Manitoba Court of Queen's Bench

Citation: Sawatzky v. Riverview Health Centre Inc.
Court File: CI 98-01-10245
Date: 1998-11-13

Beard J.

Counsel:
Richard M. Beamish, for plaintiffs.
E. Doreen Kelly, for defendant.
Sherri Walsh, for intervener.

BEARD J.:—

I. The Issue

[1] This is an application by the plaintiffs for an interlocutory injunction. In the main proceeding, the plaintiffs have applied by way of statement of claim for injunctive and declaratory relief arising from the fact that a "do not resuscitate" order has been issued in relation to Mr. Sawatzky, notwithstanding that the plaintiffs do not consent to such an order. They are now asking that this court enjoin, that is prohibit, the defendant from imposing that order or a similar health care directive against Mr. Sawatzky until the trial.

[2] The defendant has opposed the granting of the interlocutory injunction on the basis that to do so would be to order a doctor to provide medical treatment which she/he feels is not in the patient's best interests, putting her/him in conflict with the Code of Conduct of the College of Physicians and Surgeons. The defendant has argued that there is no authority in law to impose such an obligation on a doctor.

[3] As judges, we are often required to make difficult decisions which have a profound effect on the lives of others. These decisions most often involve the custody of children in a family dispute or the imposition of a prison sentence in a criminal matter. The decisions do not get any easier, no matter how often a judge must deal with the issues. This is one of the most difficult cases that I have had to deal with, as it may not only change lives, but it may have the effect of ending a life. I can assure you that the last week has been most difficult for me as I have wrestled with the competing issues that have been raised.

[4] Getting back to the issues, the defendants have argued that this is a private matter solely between the plaintiffs and the defendants. I do not agree with that characterization. While the issues have come before the court in the context of a private dispute between the parties, some of the issues that are raised are of a public concern. The issues, as I see them, are as follows:

> (1) in what factual circumstances can a doctor or health care facility issue a "do not resuscitate" order;

(2) do those factual circumstances apply in this case;

(3) can a doctor or health care facility legally issue a "do not resuscitate" order if the patient or the person entitled to consent to health care treatment for the patient refuses to consent to that order?

[5] The first and third issues are clearly of general interest and, I would suggest, of great concern to the public. They raise fundamental questions relating to a patient's right to medical treatment and a doctor's obligation to provide that treatment. Those questions raise serious legal, moral, ethical, medical and practical issues on which there is unlikely to ever be complete agreement. I think that many Canadians have been surprised to learn that a doctor can make a "do not resuscitate" order without the consent of a patient or his or her family, yet that appears to be the current state of the law in Canada, Britain and the United States. While the courts may be an appropriate place to start the discussion of these issues in that the courts can clarify the existing state of the law in light of the *Canadian Charter of Rights and Freedoms*, it may be for the government to resolve any moral or ethical questions that remain at the end of the day. The government can ensure a much wider debate including all interested sectors of society, while a court proceeding is, by necessity, relatively narrow and limited even if some interventions are allowed. Regardless of the outcome of this hearing, these issues require full public discussion.

II. The Facts

[6] Mr. Sawatzky has Parkinson's disease and certain other ailments. At present, he is a patient in the defendant's health care facility in Winnipeg and has been there since May 25, 1998, when he was admitted, according to Mrs. Sawatzky and as appears from a letter by Dr. Zeiler, for rehabilitation therapy and an assessment. Prior to that, he had been living at home with Mrs. Sawatzky, although he has had at least one other period of hospitalization.

[7] According to the affidavit of Dr. Bouschta for the defendant, Mr. Sawatzky was assessed on admission by Dr. Engel. The doctor was of the view that Mr. Sawatzky was not a candidate for resuscitation in the event that he went into arrest, but he acquiesced to Mrs. Sawatzky's request and ordered resuscitation in spite of his view to the contrary. He apparently discussed this matter with Mrs. Sawatzky over the summer, but she refused to consent and he did not change his order.

[8] During the summer, there were discussions as to Mr. Sawatzky's future care. Attempts were made to transfer him back to Beausejour, the community where the Sawatzky's are from, but, to date, those attempts have been unsuccessful and he remains at the Riverview facility.

[9] Also during the summer, Dr. Engel formed the opinion that Mr. Sawatzky required a procedure for a cuffed tracheostomy tube. Mrs. Sawatzky refused to consent to the procedure so Dr. Engel applied to the director of psychiatric services, and an order of supervision was granted under *The Mental Health Act*, R.S.M. 1987, c. M110. This order has the effect of appointing the Public Trustee as the guardian of the person of Mr. Sawatzky and, as such, she has the authority to consent to medical procedures and treatment on behalf of Mr. Sawatzky. After obtaining a second medical opinion, she consented to the procedure and it was carried

out. That order of supervision remains in effect, although Mr. Beamish indicated that he now has instructions to apply to have it set aside.

