial scrutiny entirely: *Dunsmuir*, at para. 31; *Crevier v. Attorney General of Quebec*, [1981] 2 S.C.R. 220, at pp. 236-37; *U.E.S., Local 298 v. Bibeault*, [1988] 2 S.C.R. 1048, at p. 1090. Nevertheless, respect for these institutional design choices made by the legislature requires a reviewing court to adopt a posture of restraint on review.

[63] Finally, I am not oblivious to the fact that Mr. Morlani may be unnecessarily taking up valuable resources, especially during the COVID-19 pandemic where the University Hospital is taking patients from Saskatchewan. Undoubtedly, the Board will appropriately weigh those factors in determining the best interests of Mr. Morlani, given his likely outcome.



*McKitty v. Hayani*:

[64] This brings us to the *McKitty* case. Taquisha McKitty was found unconscious on a sidewalk. She was transported to hospital and required a ventilator to support her breathing. She was examined by two critical care physicians who used the testing set out in the CMAJ Guidelines to determine if she met the criteria for neurological determination of death. Both doctors determined that the criteria were met and she was declared "brain dead". A death certificate was signed the next day.

[65] Her parents commenced an application to the court on the same day that the death certificate was signed and an *ex parte* order was granted that Ms. McKitty not be removed from the ventilator.

[66] The next day, another critical care physician completed a repeat testing for death by neurological criteria and concluded, once again, that Ms. McKitty met the criteria for neurological death. Parenthetically, I note that Dr. Shewmon and Dr. Baker were also competing experts involved in the *McKitty* case and Dr. Baker actually assessed Ms. McKitty, finding that she met all the criteria for neurological death as per the CMAJ Guidelines. It is noteworthy that Dr. Baker performed ancillary testing, which is required by the CMAJ Guidelines when it is impossible to complete the minimum criteria for a neurological determination of death. These ancillary tests confirmed the likelihood of neurological death.

[67] The *McKitty* case was before Shaw J., who heard several motions and ultimately released "Reasons for Decision", indexed as *McKitty v. Hayani*, 2018 ONSC 4015. Justice Shaw succinctly sets out that the issue she was asked to determine was if Ms. McKitty, who was declared dead by neurologic criteria on September 20, 2017, was in fact dead.

[68] Importantly, when the injunction in *McKitty* was granted, the intention was to apply to the Board. However, Shaw J. notes that there are decisions from the Board declining

jurisdiction where there has been a determination of brain death so the parties agreed to proceed with the court application and that no application would be made to the Board.

[69] Ultimately, Shaw J. found that Ms. McKitty was legally dead, which accorded with the evidence of the expert witnesses, including the experts put forth by the family of Ms. McKitty who opposed her removal from the ventilator. Shaw J. analyzed whether the Board had jurisdiction with respect to a dead person. She referred to *Rasouli*. She also referred to three recent decisions from the Board where the Board declined jurisdiction to hear matters involving individuals who had been declared brain dead.

[70] I pause to reiterate that the Board, in these cases, determined the issue of whether or not it had jurisdiction.

[71] Having found that Ms. McKitty met the criteria for brain death, Shaw J. held that it flows from those findings that she was not a person for whom any dispute regarding treatment can be heard by the Board. Having been declared dead, Ms. McKitty was not an incapable person for whom consent must be obtained from a substitute decision-maker to provide consent to treatment.

[72] I have been provided with the brief endorsement from Shaw J. which is dated September 28, 2017 and pre-dates the final hearing that resulted in her Reasons for Decision. It is clear that a death certificate had been issued, as Shaw J. notes that the parties agreed that this took away the Board's jurisdiction. Justice Shaw states as follows:

> I have ordered that Dr. Baker shall perform the tests necessary to determine if Taquisha meets the neurological criteria for death. One of those tests is the apnea test. The plaintiffs' position is that such testing will cause harm as it will deprive Taquisha of oxygen. Again, there is no evidence before the court to support that position. Dr. Baker can perform all tests required to determine if Taquisha meets the neurological criteria for death, including the apnea testing. As per section 2(1) of the *Health Care Consent Act*, this is an assessment and not treatment and consent of the SDM is not required.

