IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: ***Rotaru v. Vancouver General Hospital Intensive Care Unit,*** 2008 BCSC 318

Date: 20080314
Docket: S081164
Registry: Vancouver

Between:

Georgeta Rotaru

Petitioner

And

Vancouver General Hospital Intensive Care Unit and Dean Chittock

Respondents

Before: The Honourable Mr. Justice Burnyeat

Reasons for Judgment (In Chambers)

Appearing on her own behalf	G. Rotaru
Counsel for the Respondents	J.C. Grauer
Date and Place of Hearing:	February 21, 2008 Vancouver, B.C.

[1] The Petitioner requests the following orders pursuant to the ***Patients Property Act***, R.S.B.C., 1996, C. 349, the ***Health Care (Consent) and Care Facility (Admission) Act***, R.S.B.C., 1996, C. 181, and the ***Representation Agreement Act***, R.S.B.C., 1996, C. 405:

> (a) the medical staff of the Vancouver General Hospital Intensive Care Unit, continue to provide life support to Alecsandrina Priboi [the mother of the Petitioner] – their patient, in order to sustain life;
>
> (b) the medical staff of the Vancouver General Hospital Intensive Care Unit and any other medical section Alecsandrina Priboi may be transferred to, provide this patient, effective immediately, with medication the patient has been on before February 3, 2008 ICU transfer, medication vital to her life and well being and such staff change their death inducing actions to maintaining & supporting this patient's life.

[2] The facts upon which the Petition is based are set out by the Petitioner as being the following:

> (a) My mother, Alecsandrina Priboi, a patient in the intensive care unit of Vancouver General Hospital, is subjected to a slow death by Dean Chittock who discontinued all her medication and ventilator support.
>
> (b) At the February 5, 2008 family meeting, Dean Chittock indicated that only a court order will make him change his mind.

[3] In support of the Petition, the Petitioner states the following in her February 14, 2008 Affidavit:

> My Mother, Alecsandrina Priboi has been subjected to negligence on the part of Vancouver General Hospital staff from December 4, 2007 11:14 AM until December 5, 2007 12:30 PM while displaying symptoms indicative of an embolism, while a patient, resulting in irreversible damage to the large & vita intestines due to lack of blood flow, as well as kidneys & the vascular system.

> This condition has been worsened by lack of blood transfusions required by low haemoglobin that resulted in an ICU transfer on December 20, 2007 5:30 AM.
>
> Malabsorption caused by damaged digestive system as of December 4-5/2007 caused increased edema and respiratory failure resulting in another ICU transfer of February 3, 2008. During the family meeting of February 3, 2008, Dr. Hamid ensured the Petitioner & family members that the patient will continue to have the medical care as given all along.
>
> On February 4, 2008, Dr. Dean Chittock, without discussing with Petitioner or family, discontinued the medical care in terms of stopping the medication (Lasix, Dioxin, Plavix) TPN & Albutrin.
>
> On February 5, 2008 the Petitioner was advised by Dr. Dean Chittock that only a Court Order will make him change his mind.
>
> Despite Petitioner's requests and pleadings with Dr. Chittock and other ICU doctors, Alecsandrina Priboi remains untreated, and subjected to a premature death.

POSITION OF THE DEFENDANTS

[4] The position of the Defendants is twofold: (1) the Court is without power to make the order requested by the Petitioner; and (2) even if such an order could be made, a return of Ms. Priboi to her previous medication and treatment would be counter-productive and/or of no effect and other than in accordance with the ethical obligations of the doctors treating Ms. Priboi.