[10] According to Dr. Bouschta, Mr. Sawatzky's condition has deteriorated recently, as he has again had pneumonia. This is not his first bout of pneumonia and there is no indication that he has not recovered. Dr. Engel reconsidered the question of the "do not resuscitate" order and, on October 29 or 30, 1998, he made that order, apparently without prior notice to Mrs. Sawatzky and without obtaining a second opinion. Dr. Bouschta immediately advised Mrs. Sawatzky of the order, and Mrs. Sawatzky stated that she was still not consenting. Mrs. Sawatzky then retained legal counsel and commenced this proceeding.

[11] There is clearly a difference of opinion between Mrs. Sawatzky and the defendant as to Mr. Sawatzky's condition. Mrs. Sawatzky stated that, while her husband has difficulty communicating in a general sense due to the tracheostomy, she is able to communicate with him by a combination of vocalizations, gestures and hand signals. She also states that:

> There is no question in my mind that my husband understands his medical issues and is well aware of matters going on around him. In fact, I spend numerous hours with my husband on a daily basis, during which we communicate not only about his medical affairs, but also current events external to his situation.

[12] Dr. Bouschta does not suggest that Mr. Sawatzky is completely unaware of his surroundings. She states as follows:

> Mr. Sawatzky is able to convey his wishes only on a very inconsistent basis, and mostly through non-verbal signals, and only for very basic needs. He has difficulty swallowing, difficulty speaking and the strokes have resulted in impairment of his mental abilities.

[13] Dr. Bouschta has attached a letter to her affidavit which was written by the social worker at Riverview to the provincial psychiatrist in support of the application for the order of supervision. While the social worker does not state the source of her knowledge, she suggests that Mrs. Sawatzky has unrealistic expectations regarding her husband and seems unaware or unconcerned with his limitations. *III. The Law*

[14] The law in Manitoba regarding interim injunctions is that set out in the case of *Pereira v. Smith* (1993), 88 Man. R. (2d) 171 (C.A.) at 174:

> ... the court must consider the strength of the plaintiff's case at the same time as it considers the balance of convenience between the parties. The more equal the balance of convenience is, the stronger should the plaintiff's case appear and, of course, if the balance of convenience favours the defendant, the interlocutory relief should be refused.
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> * * * * *
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> ... the undernoted factors should be balanced once the judge is satisfied that damages are an inadequate remedy. I do not list them in order of their importance. Their relative importance depends on the circumstances of the case. The factors are:

1. The extent to which damages are inadequate as a remedy for the plaintiff, assuming ultimate success;

2. The extent to which damages, on the plaintiff's undertaking to pay them if unsuccessful at the trial, would be an adequate remedy for the defendant;

3. The balance of convenience;

4. The strength of the plaintiff's case;

5. The desirability of maintaining the status quo;

6. Any special circumstances.

[15] These factors set out in *Pereira* are taken from the case of *American Cyanamid v. Ethicon Ltd.*, [1975] 1 All E.R. 504 (H.L.). In the British case of *Re J (a minor) (a wardship: medical treatment)*, [1992] 4 All E.R. 614 (C.A.), Lord Donaldson M.R. held that there was no room for the application of the principles governing the granting of an interlocutory injunction in a case similar to the present matter. He stated that the proper approach was to consider what options were open to the court in the proper exercise of powers and, within those limits, to determine what orders would best serve the true interests of the infant pending a final decision.

[16] The *Re J (a minor)* decision is not binding on me, while the *Pereira* decision both reflects the current law in Manitoba and provides a useful framework within which to consider the issues that are raised in the matter before me.

IV. Analysis

[17] The following is a consideration of the *Pereira* factors in relation to the facts of this case.

(1) and (2): Would damages be an adequate remedy for the plaintiffs if they are ultimately successful? Clearly, damages would not be an adequate remedy in this case. If Mr. Sawatzky goes into arrest awaiting trial and is not resuscitated, he will be dead and no relief at trial can adequately compensate him or Mrs. Sawatzky for that loss.

(3) The balance of convenience: The issues to be balanced, although it was not described in those terms, are clearly set out by the British Court of Appeal in the case of *Re J (a minor).* In that case, a doctor recommended that there be no resuscitation of a severely handicapped infant. The trial judge granted an interlocutory injunction until the trial, but that injunction was immediately overturned by the Court of Appeal. In that decision, Lord Donaldson M.R. stated at p. 622:

> 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.