[73] It is not clear from any of Shaw J.'s decisions whether or not she engaged in a thorough analysis of whether apnea testing was "treatment" because it was diagnostic, or if it met the exclusion. Notably, Ms. McKitty had already been declared dead at that time, with a signed certificate of death. I also cannot comment upon the evidence before her. In the case before me, there is evidence, even if disputed, that apnea testing may cause harm.

[74] From her Reasons for Decision it is clear that the finding that Ms. McKitty was dead was an important consideration. In contrast, no death certificate has yet been issued in respect of Mr. Morlani and he has not yet been legally declared to be dead. I find that the McKitty case is distinguishable on that basis, and Shaw J.'s determination that apnea testing was "treatment" is not, in any event, binding upon me. It is simply not so clear to me that apnea testing might not constitute a diagnostic test such that it is "treatment" and for the reasons

set out above, I think that determination is within the purview of the Board. For the reasons given, Shaw J. could not refer the issue to the Board.

[75] *McKitty* was appealed (*McKitty v. Hayani*, 2019 ONCA 805). Miller J.A. framed the appeal as concerning a freedom of religion challenge to the medical criteria accepted by Ontario's common law and legislation to determine that a person has died. He upheld Shaw J.'s ultimate conclusion but found that she had erred in her analysis with respect to the *Charter*. His analysis does not engage the definition of "treatment".

[76] Miller J.A. noted the consensus in Canadian medical practice that if total brain death (or neurologically determined death) has occurred, the human person has died. The common law definition is the same: death has occurred where there is either an irreversible loss of cardiorespiratory function or total loss of neurological function (para. 5).

[77] The appellant in *McKitty* argued that the Court ought not to abdicate its responsibility to define death by deferring to the medical community. I note the following comments by Miller J.A. at para. 28:

> [28] This is a serious concern. Nevertheless, it rests on a misunderstanding of the relevant common law rule. The criteria for determining whether death has occurred is not a technical question that is indefeasibly the province of the medical profession, to which the common law must defer. The two criteria for death have not been accepted by the common law because medical practice is determinative, but because they have been judged by the common law to provide a sound answer to the question of how to determine whether a person has died. Although contemporary medical practice accepts total brain death as a specific criterion that allows physicians to declare a patient to be dead, it does not follow that should a different medical practice emerge—for example if physicians were to accept that persons who are minimally conscious meet the medical definition of death—that the common law would be obliged to accept this as well.

[78] I take the above passage as further authority for the proposition that it is not for the medical profession, unfettered, to determine what constitutes "treatment".

[79] The Respondent doctor, while asking this court to authorize the apnea test, is arguing pursuant to the common law definition that Mr. Morlani is already legally dead. While I am acutely aware of the bleakness of his prognosis, including the extreme possibility that Mr. Morlani may well already be dead, the common law, as Miller J.A. notes in *McKitty* requires irreversible cessation of all brain function. Unlike the case before Shaw J., there has been no death certificate signed. Notwithstanding Dr. Haddara and Dr. Bosma's evidence that they believe that Mr. Morlani is dead, he has not been declared dead. I am not prepared to take the next step and in effect determine that Mr. Morlani is dead prior to a formal pronouncement.

[80] Notably in *McKitty*, Miller J.A. declined to determine on the appeal whether the Board had jurisdiction in respect of a person that had been declared dead. His reasoning at para. 104, was that "such a review should be by way of judicial review of an actual decision of the Board by the appropriate court".

*Test for an Injunction:*

[81] The applicable test for an interim injunction is that set out by the Supreme Court of Canada in *RJR-MacDonald Inc. v. Canada*, 1994 CanLII 117 (SCC), [1994] 1 SCR 311, namely:

(a) Is there a serious issue to be tried?
(b) Is there a real potential for irreparable harm to ensue if relief is not granted? and
(c) Does the balance of convenience favour the granting of relief at this early stage?