[5] In his February 18, 2008 Affidavit, Dr. Copland states that he was the attending Nephrologist for Ms. Priboi from February 4 through 15, 2008. The Affidavit of Dr. Michael Copland sets out not only much of the treatment of Ms. Priboi but, also, the prognosis for her. Dr. Copland states that he reviewed the medical records of Ms. Priboi and prepared a report regarding his assessment of Ms. Priboi's clinical situation. He states in part:

She had been admitted initially due to Right leg ischemia due to a popliteal artery occlusion. This had been treated, but she then developed a perforated sigmoid colon, due to ischemic bowel associated with an occlusion of her superior mesenteric artery. Post-operatively she had shock and was in the ICU from December 5 — 16 for treatment of this. She was out on the general ward, but needed readmission to the ICU from December 19, 2007 — January 1, 2007 for recurrent shock

Following this, she had ongoing issues with GI bleeding due to persistent ischemic colitis, per the hospital notes. In discussion with the Vascular Surgical team, there was no operative solution for this issue. Mrs. Priboi has had a non-functional GI tract, and has been dependent on Total Parenteral Nutrition (TPN) due to failure to tolerate enteric nutritional support.

The initial assessment by the Nephrology consult service felt that her underlying kidney injury was secondary to several factors, including a background of renovascular disease associated with her global vascular disease, as well as an injury associated with relative underperfusion of the kidney due to her global illness state.

Therapy to optimize her renal perfusion was maintained, but despite efforts, her renal function deteriorated. Due to the irreversibility of her underlying co-morbidities, the feeling was that she was developing multi-system organ failure, and that she would not survive. Given that her renal failure was as a consequence of her global status, rather than an intrinsic renal disease, there was no realistic expectation that dialysis would benefit Mrs. Priboi in any way, and therefore the decision by Dr. Duncan, as documented on January 31, 2008 was “Overall, prognosis is grim and I have discussed this (with) daughter today. She would not, in my opinion, be an appropriate dialysis candidate given her burden of illness and prognosis.”

Again, on February 1, 2008, Dr. Duncan reassessed the patient’s condition, finding her to be ‘much the same.’ He notes again that “Poor prognosis d/w daughter and questions reviewed.”

On February 3, 2008, Mrs. Priboi suffered a respiratory arrest, and a ‘Code Blue’ was called. She was intubated and ventilated, and brought back to the ICU. As this occurred over a weekend, the on-call nephrologist, Dr. Nadia Zalunardo was asked by the ICU to ‘consider renal replacement tomorrow, after family discussion.’ Dr. Zalunardo assessed the situation, and on February 3, 2008 noted “I agree with Dr. Duncan that she is not a suitable candidate for HD. This has been d/w the daughter this past week.”

On February 4, 2008 I assumed the role as attending Nephrologist on the consult service. Again, I reviewed the situation as to whether dialysis was indicated and appropriate. To start with, at that time there was no indication that she needed dialysis immediately anyway. Reviewing my note dated February 4, 2008 I indicated "Some questions about role of RRT in reflection of this. I agree with both Drs. Duncan and Zalunardo that she would not benefit from dialysis, and therefore should not be considered."

A documented note of a Family Meeting is immediately following in the chart in which the medical status was reviewed, including the reality that she was not a surgical candidate for her status, meaning that she would not survive. The formal decision from our service not to initiate dialysis was reviewed with the family.

On February 6, 2008, a chart entry by myself reiterated the following "… dialysis would not change the outcome, as her kidney failure is as a consequence of systemic failure. Dialysis would not improve or prolong her life, and therefore is not appropriate to start."

On the evening of February 11, 2008, at approximately 1815 hours, I was paged by the ICU, at the daughter's request. As I was not on call, I was not in-house, but I did speak with the daughter for 15+ minutes. During that conversation, several things were discussed, including:

• Was cost a reason to withhold dialysis? I indicated to the daughter that cost never entered into a clinical decision for an individual patient and that this did not enter into my decision for Mrs. Priboi.

• Was dialysis withheld due to her age? I indicated to the daughter that age in and of itself is not a contraindication to dialysis. I have certainly dialyzed individuals older than her mother in the past. I indicated to the daughter that the global medical status, and expected clinical outcomes were what dictated initiation of dialysis, and that if a situation was futile, then dialysis should not be started.

• I reviewed with the daughter that the kidney failure was as a consequence of the global status, and that these issues (ie, her vascular disease) was not correctable.