[18] Balcombe L.J. explains the difficulty for the court and the doctor if such an order was made at p. 625:

> The court is not, or certainly should not be, in the habit of making orders unless it is prepared to enforce them. If the court orders a doctor to treat a child in a manner contrary to his or her clinical judgment it would place a conscientious doctor in an impossible position. To perform the court's order could require a doctor to act in a manner which he or she genuinely believed not to be in the patient's best interests; to fail to treat the child as ordered would amount to a contempt of court. Any judge would be most reluctant to punish the doctor for such a contempt, which seems to me to be a very strong indication that such an order should not be made.

[19] This same position was taken by the Manitoba Court of Appeal in the case of *Child and Family Services of Central Manitoba v. R.L.* (1997), 123 Man. R. (2d) 135, 154 D.L.R. (4th) 409 *sub nom. Child and Family Services of Central Manitoba v. Lavallee.*

[20] The courts state that the appropriate action against the doctor if he is in error in his decision not to treat the patient is a claim for negligence. This is cold comfort to Mr. and Mrs. Sawatzky, as the lawsuit cannot bring Mr. Sawatzky back if the doctor is later found to have acted negligently.

[21] The courts are left to weigh and balance the ethical problems for the doctor if she/he is faced with an order to provide specific treatment with which she/he disagrees as against the risk that the patient may die unlawfully as a result of a wrong medical decision if no court action is taken.

[22] While I recognize the dilemma for the doctor if that treatment is ordered, the question of balance of convenience should be resolved based on the specific facts of the case, which I will discuss later. While the fact situation will have to weigh heavily in favor of granting the order to outweigh the seriousness of ordering treatment where a doctor has recommended none, it would be wrong to say that the facts are always irrelevant.

> (4) The strength of the plaintiffs' case: This being an interlocutory injunction at the very earliest stage of this proceeding, there has not been an in-depth analysis of the strengths and weaknesses of the plaintiffs' case by either the lawyers or myself due to time constraints. Indeed, if the matter proceeds to trial there will be considered arguments to the court not only by the lawyers for the parties, but also by counsel for the Public Trustee and, I have no doubt, from the Constitutional Law Branch of the Manitoba Department of Justice.

[23] Based on the case law to date, the courts have stated that a decision not to provide

treatment is exclusively within the purview of the doctor and is not a decision to be made by the courts. Thus, it appears that the courts would not interfere with a medical decision not to provide treatment. I note, however, that counsel have referred to only three cases in which the facts and issues are at least somewhat closely related to this matter, although even then there are some clear differences. There is only one case from a Canadian court, being the *C.F.S. v. R.L.* decision and that case did not consider either effect of rights under the *Charter of Rights and Freedoms* (the *Charter)* or the Manitoba *Human Rights Code*, S.M. 1987-88, c. 45 (C.C.S.M., c. H175).

[24] The MLPD has indicated that it wants to argue the application of the *Charter* to the issues in this case. Without quoting extensively from the brief filed by the MLPD, it has raised the following issues:

> (i) does the "do not resuscitate" order made by or on behalf of the defendant, without the consent of the patient, deprive him of the constitutionally protected right to life and security of the person under s. 7;
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> (ii) does the "do not resuscitate" order made by or on behalf of the defendant, without the patient's consent, deprive him of the right to equal protection and benefit of the law contrary to s. 15 in that, by deciding that such treatment would be futile, it has discriminated against him on the basis of his mental and physical disability, thereby depriving him of the right to autonomy over his own body and the opportunity to make an informed decision regarding his own health care;
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> (iii) do the actions of the defendant violate s. 12 of the *Charter*, being the right not to be subjected to cruel and unusual treatment.

[25] The development of the rights protected by the *Charter* is, in many areas of the law, in its infancy. Clearly, there are no cases to date which have considered these rights in the context of the facts of this case. It was only with the 1997 decision in *Eldridge v. British Columbia (Attorney General)* (1997), 151 D.L.R. (4th) 577 (S.C.C.), that the courts have recognized that the *Charter* can apply to the actions of a hospital and the services that such a facility provides. In that case the court held (reading from the headnote at p. 579):

> Although hospitals are not "government" for the purposes of s. 32, they are carrying out a specific governmental objective in providing medically necessary services under the *Hospital Insurance Act*, and are hence subject to the Charter in the provision of those services. The alleged discrimination in this case — the failure to provide sign language interpretation — is intimately connected to the medical service delivery system instituted by the legislation. While hospitals may be autonomous in their day-to-day operations, they act as agents for the government in providing the specific medical services set out in the Act.

