CITATION: Wawrzyniak v. Livingstone, 2019 ONSC 4900
COURT FILE NO.: CV-10-409585
DATE: 20190820

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:	)	
	)	
Elizabeth Gwendolyn Joy Wawrzyniak	)	*Marshall Swadron and Nima Hojjati*, for the Plaintiff
Plaintiff	)	
– and –	)	
	)	
Donald J. Livingstone, Martin G. Chapman	)	*Erica J. Baron and Christine Wadsworth*, for the Defendants
Defendants	)	
	)	
	)	
	)	**HEARD:** March 25, 26, 27, 28, 29 and April 1, 2, 3, 4, 5, 8, 9, 10,11, 12, 2019

CAVANAGH J.

PART I - INTRODUCTION

[1] This is a medical malpractice action in which the plaintiff, Elizabeth Wawrzyniak, alleges that Dr. Donald Livingstone and Dr. Martin Chapman, two physicians at Sunnybrook Health Sciences Centre ("Sunnybrook"), failed to meet the applicable standard of care in their care and treatment of her father, Douglas DeGuerre, who died on September 22, 2008.

[2] In September 2008, Mr. DeGuerre was a patient at Sunnybrook. Mr. DeGuerre was incapable with respect to health treatments. The plaintiff was his substitute decision-maker under the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A (the "*HCCA*") and authorized to give or refuse consent to health treatments on her father's behalf. The *HCCA* provides that a health practitioner who proposes a treatment for a person shall not administer the treatment without the person's consent or, if the person is incapable, the consent of the person's substitute decision-maker.

[3] Mr. DeGuerre was elderly and was suffering from several illnesses, including gangrene in his legs. On September 17, Mr. DeGuerre underwent bilateral above the knee amputations of both of his legs. On September 20, Mr. DeGuerre was discharged from the intensive care unit and re-admitted to Sunnybrook's internal medicine ward.

[4] Sunnybrook had a policy by which a standing order existed to initiate cardiopulmonary resuscitation ("CPR") in case of cardiac or respiratory arrest unless a specific instruction not to do so was given by the patient or substitute decision-maker or a health care provider had written a medical order precluding the otherwise automatic initiation of CPR.

[5] The plaintiff was trained as a registered nurse and she was very involved in her father's care. On September 22 the plaintiff understood that a full range of resuscitative interventions, including admission to Sunnybrook's intensive care unit as needed, would be administered to her father on the onset of cardiac or respiratory arrest, to which she had consented on his behalf by asking that his resuscitative status be "full code", a request that had been recorded in her father's chart.

[6] Dr. Livingstone was the physician most responsible for Mr. DeGuerre's care when he was admitted to the internal medicine ward. Dr. Chapman was a physician on Sunnybrook's rapid response team and he was responsible for performing follow-up assessments of patients discharged from the intensive care unit and attending to urgent call situations. On September 22, Dr. Chapman and Dr. Livingstone assessed Mr. DeGuerre, separately. Each concluded that he was close to death and would almost certainly not benefit from resuscitation which, they concluded, would only cause him suffering and harm. On the afternoon of September 22, the defendants decided not to offer CPR as a treatment option for Mr. DeGuerre, co-signed a "do not resuscitate" order, and placed it his on chart.

[7] Dr. Chapman attempted to contact the plaintiff by telephone to discuss the change in her father's resuscitation status, but he did not reach her. He left a voice mail message for the plaintiff to call the ward or Dr. Livingstone. The plaintiff called the ward but did not speak with either Dr. Chapman or Dr. Livingstone. She came to the hospital to visit her father and arrived in the late afternoon. The plaintiff did not know that Dr. Livingstone and Dr. Chapman had decided not to propose CPR as a treatment option or that they had written a "do not resuscitate" order.

[8] When the plaintiff arrived at her father's room on September 22, she found him alone and in respiratory distress. She asked for help, and nurses and the on-call resident responded. At the plaintiff's request, a respiratory therapist was paged. The plaintiff overheard a nurse tell the respiratory therapist that her father was not to be resuscitated and she responded that this was wrong, and her father was to be given CPR on a "full code" basis. While Mr. DeGuerre was being treated by the respiratory therapist, he went into arrest. Dr. Chapman was paged, and he came quickly.

[9] Dr. Chapman concluded that Mr. DeGuerre was actively dying. He explained to the plaintiff that resuscitation would almost certainly not benefit Mr. DeGuerre and only cause suffering. The plaintiff was angry and upset. CPR was not offered or administered. Mr. DeGuerre died in the plaintiff's presence while she was insisting that CPR be administered, calling for help, and trying to revive her father.