• I told her that dialysis would not change the inevitable outcome for Mrs. Priboi, and that unfortunately her mother would die during the current hospitalization.

• I told her daughter dialysis was not currently indicated regardless of these other conditions.

> • I told her daughter that I was in agreement with the other specialty services involved (particularly the ICU and Vascular Surgery) that Mrs. Priboi should receive comfort measures
>
> ….
>
> ***2. The Prognosis for Mrs. Alecsandrin Priboi***
>
> As stated above, Mrs. Priboi has global, irreversible vascular disease, with inoperable lesions resulting in compromised bloodflow to vital tissues, particularly to the GI tract. She has chronic ischemic colitis, with GI bleeding and inability to support enteric nutrition requiring TPN.
>
> Her life currently is being sustained by artificial means. It is my opinion that she will not improve to the point that she will survive without these treatments, and I would expect that irrespective of our interventions that she will die. This is due to the burden of her disease state

[6] Dr. Copland was also asked to respond to the Orders sought by the Petitioner.

His comments in these regards include the following:

> ***"continue life support to Alecsandrin Priboi, in order to sustain life,"***
>
> Given the full agreement of all services, life support should not be continued. To continue life support, in my opinion, is unethical, as it has no chance of changing the prognosis, and it does do harm in that it is prolonging Mrs. Priboi's suffering.
>
> ***"the ICU (and any other unit to which she may be transferred) … change their death inducing actions to maintaining and supporting this patient's life."***
>
> This statement is patently false. No service, particularly the ICU has engaged in "death inducing actions." To the contrary, actions to date have been heroic, and have included a number of measures which have artificially extended Mrs. Priboi's life. Encompassed under these actions are:
>
> • Interventions to support her blood pressure and normalize her fluid status
>
> • Interventions to maintain nutritional support (TPN)
>
> • Interventions to maintain respiration (artificial ventilation)

[7] Dr. D. Lynn Doyle is the Acting Head of the Division of Vascular Surgery at V.G.H. and The University of British Columbia. Dr. Doyle states: "I was involved in the care of Ms. Alecsandrin Priboi as attending vascular surgeon, for much of the past two weeks, including last weekend [February 16-17, 2008]." Dr. Doyle states that the following note was made in the "physician history & progress notes" maintained for Ms. Priboi:

> Vasc. Dr. Doyle covering for Dr. Gagnon.
> I know pt well. Events reviewed. Mrs. Priboi has no surgically correctable lesions. On ward failed to thrive with full/aggressive care. In step-down unit she had worsening renal function, failure to thrive and due to chronic uncorrectable gut ischemia, unable to maintain nutrition. Support direction of Nephrology – Dr. Copland + ICU – Dr. Chittock. Futile advanced heroics not indicated.

[8] Regarding the statement that "Mrs. Priboi has no surgically correctable lesions", Dr. Doyle states: "I meant that none of Mrs. Priboi's underlying disease processes are amenable to correction or alleviation by means of surgery, and that remains my opinion."

[9] In evidence was a February 20, 2008 assessment of the clinical situation by Dr. Chittock as the Regional Medical Doctor Critical Care for the Vancouver Coastal Health unit and the Medical Leader Critical Care of V.G.H. who provided his report "… from my perspective as an Intensivist". The report stated in part::

> While on the ward, Mrs. Priboi continued to have ongoing issues with GI bleeding due to persistent ischemic colitis, per the hospital notes. In discussion with the Vascular Surgical team, there was no operative solution for this issue. Mrs. Priboi has a non-functional GI tract, and has been dependent on Total Parenteral Nutrition (TPN) due to failure to tolerate enteric nutritional support. She had been receiving ongoing treatments for her heart failure and infections and repeated attempts to

maintain on heparin anticoagulation failed due to bleeding complications. Progressive renal insufficiency was noted on the 25th of January and the nephrology service was asked to see the patient on the on January 27th, 2008.