[26] There are significant differences between the facts of this case and those of the *Eldridge* case, one major one being that, unlike this case, there were no ethical issues related to the provision of the translation services ordered in that case. It is not the role of a judge on an interlocutory injunction application to decide the merits of the case. As was stated in the

Pereira case, the plaintiff need only show that its claim is not frivolous or vexatious. I am satisfied that there are meritorious issues to be tried in this case and that the application is neither frivolous nor vexatious. It is, however, difficult to comment on the strength of that case, given that the plaintiffs and the MLPD are raising issues that have not been litigated before. It is true that, in many instances, the courts have recognized or developed new rights under the *Charter.* Whether this is one of those cases will have to be determined after a trial and a full examination of the law.

> (5) The desirability of maintaining the status quo: The situation today is that there is a "do not resuscitate" order against Mr. Sawatzky; however, this has been the case for only 10 or 11 days. Prior to that, the doctor had issued an order to resuscitate which was in effect for five months. I am going to treat the situation prior to the "do not resuscitate" order of October 29 or 30, 1998, as the status quo.

[27] The following factors are relevant to a consideration of the desirability of maintaining the status quo:

> (i) The doctor had, on his own volition, albeit at the insistence of Mrs. Sawatzky, ordered that Mr. Sawatzky be resuscitated, and that order was in effect for five months. If he viewed that decision as an ethical dilemma, it was clearly one that he was able to live with for some time.
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> (ii) The treatment involved in resuscitating Mr. Sawatzky, as it is described by Dr. Bouschta in her affidavits, is not extensive. According to the doctor, it would require that the defendant provide CPR and call 911. Neither step is onerous for the defendant.
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> (iii) This treatment is not as invasive as most, in that it does not involve surgery or any other specialized procedure.
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> (iv) The provision of the treatment in question does not depend upon the special skills of Dr. Engel and, in fact, is likely to be provided by someone other than him. The treatment, that is, the CPR would be provided by the first qualified person who found Mr. Sawatzky in arrest, which is more likely to be someone other than the doctor.
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> (v) The treatment does not, in and of itself, raise the same type of ethical problems for the doctor that could be associated with controversial procedures like abortions.

[28] When one considers these facts, the desirability of maintaining the status quo as it was immediately before the doctor's "do not resuscitate" order resolves itself in favor of the plaintiffs.

> (6) Special Circumstances: There are also some special circumstances which must be considered in this case.
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> > (i) In the cases quoted, the courts have been faced with persons in a persistent vegetative state or, in the case of *Re J*, a 16-month old baby who was profoundly mentally and physically handicapped and who was not expected to live long. Clearly,

> Mr. Sawatzky is not in a persistent vegetative state. While he requires some medical treatment, he is not on life support systems and Dr. Engel described him as "alert" in the report that he submitted to the provincial psychiatrist in August 1998. There is no evidence that his condition has changed significantly since then. Thus, his medical condition is significantly different from that in the precedent cases, which raises issues not considered in those cases.
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> (ii) In the cases quoted, the courts refer to there being opinions from several medical specialists as to the patient's condition. In none of the cases is there any indication of a dispute between the parties as to that condition. That is not the case here, as there is clearly a dispute between Mrs. Sawatzky and the defendant as to Mr. Sawatzky's condition and his prognosis for the future. To further complicate the matter, the defendant is alleging that Mrs. Sawatzky is being unrealistic in her assessment of her husband's present capabilities and leaves the impression that she is not acting in his best interests. This discrepancy in the evidence cries out for some clarification.

[29] A consideration of these special circumstances again supports the application for an interlocutory injunction, at least until the discrepancies can be resolved.

[30] The question must be asked: "What role can the courts play in a case dealing with the appropriateness of future medical care or, in a case such as this, the refusal to provide care?" This matter was examined at some length in the British case of *Airedale NHS Trust v. Bland*, [1993] 1 All E.R. 821 (H.L.), a case about an application for a declaration regarding the legality of the withdrawal of basic life support services for a young man in a persistent vegetative state. While the House of Lords concluded that the withdrawal of life support was not illegal without a court order, it also ordered that, at least for a time, an application should be made to court for approval before so doing. I recognize that the law presently treats active treatment decisions and decisions not to treat differently (although this is often a distinction without a difference as is noted by Lord Lowry at p. 875 of *Airedale)*, but even if there is a difference, many of the moral and ethical issues are the same.

[31] Lord Keith made the following comments at p. 862 regarding the reason for court involvement in such a matter:

> The decision whether or not the continued treatment and care of a PVS patient confers any benefit on him is essentially one for the practitioners in charge of his case. The question is whether any decision that it does not and that the treatment and care should therefore be discontinued should as a matter of routine be brought before the Family Division for indorsement or the reverse. ... this would be in the interests of the protection of patients, the protection of doctors, the reassurance of the patients' families and the reassurance of the public. I respectfully agree that these considerations render desirable the practice of application.