[10] The plaintiff makes three claims. First, she claims damages under the *Family Law Act*, R.S.O. 1990, c. F.3 ("*FLA*") for her pecuniary loss resulting from her father's death to compensate her for the loss of guidance, care and companionship that she might reasonably have

expected to receive from her father if he had not died by the defendants' alleged fault or neglect. Second, she claims damages for severe and lasting mental injuries caused to her by breaches of a duty of care and fiduciary duty that she alleges the defendants owed to her father. Third, she claims these damages for breaches of a duty of care and a fiduciary duty that she alleges the defendants owed directly to her.

[11] The plaintiff alleges that the defendants failed to meet the standard of care which applied on September 22, 2008 in two respects. First, by failing to obtain her consent, as her father's substitute decision-maker, to the writing of the "do not resuscitate" order, removing CPR from her father's plan of treatment, and withholding administration of CPR which, she contends, fall within the meaning of "treatment" in the *HCCA*. Second, and alternatively, if the defendants were not required to do so, by depriving her of information concerning her father's health status to which she was entitled, including the proposed change to her father's resuscitation status, when they made the "do not resuscitate" order.

[12] For the following reasons, I conclude:

(a) The defendants did not fail to meet the applicable standard of care when they assessed Mr. DeGuerre on September 22, 2008, exercised their clinical judgment, and concluded Mr. DeGuerre was close to death and CPR would almost certainly not benefit him and would only cause suffering and harm.

(b) The defendants' medical decision on September 22, 2008 not to offer CPR as a treatment option for Mr. DeGuerre and to write a "do not resuscitate" order to preclude the otherwise automatic initiation of CPR, and Dr. Chapman's decision at Mr. DeGuerre's bedside not to offer or administer CPR, do not fall within the meaning of "treatment" in the *HCCA*. The defendants did not fail to meet the applicable standard of care by failing to comply with the *HCCA*.

(c) The defendants did not fail to meet the applicable standard of care at common law by failing to obtain consent to their medical decision not to offer CPR as a treatment option for Mr. DeGuerre.

(d) The defendants did not fail to meet the applicable standard of care by not informing the plaintiff before writing the "do not resuscitate" order of their conclusion that he would almost certainly not benefit from CPR and that they intended to make a DNR order, or in the way they communicated with the plaintiff after making this order.

[13] The plaintiff's action is dismissed.

PART II - BACKGROUND FACTS

[14] The parties agreed on many facts, and these were set out in an Agreed Statement of Facts which was marked as an exhibit.

[15] I set out below facts that provide the context for my analysis of the issues raised in this action, some of which are taken from the Agreed Statement of Facts and some of which are additional facts that I find have been established by the evidence.

Mr. DeGuerre's prior medical history

[16] Evaluation of Mr. DeGuerre's health conditions on September 22, 2008 requires a review of Mr. DeGuerre's medical history and his health conditions in the period leading up to the defendants' decision not to offer CPR.

(a) Mr. DeGuerre's medical history prior to May 2008

[17] Mr. DeGuerre was born on April 22, 1920. In September 2008 Mr. DeGuerre was 88 years old. In 1985, Mr. DeGuerre was diagnosed with ischemic cardiomyopathy after he had a heart attack. He was diagnosed with atrial fibrillation, which is an ongoing abnormal heart rhythm associated with an increased risk of stroke. The following year, he was diagnosed with Type II diabetes, and suffered from a stroke.

[18] In early to mid-2006, Mr. DeGuerre develop shortness of breath on lying down and was diagnosed with congestive heart failure. In September 2006, Mr. DeGuerre had a chest x-ray that showed abnormal enlargement of the heart and degenerative changes of the thoracic aorta. In October 2006, chest x-ray again showed that Mr. DeGuerre's heart was enlarged and that there was an unfolding of the aorta.

[19] In addition to his chronic heart disease, Mr. DeGuerre also suffered from end-stage kidney disease. In September 2006, he underwent surgery to have an AV fistula placed in his left wrist to facilitate hemodialysis three times a week. His end-stage renal failure resulted from the progressive kidney failure he had developed over the prior years as a complication of his diabetes.

[20] Mr. DeGuerre also suffered from peripheral vascular disease, chronic obstructive pulmonary disease (COPD), hypertension, coronary artery disease, chronic pleural effusion, and anemia. As a consequence of his peripheral vascular disease, Mr. DeGuerre's blood vessels could not supply enough oxygenated blood to his legs which resulted in tissue death and gangrene, eventually resulting in his hospitalization at Lakeridge Hospital in May 2008. Mr. DeGuerre's gangrene became progressively worse over the following months.