Therapy to optimize the patient's renal function was initiated, but despite efforts, her renal function deteriorated. Due to the irreversibility of her underlying co-morbidities, the feeling was that she was developing multi-system organ failure, and that she would not survive. ….

On February 1st, due to progressive renal dysfunction both the digoxin and Simvastatin were held due to concerns about potential toxicity.

Again, on February 1, 2008, Dr. Duncan reassessed the patient's condition, finding her to be 'much the same'. He notes again that "Poor prognosis d/w daughter and questions reviewed. Albumin infusions were attempted and ongoing use of TPN but it was noted that the albumin was resulting in fluid overload and the TPN was contributing to progressive renal failure given the urea load. Unfortunately, on February 3, 2008, Mrs. Priboi suffered a hypoxic and hypercarbic respiratory arrest, and a 'Code Blue' was called. She was intubated and ventilated, and brought back to the ICU. The cause of the arrest was multi-factorial including a left lower lobe pneumonia, fluid overload secondary to congestive heart failure, associated with oliguric renal failure.

On February 4th, 2008 I took over the care of Mrs. Priboi from Dr. M. Hammed. At that time the patient was in respiratory failure fully supported by mechanical ventilation and in anuric renal failure. A diagnosis of pneumonia had been made and treatment with broad spectrum antibiotics was instituted. The TPN was stopped due to progressive renal failure as was the digoxin, albumin and lasix therapies as they are likely to cause further complication. The on-call nephrologist, Dr. Nadia Zalunardo was asked by the ICU to 'consider dialysis. Dr. Zalunardo assessed the situation, and on February 3, 2008 noted "I agree with Dr. Duncan that she is not a suitable candidate for HD. This has been d/w the daughter this past week." Repeated documentation and discussions with the family by the ICU service and the nephrology service outline the poor prognosis and that Mrs. Priboi was not a dialysis candidate. I met with the daughter of Mrs. Priboi for extended periods on both February 6th & 7th, 2008 to outline clearly the above issues and poor prognosis. In particular I clearly indicated that the patient had failed enteral feeding due to ischemic bowel and now had a complication of renal failure that prohibited the use of TPN. No options therefore existed to provide nutrition. Given this, the present of progressive renal failure in the setting of global burden of cardiovascular disease, ongoing supportive care in the ICU was futile and consideration to move the patient to comfort care only should be made. The vascular surgery service and the nephrology service were in full agreement with

> this approach. The family disagreed with this opinion. Given this, it was agreed that we would continue to provide supportive care and I outlined that I would continue to attempt to wean Mrs. Priboi from mechanical ventilation but that if this proved to be impossible, we needed to consider the withdrawal of mechanical ventilation. The family requested that we provide enteral nutrition despite the presence of the ischemic bowel. It was explained that this may result in bleeding, pain, and diarrhea but the daughter (Georgette) insisted we try. We agreed to do this as long as it did not result in patient discomfort.

[10] Dr. Chittock was asked to provide his prognosis and was also asked to respond to the requests made in this Petition:

> ***2. The Prognosis for Mrs. Alecsandrin Priboi***
>
> As outlined above, Mrs. Priboi has global, irreversible, inoperable cardiac and vascular disease, resulting in compromised blood flow to vital tissues, particularly to the GI tract. She has chronic ischemic colitis, with GI bleeding and inability to support enteric nutrition or tolerate TPN. Her condition is further complicated by acute renal failure and a depressed level of consciousness. It is my opinion that given the overwhelming burden of disease in association with multiple organ failure, she will not be expected to survive this hospital stay, irrespective of our interventions. Mrs. Priboi's condition will inevitably deteriorate further. At that point, the question will arise as to whether she should be put back on ventilation (artificial breathing). It is my opinion that that would be medically and ethically inappropriate ….
>
> ***4. My view on the order sought to "continue life support to Alecsandrin Priboi, in order to sustain life," and "the ICU (and any other unit to which she may be transferred)... change their death inducing actions to maintaining and supporting this patient's life."***
>
> The claim that actions to date have been anything other than 'life-sustaining' is false, and in fact the ICU has already been aggressively maintaining and supporting her life. Appropriate medical care has been continuously provided to Mrs. Priboi.
>
> Given the extensive and terminal nature of Mrs. Priboi's disease, additional life supportive measures should not be instituted beyond those presently in place. To do otherwise, in my opinion, would be unethical. It cannot alter her prognosis or improve her health, but will only prolong Mrs. Priboi's suffering. No service has engaged in "death inducing actions." To

> the contrary, all actions to date have provided aggressive medical care, and have artificially extended Mrs. Priboi's life.