[32] This question was also considered by Lord Goff at p. 872:

> The truth is that, in the course of their work, doctors frequently have to make decisions which may affect the continued survival of their patients, and are in reality far more

> experienced in matters of this kind than are the judges. It is nevertheless the function of the judges to state the legal principles upon which the lawfulness of the actions of doctors depend; but in the end the decisions to be made in individual cases must rest with the doctors themselves. In these circumstances, what is required is a sensitive understanding by both the judges and the doctors of each other's respective functions, and in particular a determination by the judges not merely to understand the problems facing the medical profession in cases of this kind, but also to regard their professional standards with respect. Mutual understanding between the doctors and the judges is the best way to ensure the evolution of a sensitive and sensible legal framework for the treatment and care of patients, with a sound ethical base, in the interest of the patients themselves.

[33] While courts and judges do not have any expertise in making medical decisions, they do have expertise in resolving factual disputes and in making legal decisions. In the case of non-consensual medical decisions, be they decisions to provide, withdraw or refuse care or treatment, there is a role for the courts to play in making factual determinations and advising of the legality or illegality of disputed decisions before the patient is dead. The very suggestion that there is the option of a claim in negligence raises the fact that doctors can and, on occasion, do make mistakes. Further, many of the decisions that they make are qualitative and there is much room for individual disagreement on the correctness of the decision. Such findings would surely guide the doctor as she/he makes these decisions.

[34] There is also a public interest aspect involved in some of these issues which needs to be recognized including, as was stated by Lord Keith in the *Airedale* case, the protection of the patients, the reassurance of the patients' families and the reassurance of the public. At the end of the day, it is the doctors who will have to make the medical decisions, but they will do so knowing the facts and the likely legal outcome of those decisions. As is often said, justice must not only be done but be seen to be done. This is appropriate whether speaking of justice in the court room or justice in terms of medical care.

[35] My earlier analysis of the facts of this case as they relate to the factors set out in the *Pereira* case would indicate that the interlocutory injunction should be granted. The following is a summary of the special and extraordinary circumstances which make a court order appropriate:

> (i) The treatment at issue is basic resuscitation. If needed, it will mean the difference between life and death. Unlike some procedures, there is no suitable treatment that can be substituted until the trial. Due to the nature of an arrest and resuscitation, it is impossible to know when or if such treatment will be required, so it is not possible to postpone a decision on the "do not resuscitate" order until trial.
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> (ii) There is no consent from the patient, his family or his substitute decision-maker for the health care decision that has been taken by the doctor. Even if the doctor can act without that consent, the importance of attempting to obtain the consent of the family or other decision-maker has been recognized by both the courts and the College of Physicians and Surgeons.
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> (iii) While the ethical dilemma for the doctor is a serious concern, in this case he

voluntarily accepted and lived with that dilemma for five months. There has been no significant change in Mr. Sawatzky's condition since that time which would change the nature of that dilemma for him if his resuscitation order is extended for a short time to allow for the independent medical opinions, for Mrs. Sawatzky to consult with her lawyers and for the Public Trustee to become involved.

(iv) As has been pointed out by Dr. Bouschta, disagreement as to the appropriateness of a "do not resuscitate" order is extremely unusual, so that applications of this type are likely to be extremely rare. She said that she has never before seen a case where this issue has not been resolved by agreement.

(v) There is a dispute as to the patient's condition and, to date, neither party has obtained another opinion to resolve this dispute.

(vi) There is no evidence that Mrs. Sawatzky was given any warning of the decision to rescind the doctor's resuscitation order to enable her to obtain a second, independent opinion or to attempt to have Mr. Sawatzky transferred to another facility, which raises the question of whether she and her husband were treated fairly. While to date they have not been able to arrange to move Mr. Sawatzky to Beausejour, they should have some time to locate another facility.

(vii) There is a suggestion that Mrs. Sawatzky is being unrealistic as to her husband's condition, but to date, no one is involved in this matter to protect his interests where they diverge from those of his wife. The interests of mentally incompetent patients are usually protected by the Public Trustee, but in this case she has declined to become involved, notwithstanding that she already has an order of supervision and was served with the court material in this matter. I find her refusal to become involved to protect Mr. Sawatzky's interests incomprehensible and inexcusable.