(b) Admissions to Lakeridge Hospital and St. Michael's Hospital in May 2008

[21] In 2007-2008, Mr. DeGuerre continued to live in his own home in Oshawa. On May 2, 2008, Mr. DeGuerre was admitted to Lakeridge Hospital (Oshawa), following referral by his dialysis team, for treatment of dry gangrene of the toes secondary to diabetes and peripheral vascular disease. He was still able to walk at this time, although his toes had signs of gangrene. By this time, the gangrene had begun to limit his activities. For example, he had stopped bowling.

[22] On May 14, 2008, Mr. DeGuerre was transferred from Lakeridge Hospital to St. Michael's Hospital where he underwent a left Superficial Femoral Artery ("SFA") stenting and angioplasty on May 16, 2008 in hopes of improving the circulation in his left leg. By this point in time, the plaintiff was using a wheelchair to transport Mr. DeGuerre as walking had become difficult for him.

[23] On May 17, 2008, Mr. DeGuerre was transferred back to Lakeridge Hospital. The following day, he was found unresponsive and was suspected to have experienced a transient ischemic attack ("TIA"). During the submission at Lakeridge, he also experienced a large right pleural effusion (a large collection of fluid between the lung and chest wall). A chest tube was inserted June 4 until June 9, 2009 to drain the pleural effusion.

[24] On July 2, 2008, both the plaintiff and Mr. DeGuerre participated in a family meeting at Lakeridge at which Mr. DeGuerre's overall health condition was discussed. When code status was raised at the meeting, Mr. DeGuerre responded that he wanted to be full code.

Admission to Sunnybrook's Division of Long-Term Care (K-Wing) in July 2008

[25] In July 2008, Mr. DeGuerre agreed to move to a long-term care facility as he recognized he could no longer manage his needs in his own home. He was transferred from Lakeridge Hospital to Sunnybrook's Division of Long Term Care (also known as the Veterans' Affairs Unit or K-Wing) by ambulance on July 29, 2008.

[26] Mr. DeGuerre was admitted to K-Wing on July 29, 2008. He remained in K-Wing until his September 10, 2008 admission to Sunnybrook Hospital, aside from an admission to Sunnybrook Hospital from August 13, 2008 to August 27, 2008 for an infection.

[27] On August 6, 2008 the plaintiff and Mr. DeGuerre attended an appointment with Dr. Dueck, a vascular surgeon at Sunnybrook. The purpose of the appointment from the plaintiff's perspective was to determine if anything short of amputation could be done to save Mr. DeGuerre's legs. Dr. Dueck informed her on that day that he would order a CT scan to determine whether there was any option short of amputation, although he was doubtful.

[28] On August 13, 2008, before her father was transferred to the Emergency Department at Sunnybrook Hospital, the plaintiff advised of the staff at K-Wing that she agreed on behalf of her father to CPR and breathing support (including intubation and/or mechanical ventilation). The plaintiff acknowledged that this treatment plan was only applicable at K-Wing, and that if her father had been transferred to another long-term care facility, the conversation would have to happen again at the next facility.

[29] On August 28, 2008 after her father's return to K-Wing, the plaintiff attended a Long Term Care Family Conference. Mr. DeGuerre was not in attendance. The plaintiff signed an amendment to the Long Term Care Treatment Plan originally completed on August 13, 2008 that stated:

> I understand if Mr. DeGuerre is found unconscious, without a pulse, and no respirations that 911 should not be called and CPR not started.

[30] During his time at K-Wing, Mr. DeGuerre began to experience a change in his level of consciousness. On a Mini-Mental State Exam conducted on August 8, 2008, he scored 20/30. This test was repeated on September 5, 2008 and he scored 15/29. Near the beginning of September 2008, Mr. DeGuerre was confused and could not recognize the plaintiff. He was also in increasing pain and the slightest pressure caused him discomfort.

[31] On September 9, 2008, Mr. DeGuerre was transferred again to Sunnybrook's Emergency Department due to the gangrene in both of his legs. A CT scan was performed. He was seen by an emergency room physician early in the morning of September 10, 2008 who diagnosed him with delirium secondary to his gangrenous legs.

[32] Around midnight on September 10, 2008, Mr. DeGuerre was moved from the ER to an internal medicine inpatient unit (C-4).