IS THE COURT IN A POSITION TO INTERVENE TO REQUIRE MEDICAL DOCTORS TO UNDERTAKE PARTICULAR TREATMENT?

[11] In ***Legal Liability of Doctors and Hospitals in Canada*** (4th Ed.) (Thomson-Carswell), the learned authors make this statement regarding "Futile or Inappropriate Treatment":

> As we have seen, once a doctor-patient relationship is formed, the doctor's obligation is to treat the patient. However, this does not mean that the doctor has a duty to provide (and the patient a correlative right to receive) whatever treatment the patient may request. If a patient requests treatment which the doctor considers to be inappropriate and potentially harmful, the doctor's overriding duty to act in the patient's best interests dictates that the treatment be withheld. A doctor who accedes to a patient's request (or demand) and performs treatment which he or she knows, or ought to know, is contra-indicated and not in the patient's best interests, may be held liable for any injury which the patient suffers as a result of the treatment.
>
> Likewise, there is no legal duty to perform treatment which the doctor reasonably believes to be medically futile, that is, treatment which offers no prospect of therapeutic benefit for the patient. However, many commentators have emphasized the potential dangers and problems underlying the concept of medical futility, particularly if it is interpreted broadly and used to justify the withholding of treatment for socio-economic and value-laden reasons. It is essential that strict limits be placed on this concept. Useful guidance is to be found in the report of the Special Senate Committee on Euthanasia and Assisted Suicide, which recommended that "futility" in this context should be construed very narrowly to mean "treatment that will, in the opinion of the health care team, be completely ineffective."

[12] The question of whether the Court exercising inherent jurisdiction can order a doctor to treat a patient in a manner contrary to the judgment of the doctor may not have been before a Canadian Court. However, this question was considered in England in ***Re J (a minor) (wardship: medical treatment)***, [1992] 4 All E.R. 614 (C.A.)

where the Court dealt with the situation where a doctor stated that a 16 month old child who was profoundly handicapped both mentally and physically would be unlikely to survive positive pressure ventilation if the infant was unable to breath spontaneously. The local authorities had sought leave under s. 100 of the ***Children Act*** 1989 to invoke the inherent jurisdiction of the High Court to determine whether artificial ventilation and/or other life-saving measures should be given to the infant if he suffered a life-threatening event and had sought an order requiring the health authority to continue to provide all available treatment including 'intensive resuscitation'. The judge made an interim order and injunction to that effect and the health authority supported by the Official Solicitor as the guardian ad litem appealed that order. On the appeal, Lord Donaldson of Lymington MR stated:

> Let me say once that, in a matter of this nature, there is absolutely no room for the application of the principles governing the grant of interlocutory relief which were laid down by Lord Diplock in *American Cyanamid Co v Ethicon Ltd* [1975] 1 All ER 504 at 510-511, [1975] AC 396 at 408. The proper approach is to consider what options are open to the court in a proper exercise of its inherent powers and, within those limits, what orders would best serve the true interests of the infant pending a final decision. There can be no question of 'balance of convenience'. There can be no question of seeking, simply as such, to preserve the status quo, although on particular facts that may well be the court's objective as being in the best interests of the infant. There can be no question of 'preserving the subject matter of the action'. Manifestly there can be no question of considering whether damages would be an adequate remedy.
>
> The fundamental issue in this appeal is whether the court in the exercise of its inherent power to protect the interests of minors should ever require a medical practitioner or health authority acting by a medical practitioner to adopt a course of treatment which in the bona fide clinical judgment of the practitioner concerned is contraindicated as not being in the best interests of the patient. I have to say that I cannot at present conceive of any circumstances in which this would be other than an abuse of power as directly or indirectly requiring the practitioner to act contrary to the fundamental duty which he owes to his patient. This, subject to obtaining

any necessary consent, is to treat the patient in accordance with his own best clinical judgment, notwithstanding that other practitioners who are not called upon to treat the patient may have formed a quite different judgment or that the court, acting on expert evidence, may disagree with him.