V. Order and Directions

[36] For these reasons, I find that it would be appropriate to grant the interlocutory injunction requested; however it will be on very limited conditions. The injunction will be as follows:

(i) the "do not resuscitate" order of Dr. Engel made on October 29 or 30 1998, is withdrawn, and the resuscitation order which was in effect immediately prior thereto will remain in effect until further order of this court;

(ii) the Public Trustee is ordered to represent the interests of Mr. Sawatzky in this proceeding;

(iii) the Public Trustee and the defendant are to each obtain an independent medical opinion as to Mr. Sawatzky's current condition and the advisability of the "do not resuscitate" order;

(iv) Mrs. Sawatzky is given leave to obtain her own separate medical opinion as to her husband's condition and the advisability of the "do not resuscitate" order if she wishes; however, she is not required to do so;

(v) Mrs. Sawatzky, through her lawyer, is to advise both the Public Trustee and the defendant within one week as to whether she will be obtaining her own report;

(vi) counsel are to advise me in writing within one week as to when they expect to have their reports available; however, I expect them to be available in very short order;

(vii) any medical reports obtained are to be forwarded to the other two persons obtaining reports and to the court immediately upon receipt;

(viii) the parties can return to court for a review of this order if there is a significant change in Mr. Sawatzky's condition;

(ix) this order will remain in effect until the return of this matter to court.

[37] If the parties are not able to resolve this matter after receiving the independent medical reports, I will hear further argument on whether to terminate the injunction or extend it until trial.

[38] I would like to say that I recognize the very difficult position that both of the parties found themselves in and which resulted in them being in court. The defendant found itself faced with a patient who may not be able to fully understand his condition. Having the Public Trustee appointed as committee did little to help because she was not prepared to perform her role as committee by putting forward Mr. Sawatzky's position in relation to the "do not resuscitate" order, to the extent that his position could be determined, or to act to protect his interests. Mrs. Sawatzky, his next-of-kin, was adamant in refusing to consent to treatment or to the "do not resuscitate" order, and they had concluded that she was not accepting the reality of his medical condition as they saw it.

[39] Mrs. Sawatzky is also in a very difficult position. I am sure that she loves her husband very dearly. They have been married for over 40 years and, even now, she states in her affidavit that she spends hours with him on a daily basis. The information on the file indicates that Mr. and Mrs. Sawatzky do not have any children and seem to have limited family or social support. When he dies she will be terribly lonely, and I have no doubt that the thought of being without him is very difficult for her. She has certainly demonstrated her devotion to him during these last number of months.

[40] To date, it appears that Mrs. Sawatzky has been making decisions largely on her own, with whatever help she can get from her husband. Now she has the assistance and support of the MLPD and a very able lawyer. I hope that they will accept a role in providing helpful advice to Mrs. Sawatzky, both about her legal claim and, perhaps more importantly, about the reality of her husband's medical condition if it turns out that the independent reports do not confirm her belief regarding his condition. I can only hope that once the Public Trustee shows up, she or her designate will also be sensitive to the needs of both of the Sawatzkys and assist to

resolve this matter.

[41] It is my sense that, despite the clear public interest issues raised by this matter, it would be best for the Sawatzkys if it could be resolved out of court. I am sure that the defendant would prefer not to be in the spotlight either. A resolution may become easier with the independent medical opinions which should really have been obtained before this matter ever got this far. If the courts can be of any assistance in resolving this matter, I invite counsel to give me a call, and I will do whatever I can to assist.

[42] If this matter is to go to trial, I recommend that counsel consider requesting that the matter be case managed to ensure a quick solution. Again, if I can be of assistance please contact me.

VI. Public Trustee

[43] I wish to make a few comments about the Public Trustee's role and participation in this matter. As I understand the situation, the Public Trustee was served with a copy of the application filed in this matter, and there have been discussions between Mr. Beamish and the Public Trustee's office regarding this proceeding. Notwithstanding those discussions and the fact that the Public Trustee is Mr. Sawatzky's committee pursuant to an order of supervision under *The Mental Health Act* made by the Director of Psychiatric Services in August 1998, the Public Trustee has chosen to file no material in this proceeding, to make no representations and to take no part whatsoever in this matter.

[44] I contrast this with the very active role apparently played by the various government departments in England as appears in the cases such as *Airedale NHS Trust v. Bland.* In that case, Sir Stephen Brown P. notes the legal representation in the proceedings as follows [at p. 825]:

> Because Anthony Bland himself is wholly incapable of taking any step with regard to this matter the Official Guardian of the Supreme Court has been appointed to act as his guardian ad litem. He has instructed counsel to appear on the hearing of this summons.