Mr. DeGuerre's admission to an internal medicine inpatient unit at Sunnybrook on September 10, 2008 and Dr. Livingstone's assessment

[33] Mr. DeGuerre was transferred to C-4 on September 10, 2008 and he remained there until his bilateral above knee amputation surgery on September 17, 2008. Throughout both his pre-surgery and post-surgery period in C-4, Mr. DeGuerre was regularly seen by members of the clinical team and treated for a variety of medical issues. In addition to physicians and medical students working with Dr. Livingstone, he was seen by specialists from Infectious Diseases, Nephrology (Kidney Disease), Geriatrics, Vascular Surgery, and Orthopedics and by a registered dietitian (Clinical Nutrition). When the services made suggested orders for Mr. DeGuerre's care, they were almost always co-signed by a physician member of the Blue Team so that they could be carried out by the nurses involved in Mr. DeGuerre's care.

[34] Mr. DeGuerre also received regular hemodialysis (Tuesday, Thursday and Saturday) throughout this period. Nurses were responsible for administering medications ordered by the physicians. Nurses were responsible for recording the orders on a medical administration record ("MAR") and if necessary ordering the drugs from the pharmacy. The physicians would typically not review the MAR to ensure orders were being followed unless the patient was being discharged home or there was a concern that the ordered medication was not working.

[35] The plaintiff visited her father throughout this period, usually in the evenings. Dr. Livingstone was typically not present at the hospital when the plaintiff attended in the evenings. When the plaintiff asked to speak with a member of the clinical team, a member would make himself or herself available.

[36] Dr. Livingstone first became involved in Mr. DeGuerre's care on September 10, 2008. Dr. Livingstone was Mr. DeGuerre's most responsible physician from September 10 until his death on September 22, 2008 except during the period when Mr. DeGuerre was admitted to the ICU for surgery, from late on September 17 until 7:00 p.m. on September 20, 2008.

[37] On September 10, a medical student assessed Mr. DeGuerre and wrote a note. Dr. Livingstone also assessed Mr. DeGuerre himself that day. Dr. Livingstone wrote his own note

following his assessment of Mr. DeGuerre in the emergency room. Dr. Livingstone explained that this note was lost (in addition to some other records from that day) and that the medical student's note accurately set out Mr. DeGuerre's condition on that day. This note described Mr. DeGuerre as having experienced a recent change in his level of consciousness, which Dr. Livingstone described as a delirium typical of patients of Mr. DeGuerre's age with his comorbidities. The note described Mr. DeGuerre as moribund-appearing (that is, near death), cachectic (that is, profoundly wasted and skeletal) and drowsy.

[38] With respect to the extensive gangrene on Mr. DeGuerre's legs secondary to his peripheral vascular disease, Dr. Livingstone had never seen anything like that before or since. Dr. Livingstone would have seen 50 to 75 diabetic patients per year over a 15 to 20 year period with complications relating to diabetic foot disease, but he had never seen anything as horrific as Mr. DeGuerre's legs.

[39] Mr. DeGuerre's Achilles tendon was not covered by any skin. His legs were mostly covered by dry gangrene and there was an area of wet gangrene on his left foot (which Dr. Livingstone described as being similar in appearance to a soft cheese that was overripe and had become mouldy and infected). Mr. DeGuerre also had two large areas of ulceration - a 15 cm. wound on one leg, and a 20 cm. wound on the other - both with necrotic underlying tissue. Dr. Livingstone described one ulcer on the right leg is being about the size of a dinner plate and another as being the size of a bread and butter plate. He described the legs as having dramatic blue discolouration throughout, which was representative of dead and dying tissue.

[40] Although Mr. DeGuerre was experiencing numbness in his lower limbs as a result of his peripheral vascular disease, Dr. Livingstone explained that the pain from the severe necrotic tissue would likely have overridden the numbness. The plaintiff filled out a form ranking Mr. DeGuerre's degree of pain on September 10, 2008. In the form, she indicated that his pain got in the way of his activities and interfered with his ability to sleep and his well-being.

[41] On September 10, Dr. Livingstone formed the opinion that Mr. DeGuerre was going to die in the very near term. His prior clinical records indicated that he was full code. Dr. Livingstone testified that he thought that Mr. DeGuerre's code status should be re-evaluated given his then current condition. Dr. Livingstone formed an opinion that Mr. DeGuerre was not capable of making health care decisions for himself. The plaintiff was not present at the time of Dr. Livingstone's assessment, so he phoned her following his assessment of Mr. DeGuerre.