[82] With respect to the serious issue to be tried, in my view it remains an open question whether apnea testing is "treatment" because it is diagnostic or whether it is not treatment because it fits within one or more exclusions in the HCCA. There are competing experts who each present rationales why the apnea test should or should not require consent before being conducted. At the very least, there is an arguable case on the merits.

[83] In determining whether there is a real potential for irreparable harm, I am going to refrain from favouring one side or the other in the debate between the competing expert evidence. Suffice it to say that if the injunction does not issue and the apnea test proceeds, and the fears raised by Drs. Shewmon and Joffe are legitimate, then the harm that Mr. Morlani would constitute irreparable harm.

[84] In assessing the balance of convenience, the competing interests are the unequivocal end of Mr. Morlani's life against the resources being expended while this dispute lingers. Without question if Mr. Morlani is already dead, it is a terrible waste of resources for him to occupy a bed in the Intensive Care Unit, ingesting fluids and medications. However, I have already determined that I am not prepared to make that final leap short of the requisite apnea test for which the Board may determine consent is required.

[85] There is an expedited process for both the Board and any appeal, which mitigates, to some extent, the wasted resources.

[86] In the end, having determined that the issue of whether the apnea test is "treatment" is property determined by the Board, it would render that determination moot for Mr. Morlani if the apnea test proceeded. Accordingly, an injunction shall issue, enjoining the Respondent, or any other health practitioner, from administering the apnea test, pending either consent of the substitute decision makers or a determination of the Board that consent is not required, or alternatively, an order of the Board granting consent.

*Standing:*

[87] The Respondent raised the issue of standing during oral argument. As I understand the arguments, two concerns are raised, which can both be dealt with quickly.

[88] First, the manner in which the Application before me is constituted describes Deborah Morlani as Litigation Guardian for Marco Morlani. It is submitted that Deborah Morlani has not complied with the requirements of Rule 7.02. The problem with that argument is that the very proceeding before the Board will determine who shall act as substitute decision-maker for Marco Morlani. The HCCA sets out a hierarchy in that regard, including the possibility of the involvement of the PGT where there are two equally ranked SDMs who cannot agree. In any event, I have the authority to "order otherwise". I would not give effect to this argument.

[89] If the concern is that there is no affidavit from the litigation guardian under Rule 7.02, this application was scheduled on an urgent basis. The parties were able to secure a telephone case conference with me on Friday, October 29, 2021 at 4:30 pm. The parties were directed to file material over the weekend. To their credit both parties were able to put motion records, briefs of authorities and factum before me that were well done. The motion was heard on Monday, November 1, 2021 at 11:00 am. At the time the argument was commenced, I do not even believe the Court had assigned a file number. In short, this matter came together with incredible dispatch and I do not fault the Applicant in failing to file an affidavit of litigation guardian.

[90] I extend the time for filing an affidavit of Litigation Guardian.

*Disposition*:

[91] For the above reasons, I have determined that the Consent and Capacity Board should determine, at first instance, whether the proposed apnea test is "treatment" for which consent is required, or falls within a statutory exclusion such that no consent is required. The Board may determine that issue in the order that it deems most appropriate.

[92] A decision from the Board may well lead to a conclusive determination of whether apnea testing is "treatment" on a complete and tested record and resolve future disputes on this issue before the Board.

[93] Accordingly, I order that no person shall conduct an apnea test on Marco Morlani, and his current plan of treatment shall continue unless and until:

(a) Consent is obtained by the substitute decision makers;
(b) The Board determines that the apnea test is not "treatment" such that consent is not required; or
(c) The Board substitutes its own consent for the apnea test for the consent of the substitute decision makers.

[94] Should costs be sought and not agreed upon, the Applicant may provide written submissions through the London trial coordinator no later than December 3, 2021. The Respondent shall submit responding submissions no later than December 14, 2021. The submissions shall be no longer than three pages in length, double-spaced.

Justice Spencer Nicholson

Date: November 2, 2021