[45] In this case, it is not necessary for the court to appoint the Public Trustee (our equivalent of the Official Guardian) to represent Mr. Sawatzky, as she has already been so appointed by the order of supervision. Her obligation to represent Mr. Sawatzky is clear from both the Queen's Bench rules and *The Mental Health Act.*

[46] The active role of the Official Guardian was commented upon by Lord Goff at pp. 864-865 as follows:

> The Official Solicitor, acting on behalf of Anthony Bland, appealed against that decision [that is, the trial decision] to the Court of Appeal, which dismissed the appeal. Now, with the leave of the Court of Appeal, the Official Solicitor has appealed to your Lordships' House.
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> In so acting, the Official Solicitor has ensured that all relevant matters of fact and law are

> properly investigated and scrutinized before any irrevocable decision is taken affecting Anthony Bland, for whom he acts as guardian ad litem. This function was performed by Mr. James Munby QC, who appeared before your Lordships as he did before the courts below ... I have come to the conclusion that I am unable to accept Mr. Munby's submissions; but I have nevertheless found then to be of great assistance in that they have compelled me to think more deeply about the applicable principles of law and, I hope, to formulate those principles more accurately. [Words in parenthesis are mine.]

[47] This must be contrasted with the complete inaction on the part of our Public Trustee — in fact, the complete abdication of her responsibility to Mr. Sawatzky, for whom she is responsible. When the doctors wanted to do a tracheostomy on Mr. Sawatzky and his wife refused to consent, the Public Trustee was appointed as his committee, obtained a second medical opinion and consented to the treatment. When the doctor ordered a "do not resuscitate" order, an action with much more serious implications for Mr. Sawatzky, there appears to be no action whatsoever by her on his behalf — there is complete silence from the Public Trustee. Did the Public Trustee send someone to see Mr. Sawatzky? Was there any effort to determine whether he had ever expressed an opinion on this matter? Was there any effort to represent his views, to the extent that they could be determined? None of the above, as far as I can determine.

[48] This brings us to the role of the Public Trustee in cases like this. Section 80 of *The Mental Health Act* authorizes the Public Trustee to consent to medical or health treatment or health care on behalf of her wards. By s. 80(1.4), the Public Trustee is required to act in accordance with the principles of subsections 24.1(3) and (4) of *The Mental Health Act* when making health care decisions. Those subsections state as follows:

> Best interests of the patient
>
> 24.1(3) A person authorized to make treatment decisions on behalf of a patient under clause (1)(*a*) or *(b)* shall do so
>
> *(a)* in accordance with the wishes of the patient, if the person knows that the patient expressed such wishes when apparently mentally competent; or
>
> *(b)* in accordance with what the person believes to be in the best interests of the patient.
>
> 24.1(4) In order to determine the best interests of the patient in relation to treatment, a person referred to in clause (1)(*a*) or *(b)* shall have regard to all the relevant circumstances including the following:
>
> *(a)* whether the conditions of the patient will be or is likely to be improved by the treatment;
>
> *(b)* whether the patient's condition will deteriorate or is likely to deteriorate without the treatment;

(c) whether the anticipated benefit from the treatment outweighs the risk of harm to the patient;

(d) whether the treatment is the least restrictive and least intrusive treatment that meets the requirements of clauses *(a), (b)* and (*c*).

[49] The Public Trustee apparently did none of these things.

[50] On a more general note, it appears from the information that has been provided to me that the Public Trustee has completely abdicated her responsibility not only to Mr. Sawatzky, but to all of her wards in the circumstance where the doctor is proposing a "do not resuscitate" order, and she is doing this on the basis of the *C.F.S. v. R.L.* decision. This is clear from the letter that she sent out to the Health Sciences Centre following that decision. In that letter she stated, in part:

> Therefore, effective immediately, the Public Trustee will not consider the issue of whether a do not resuscitate order should be placed on a client's chart. Consent of the Public Trustee should be sought only where the proposed course of treatment involves a touching of the patient's person in a non-emergent situation. Consent cannot be given to withholding treatment.

[51] The message in this? Don't call us, we won't be home.

[52] The question of whether consent or a court order is ultimately required by the doctor for the withholding of treatment is only one facet of participating in a decision regarding the withholding of treatment. Is there not a role for a substitute decision-maker such as the Public Trustee to determine the person's wishes and convey them to the doctor? Should the substitute decision-maker not inquire into the person's condition to ascertain, for that person's protection, that such a decision appears appropriate, or to determine whether there should be a second, independent opinion? Is this not particularly true in the present case, where Mr. Sawatzky is not in a persistent vegetative state and there is controversy as to his exact condition? Is this not what a person would do for himself/herself if he or she were competent? It is often the case that the Public Trustee's wards do not have any next-of-kin to take an interest in their well-being, so they are dependent on the Public Trustee to perform the role usually filled by a family member.

[53] Other issues arise on the issue of medical care where the decision is not to treat. Is it fair to the doctor for the substitute decision-maker to refuse to participate in this life and death decision and to completely abdicate this responsibility so that the doctor must assume the whole burden? How does the doctor carry out his/her obligation to make decisions regarding "do not resuscitate" orders only after taking into account the patient's "express opinion" where the substitute decision-maker, who has the legal obligation to authorize treatment according to those wishes will not participate?