[42] Dr. Livingstone told the plaintiff that her father was in the process of dying, and that his death was likely to occur within days and almost certainly in less than two weeks. He thought Mr. DeGuerre's death was imminent. Dr. Livingstone outlined that there were two options for treating Mr. DeGuerre: 1) palliative: that is, aggressive management of pain to keep him comfortable; and 2) a possible bilateral amputation: that is, the amputation of both of Mr. DeGuerre's gangrenous legs assuming he could be sufficiently optimized for surgery. Dr. Livingstone was clear that he thought Mr. DeGuerre would still die even if he had the surgery but managing his pain would be easier if his legs were removed. He told the plaintiff that if it was him, he would want to be palliated.

[43] Dr. Livingstone had also undertaken a medical literature review, and he informed the plaintiff that the mortality associated with a bilateral amputation in Mr. DeGuerre's circumstances was very high - near unity or 100%. The plaintiff acknowledged that Dr. Livingstone discussed this topic with her on September 10. The plaintiff acknowledged that Dr. Livingstone had communicated to her that her father would die within weeks at most whether or not he had the surgery. The plaintiff understood that if her father did not have surgery, there was a 100% chance that he would die as a result of the gangrene in his legs.

[44] The plaintiff told Dr. Livingstone that she wanted her father to be full code, and CPR was to be administered. They agreed that the discussion about whether to proceed with surgery would be deferred since he was too unwell for surgery at that time. Dr. Livingstone expected the conversation concerning end-of-life care to continue. At the end of the conversation, Dr. Livingstone told the resident that he felt he had failed Mr. DeGuerre because the plaintiff did not appear to appreciate the severity of his condition.

Dr. Livingstone's September 12, 2008 assessment

[45] When Dr. Livingstone assessed Mr. DeGuerre on September 12, his condition appeared to have slightly improved. Dr. Livingstone noted that Mr. DeGuerre appeared very ill, disoriented, confused and delirious and his legs had not improved. However, he was able to eat some food by mouth and was not particularly short of breath. Dr. Livingstone was still very confident that there was an overwhelming probability that Mr. DeGuerre would die, but his improvement had raised the possibility that Dr. Livingstone described as a "thin thread of a suggestion" that Mr. DeGuerre might survive. Dr. Livingstone still thought that Mr. DeGuerre would die in the very near future, but he felt the door was "slightly ajar" to his recovery. Given this possibility, Dr. Livingstone felt that surgery was an option. It was clear to Dr. Livingstone that unless the decision was to move aggressively to the palliative route, the only option was palliative bilateral above-knee amputation for symptom relief.

[46] Dr. Livingstone met with the plaintiff in the latter part of the afternoon on September 12 when she was present at the hospital. He told the plaintiff "I need to eat crow". He explained to the plaintiff that Mr. DeGuerre's pain was not well-controlled and that he needed a much more aggressive palliative pain management strategy because, as Mr. DeGuerre's legs deteriorated further, his pain would not be able to be controlled. In this discussion, Dr. Livingstone supported surgery because Mr. DeGuerre's pain could not be managed without surgery. Dr. Livingstone

[47] The plaintiff discussed with Dr. Livingstone what should be done if Mr. DeGuerre were to have cardiac arrest. Dr. Livingstone asked her what she wanted done if her father had a heart attack during surgery. The plaintiff testified that she wanted everything done, but if her father was unable to breathe on his own after cardiac arrest, she would not want him intubated (put on a mechanical ventilator). Dr. Livingstone wrote an order in Mr. DeGuerre's chart and signed it:

> In the event of arrest - no ventilation, but other resuscitative measures to be attempted.

Dr. Livingstone showed the order to the plaintiff who then requested that a clarifying provision be added to the order. Dr. Livingstone added the following language:

> For purposes of clarity "other measures" to include drugs, external pacemakers, etc.

The plaintiff reviewed the order and did not request further clarification. Dr. Livingstone signed the addition to the order.

[48] Dr. Livingstone understood that the order was to apply to Mr. DeGuerre generally and not just during surgery. There is no record of a note from Dr. Livingstone of his conversation with the plaintiff, other than the order itself. It was clear to the plaintiff, however, that she and Dr. Livingstone were discussing resuscitative measures to be taken while Mr. DeGuerre was in the operating room. Each of Dr. Livingstone and the plaintiff had a different understanding of the order, but nothing turns on this because it is agreed that on September 22, 2008, before the "do not resuscitate" ("DNR") order was made, Sunnybrook Hospital's standing offer to initiate CPR was in effect to which consent had been given by the plaintiff when she asked that her father be treated as "full code".

[49] After speaking with Dr. Livingstone on September 12, the plaintiff spoke with a resident from orthopedic surgery, and reviewed the results of the CT scan. The resident confirmed that there was no alternative to surgery, and that Mr. DeGuerre would not survive if he did not have the amputation. The plaintiff consented to the surgery on Mr. DeGuerre's behalf and signed a consent form.