It is said that the views which I expressed in my judgments in *Re J (a minor) (wardship: medical treatment)* [1990] 3 All ER 930, [1991] Fam 33 and *Re R (a minor) (wardship: medical treatment)* [1991] 4 All ER 177, [1992] Fam II which are relevant to this were obiter and did not receive the express assent of those sitting with me. So be it but, remaining as I am of the view that they were a correct expression of the law, I repeat them as part of the ratio of my decision in this case. From *Re J* [1990] 3 All ER 930 at 934, [1991] Fam 33 at 41:

> ‘No one can *dictate* the treatment to be given to the child, neither court, parents nor doctors. There are checks and balances. The doctors can recommend treatment A in preference to treatment B. They can also refuse to adopt treatment C on the grounds that it is medically contra-indicated or for some other reason is a treatment which they could not conscientiously administer. The court or parents for their part can refuse to consent to treatment A or B or both, but cannot insist on treatment C. The inevitable and desirable result is that choice of treatment is in some measure a joint decision of the doctors and the court or parents. This co-operation is reinforced by another consideration. Doctors nowadays recognise that their function is not a limited technical one of repairing or servicing a body. They are treating people in a real life context. This at once enhances the contribution which the court or parents can make towards reaching the best possible decision in all the circumstances.’ (My original emphasis.)

From *Re R* [1991] 4 All ER I77at I84, 187, [1992] Fam II at 22, 26

> ‘It is trite law that in general a doctor is not entitled to treat a patient without the consent of someone who is authorised to give that consent … However consent by itself creates no obligation to treat. It is merely a key which unlocks a door ... No doctor can be required to treat a child, whether by the court in the exercise of its wardship jurisdiction, by the parents, by the child or anyone else. The decision whether to treat is dependent upon an exercise of his own professional judgment, subject only to the threshold requirement that, save in exceptional cases usually of emergency, he has the consent of someone who has authority to give that consent.’ (at pp. 622-3)

[13] In a concurring judgment, Balcombe L.J. stated:

> So, recognising that there are limits to the exercise of this inherent jurisdiction [with respect to children], I agree with Lord Donaldson MR that I can conceive of no situation where it would be a proper exercise of the jurisdiction to make such an order as was made in the present case: that is to order a doctor, whether directly or indirectly, to treat a child in a manner contrary to his or her clinical judgment. I would go further. I find it difficult to conceive of a situation where it would be a proper exercise of the jurisdiction to make an order positively requiring a doctor to adopt a particular course of treatment in relation to a child, unless the doctor himself or herself was asking the court to make such an order. Usually all the court is asked, or needs, to do is to authorise a particular course of treatment where the person or body whose consent is requisite is unable or unwilling to do so. (at p. 625)

[14] The judgment of Leggatt L.J. was of similar effect:

> But the essential distinction remains: whether the court should positively order treatment to be given or not to be given, or whether it should do no more than consider whether or not to authorise it, where authority is needed. I can myself envisage no circumstances in which it would be right directly or indirectly to require a doctor to treat a patient in way that was contrary to the doctor's professional judgment and duty to the patient.
>
> A court can give or withhold a consent or authority such as might be given or withheld by a patient or a child's parent. But no reported case has been cited to the court in which any judge in any jurisdiction has ever purported to order a doctor to treat a patient in a particular way contrary to the doctor's will until Waite J made his order in the present case. The order which he in fact made was against the health authority requiring it to 'cause such measures (including, if so required to prolong his life, artificial ventilation) to be applied to [the child] for so long as they are capable of prolonging his life'. That was an order with which it was probably impossible for the health authority to comply, because it has no power, contractual or otherwise, to require doctors to act in a way which they do not regard as medically appropriate. If it could comply, it would be obliged to accord to this baby a priority over other patients to whom the health authority owes the same duties, but about whose interests the court is ignorant. (at p. 626)