[54] Surely the role of the Public Trustee as committee and her duty to her wards extends past consenting to active treatment and encompasses participating in decisions leading to death even if, at the end of the consultation process, the doctor can act contrary to the wishes

of the ward as they are expressed by the Public Trustee. She is still to express the ward's wishes to the doctor. In many cases, if she refuses to do so, there will be no vehicle for those wishes to be expressed. Surely, those who are not competent to speak on their own behalf deserve at least this level of representation in the decision to end their lives. I cannot believe that the Court of Appeal ever intended their decision to be used by the Public Trustee in this manner.

[55] I recognize that I am making these comments without the Public Trustee having had an opportunity to argue her position on the question of her role in relation to her wards, to explain the position taken in her letter following *C.F.S. v. R.L.* or to respond to the other issues that I have raised. It must be pointed out, however, that she chose not participate in this matter.

[56] Because of her role as Mr. Sawatzky's committee, I am now ordering her to respond to this application. This is essential for the following reasons:

> (i) the evidence before me as to Mr. Sawatzky's condition is contradictory and needs to be clarified before trial, including obtaining a second, independent medical opinion, presumably from a specialist in geriatric medicine;
>
> (ii) someone must determine whether there is evidence apart from Mrs. Sawatzky as to whether Mr. Sawatzky expressed any wishes regarding his treatment and put those wishes forward; (iii) the defendant has suggested that Mrs. Sawatzky has been unrealistic in her expectations for her husband's rehabilitation and that she poses a danger to him, and this should be clarified by independent investigation to the extent possible.

[57] Again, on a more general note, this proceeding raises serious and far-reaching legal and ethical questions which need the widest airing following thoughtful arguments. The decisions are no less than life and death matters. While the Public Trustee is not, as a matter of policy, participating in these decisions at present, I assume that she did so until recently. I am sure that her office has valuable experience to bring to the discussions. I certainly welcome her active participation from this point forward.

VII. Addendum to Reasons

[58] After giving further consideration to the order that I made in the above-noted matter on November 13, 1998, I would like to clarify the information I will be looking for in any additional medical reports or other evidence to be filed if there is a hearing regarding the continuation or termination on the interim injunction pending the trial. I want to make certain that that evidence complies with the following:

> (1) Any medical reports that are submitted should be written in language that can be understood by a layman, that is, someone who does not have any expertise in medical terminology.
>
> (2) That additional evidence should include a comprehensive description of Mr.

Sawatzky's current condition and his current level of functioning, to include the following:

(i) Is he confined to his bed? If not, to what extent and under what conditions is he able to leave his bed, and what type of assistance is required to do so?

(ii) Is Mr. Sawatzky in any pain or discomfort at the present time?

(iii) Is Mr. Sawatzky able to read or watch television with any degree of comprehension and, if so, does he participate in either of those activities?

(iv) A description of how Mr. Sawatzky spends his time each day.

(v) To what degree is Mr. Sawatzky able to understand conversations, to comprehend information given to him and to participate in decisions about his care or, in general, to communicate? Is it possible that Mrs. Sawatzky has more success at communicating with him because of her greater familiarity with him than that of his caregivers? Does he ever participate in decisions that are being made about his treatment?

(vi) Is Mr. Sawatzky's condition the same today as it was when he came to Riverview and, if not, to what extent has he deteriorated? If he is not able to communicate or give instructions today, was he able to do so when he first came into Riverview? If he was able to communicate when he came into Riverview, did he give any instructions or any indication as to his preference regarding resuscitation, palliative care or other treatment preferences at that time?

(vii) I noted in the social worker's report attached to one of the affidavits that Mr. and Mrs. Sawatzky belong to the Jehovah's Witness faith. Are there any tenets or beliefs of that faith that would indicate what type of treatment should be given to a person in Mr. Sawatzky's position. How strongly did Mr. Sawatzky follow his faith, and is he likely to have followed the beliefs of his faith in relation to his own care?

(viii) It may be of assistance to advise the court more specifically as to what type of treatment would be involved in resuscitating Mr. Sawatzky and to have each doctor comment on the likely effects of that treatment on Mr. Sawatzky. To the extent that it is possible, I would like to know the best and worst case scenarios and the probability of the outcome of that treatment.

[59] If there is any other information that counsel or the doctors feel might assist me in resolving this matter if it comes back to court, I would appreciate having that included in the material that is submitted to me.

[60] If counsel have any questions as to the information required or require any clarification in relation to the above, please feel free to contact me, with copies to other counsel.

[61] Application granted.