[50] On September 15, 2008, the geriatrics service saw Mr. DeGuerre and noted that he was looking much worse, and a very high mortality risk. Geriatrics left a written recommendation of "Palliation" on Mr. DeGuerre's chart.

Mr. DeGuerre's bilateral amputation surgery and ICU Admission on September 17, 2008

[51] Mr. DeGuerre's bilateral amputation surgery occurred on the evening of September 17. The surgery was delayed because: (i) it was necessary to reverse the effect of Mr. DeGuerre's anticoagulant medication before surgery (to reduce the risk of bleeding to death); (ii) on one occasion, Mr. DeGuerre had eaten prior to being advised that he would be having the surgery; and (iii) the availability of a monitored post-operative bed.

[52] Following the surgery, Mr. DeGuerre was admitted to the B5 ICU under the care of Dr. Sinuff, a critical care physician who was the attending physician in the ICU at that time. During this period of time, neither Dr. Livingstone nor Dr. Chapman was involved in Mr. DeGuerre's care. Although Mr. DeGuerre's gangrenous legs had been amputated, he still had remaining ulcers on his arms and trunk as a result of his peripheral vascular disease.

[53] On September 18, 2008, the plaintiff had a discussion with Dr. Bellini, a visiting fellow, in the ICU. Dr. Bellini approached the plaintiff and wanted to clarify the order of Dr.

Livingstone. The plaintiff told Dr. Bellini that she wanted her father to be full code. Dr. Bellini wrote an order stating that Mr. DeGuerre "is now full code". Dr. Bellini did not testify at trial.

[54] Mr. DeGuerre remained in the B5 ICU until he was transferred back to the internal medicine ward (C4). On September 19, Dr. Aoun (a junior resident member of the Blue Team), was asked to assess Mr. DeGuerre as the ICU physician had determined he was ready to be discharged. Dr. Aoun wrote a note, which included a notation that goals of care would be discussed with the family "as now patient made full code". Dr. Aoun had seen Dr. Bellini's note and order about code status but had not discussed this with the plaintiff herself. Mr. DeGuerre was not transferred back to C4 on that day because there was no bed available on that ward.

Mr. DeGuerre's admission back to Sunnybrook's internal medicine ward (C4) on September 20, 2008, post-surgery

[55] On September 20, Mr. DeGuerre received dialysis in accordance with his regular schedule. At approximately 7:00 p.m., Mr. DeGuerre was discharged from the ICU back to the internal medicine ward (C4).

[56] Dr. Gamez, a resident in internal medicine but not a member of the Blue Team, assessed Mr. DeGuerre to determine whether he was still appropriate for transfer and wrote the transfer orders. Upon Mr. DeGuerre's return to C4, Dr. Livingstone once again became his most responsible physician.

[57] Following her visit on September 20, the plaintiff wrote a series of messages to Mr. DeGuerre's clinical team, including concerns about pain management and her father's stumps.

[58] By September 20, 2008, Mr. DeGuerre's left stump was already appearing dusky, suggesting a lack of blood flow and tissue death despite the above-knee amputation.

[59] On September 21, 2008, Dr. Chapman first became involved in Mr. DeGuerre's care. Mr. DeGuerre was assessed by Katie Weaver, the nurse member of the Rapid Response Team, on the morning of September 21, 2008. The Rapid Response Team was assessing Mr. DeGuerre as part of a routine 24-hour follow-up because he had been discharged from the ICU the prior day. Ms. Weaver observed that Mr. DeGuerre appeared skinny and frail. Dr. Chapman would have seen Mr. DeGuerre as part of the list of patients the Rapid Response Team assessed that day and it was part of his standard practice to do a brief end-of-bed assessment of these patients. Nephrology assessed Mr. DeGuerre and determined there was no need for dialysis before the regularly scheduled session on Tuesday, September 23.

[60] The plaintiff arrived at the hospital at approximately 10:00 p.m. on September 21. The plaintiff asked the nurse a series of questions and, as a result, the nurse arranged for the resident on call, Dr. Aoun, to speak with the plaintiff.

[61] Dr. Aoun assessed Mr. DeGuerre at approximately 11:00 p.m. Mr. DeGuerre's white blood cell count was elevated. Nephrology suggested that Mr. DeGuerre undergo a blood culture test and a chest x-ray and that the broad-spectrum antibiotic Meropenem be prescribed. Dr. Aoun assessed Mr. DeGuerre and made a note in the Progress Notes section of the chart. By co-signing

suggestions from the nephrology service, Dr. Aoun ordered blood cultures which were taken early the following morning, a chest x-ray which was completed the following day, and an additional antibiotic. He also ordered chest physiotherapy, a swallowing assessment by a speech language pathologist, an assessment by the Acute Pain Service and overnight oxygen saturation monitoring. Dr. Aoun documented in Mr. DeGuerre's chart that the plaintiff wanted her father to be "full code".