JUDGMENT AND ORDER

[15] It should be noted that this decision does not involve the consideration of whether medical advisors can be prohibited from withdrawing forms of treatment or life-support systems. Accordingly, what is requested in this Petition can be distinguished from the situation that was before Schulman J. in ***Golubchuk v. Salvation Army Grace General Hospital et al***, 2008 MBQB 49. Rather, the Petition raises the issue of whether, after certain treatment has ceased, the Court is in a position to order that the treatment resume where the medical advisors state that it is in their *bona fide* clinical judgment that the former treatment is contra-indicated. It is the position of the Respondents that the Court cannot require a medical advisor to act in a manner contradictory to the fundamental duty which that medical advisor owes to the patient.

[16] When faced with a similar situation, the Lord Justices in ***Re J***, *supra*, were of the view that they could not conceive of any circumstances in which it would be other than an abuse of power to require a medical practitioner to act contrary to the fundamental duty which that practitioner owed to his or her patient. The statements to that effect set out in clear and strong language the position taken in ***Re J***, *supra*. I agree with that view.

[17] It should also be noted that the Court in ***Re J*** was dealing with the jurisdiction of the Court in the exercise of its inherent power to protect the interest of minors. I do not assume that there is a similar inherent jurisdiction available to the Court when dealing with patients who are not minors or that this inherent jurisdiction exceeds the traditional authority assumed by the Court when dealing with minors.

[18] Even assuming that such an intervention could be undertaken by the Court, I am satisfied that such an intervention would be inappropriate in this case. It is only the Petitioner who is of the view that there should be resumption of the previous treatment program for her mother. In fact, it is the opinion of the medical advisors of Ms. Priboi that what was previously part of the treatment program would no longer be suitable and would, in fact, be harmful. In particular, digoxin and simvastatin were discontinued on February 1 "… due to concerns about potential toxicity". Similarly, "albumin" was discontinued because it was "resulting in fluid overload" and TPN (Total Parenteral Nutrition) was discontinuing because it was "… contributing to progressive renal failure given the urea load". Why certain treatment was discontinued was best described on February 4, 2008: "The TPN was stopped due to progressive renal failure as was the digoxin, albumin and lasix therapies as they are likely to cause further complication." To date, only the Petitioner is of a contrary view. There is no doubt in my mind that the Petitioner hopes that something can be done to reverse what the medical advisors believe is the inevitable result of the condition of her mother. The love for her mother was clearly evidenced by the submissions made by the Petitioner. However, that is not enough to ground an order to a medical advisor to treat Ms. Priboi in a manner which is contrary to his or her clinical judgment even if such an order could be made by this Court.

[19] As well, this is not a situation where other medical advisors have formed a quite different opinion about what treatment of Ms. Priboi is advisable. This is also not a situation where a medical advisor to Ms. Priboi is asking the Court to make an order that a particular course of treatment be undertaken where that course of treatment is

opposed by those close to the patient. Without assuming that this decision would be different if contrary medical advice was in evidence, I am not in a position to accede to the relief sought by the Petitioner. Rather than dismiss the Petition, the hearing of the Petition is adjourned generally.

[20] However, I will order that all of the medical records available at Vancouver General Hospital will be made available to a licensed medical practitioner so that the Petitioner will be in a position to receive an independent view of what is in the best interests of her mother. I will remain seized of any application by a licensed medical practitioner regarding his or her recommended treatment of Ms. Priboi or of the further hearing of the relief sought by the Petitioner in this Petition. In the circumstances, the parties will bear their own costs of this application.

"The Honourable Mr. Justice Burnyeat"