[62] Blood culture results taken on September 16 were reported on September 21, 2008 as showing no growth after five days.

Tests and lab results on September 22, 2008

[63] At 12:39 p.m. on September 22, 2008, a chest x-ray was taken. The x-ray report was signed at 14:51 on September 22 by the same radiologist as the 07:00 x-ray. The x-ray indicated some improvement in the right pleural effusion since a previous x-ray taken on September 8. There was no finding of pneumonia in the report.

[64] Blood cultures were taken on the morning of September 22. The results became available on September 24, 2008. The only finding was that coagulase negative staphylococci was present. This is a common contaminant found in blood samples that results from contamination of the needle (or not completely cleaning the surrounding skin) when drawing blood.

[65] Blood tests drawn earlier in the day were reported at 15:46 p.m. and showed an elevated potassium level of 6.4. The lab called the floor with this result shortly before 4:00 p.m. Dr. Bryan (then Dr. Ahmed), the junior resident on call, was paged about the result. Dr. Bryan phoned Dr. Livingstone to inform him of the results and together they decided to order a repeat blood test and an electrocardiogram, administer kayaxelate (a medication used to treat high potassium levels) and contact the nephrology service to assess Mr. DeGuerre in the event that he needed early dialysis. Nephrology assessed Mr. DeGuerre between 5:45 and 6:15 a.m. and sent the dialysis team to Mr. DeGuerre's room in the event urgent dialysis was indicated.

Assessments of Mr. DeGuerre and the DNR Order on September 22, 2008

[66] Ms. Weaver assessed Mr. DeGuerre again in the morning of September 22 for the 48-hour follow-up visit. She felt his condition was worse from the day before - his lips were dusky, he was combative and confused, and he was "swatting" people to stay away from him. When she assessed him, Mr. DeGuerre did not want to be spoken to or touched and was generally unhappy and in discomfort. Ms. Weaver suctioned his secretions to try to improve his respiratory status and contacted Dr. Chapman to assess Mr. DeGuerre.

[67] Dr. Chapman assessed Mr. DeGuerre at approximately 11:00 a.m. He was struck by Mr. DeGuerre's physical appearance, and observed that he appeared cachectic and frail, although his vital signs were normal. When he conducted his assessment, Mr. DeGuerre was exhibiting delirium, drowsiness and agitation. Dr. Chapman formed the opinion that Mr. DeGuerre was in the final phase of his life and the time he had remaining seemed short. He felt that further aggressive therapy (e.g., CPR, ICU care) would almost certainly not provide any lasting benefit to Mr. DeGuerre's health, and only increases suffering. Dr. Chapman wrote a note in Mr.

DeGuerre's chart reflecting his assessment, and he was guided by the policy of the College of Physicians and Surgeons of Ontario on decision-making for the end of life.

[68] Dr. Livingstone also conducted an assessment of Mr. DeGuerre that day. He observed that Mr. DeGuerre looked dreadful, was not rouseable to voice, unable to clear his own secretions (unable to swallow or cough as a result of suppressions of his level of consciousness), and he was peripherally constricted (that is, the blood vessels in his arms were constricted in order to shunt blood to the core of his body to protect his vital organs). Dr. Livingstone observed that Mr. DeGuerre also had a dark blue left stump, which indicated to him that it was becoming gangrenous and would become increasingly gangrenous.

[69] Dr. Livingstone felt that Dr. Chapman's note was comprehensive and there was nothing else he could add, and he made a notation in the chart that he agreed with Dr. Chapman's assessment.

[70] In addition to consulting with Dr. Livingstone, Dr. Chapman also consulted Dr. Sinuff because she had overseen Mr. DeGuerre's care in the ICU. Dr. Sinuff agreed that Mr. DeGuerre would not benefit from CPR or intubation, as his death was imminent and his condition irreversible. Dr. Chapman referenced his discussions with both Dr. Livingstone and Dr. Sinuff in his note.

[71] All three physicians agreed that resuscitation should not be offered to Mr. DeGuerre and that this was the consensus of their medical opinion. Accordingly, Dr. Chapman noted that resuscitation would not be offered to Mr. DeGuerre in the event of an arrest.

[72] Dr. Chapman also wrote the DNR order on Mr. DeGuerre's chart, which Dr. Livingstone co-signed. The order reads:

> Do not attempt resuscitation in the event of cardiorespiratory arrest. No transfer to ICU.

[73] There was no emergency on September 22, 2008 when the DNR order was written.

[74] Immediately afterwards, Dr. Chapman called the plaintiff at home to inform her of the decision and the DNR order, but he was unable to reach her. He left the following voicemail message at 1:58 p.m. asking the plaintiff to contact Dr. Livingstone or the ward:

> This is a message for Joy. My name is Dr. Chapman from Sunnybrook Hospital. I work in the intensive care unit. I want to talk to you about your father. I wonder if you could contact the ward or contact Dr. Livingstone just to be updated on the situation. Nothing particularly has changed, but we just wanted to talk to you about a few things. Thank you very much.

[75] The plaintiff listened to the voicemail message. She had never met or heard of Dr. Chapman before. She did not detect a sense of urgency because Dr. Chapman's voice was quiet and calm. The plaintiff was reassured by the part of the message where Dr. Chapman said that nothing particularly had changed. The plaintiff did not know how to reach Dr. Chapman, who

had not left a number, and she did not have Dr. Livingstone's number. The plaintiff knew how to reach the ward, and she phoned the C4 ward and spoke with one of the nurses at 3:08 p.m. The nurse identified herself and said she had no idea what the message was about. The plaintiff did not ask to speak to Dr. Chapman or Dr. Livingstone. The plaintiff was planning on coming to the hospital to visit her father, so she got in her car and drove to the hospital.

Decline of Mr. DeGuerre's condition in the late afternoon of September 22

[76] In the late afternoon of September 22, Mr. DeGuerre's condition began to decline. His vital signs at 4:00 p.m. were still stable save for a drop in oxygen saturation on room air which quickly recovered once supplemental oxygen was given. Mr. DeGuerre was assessed by the geriatrics service at 4:20 p.m. During the assessment, he woke up and was afraid. He pulled off his shirt. He eventually fell back to sleep but continued to wake up in fear.

[77] The plaintiff arrived at the hospital in the late afternoon, between 4:30 and 5:00 p.m. When she arrived at her father's room, he was alone and in respiratory distress. The plaintiff took her father's vital signs. She inquired of the nurse. Dr. Bryan (then Dr. Ahmed), the resident on the ward, was called to assess Mr. DeGuerre. Dr. Bryan did not inform the plaintiff of the DNR order.

[78] At this time, the nurses attempted to suction Mr. DeGuerre. Although he was generally unresponsive, he became agitated during suctioning attempts and resisted suctioning. The plaintiff was concerned and asked for a doctor to be paged.

Mr. DeGuerre's death

[79] At approximately 6:00 p.m., Mr. DeGuerre's respiratory status declined precipitously. The plaintiff went to the nursing statement to page a respiratory therapist. Ryan Smith, a respiratory therapist on the Rapid Response Team, was paged and came quickly at approximately 6:10 p.m. An order for Haldol was written but the plaintiff refused to allow this to be administered.

[80] When Mr. Smith arrived, he was taken aback by Mr. DeGuerre's appearance – Mr. DeGuerre had sunken eyes and cheeks and Mr. Smith could see how emaciated he was. Mr. DeGuerre was very cyanotic, meaning he appeared pale or ashen and his skin was blue-purple. He also exhibited agonal respirations with gargling secretions. Mr. DeGuerre still had a gag reflex, which meant that he could not be intubated without sedation.

[81] After Mr. Smith arrived the plaintiff heard her father say, "I'm drowning, I'm drowning". She asked Mr. Smith to help her father. The healthcare team members who were present did not hear Mr. DeGuerre say anything. Mr. DeGuerre was in distress and having difficulty breathing.

[82] Mr. Smith assisted the nurses with suctioning and breathing support using an ambu bag. The plaintiff heard a nurse say quietly to Mr. Smith that her father was DNR. The plaintiff became very upset and disputed that her father's code status was DNR. She explained that she was her father's attorney for personal care and substitute decision-maker, and that his resuscitation status was full code.

[83] Mr. Smith asked for Dr. Chapman to be paged. Dr. Chapman was paged at 18:22 p.m. and arrived at Mr. DeGuerre's bedside within minutes.

[84] Dr. Chapman explained to the plaintiff that resuscitation would almost certainly be of no benefit and would only cause suffering. Dr. Chapman told Mr. Smith that he did not have to provide resuscitation and he stopped. The plaintiff estimated that Mr. Smith was providing Mr. DeGuerre with breathing support for at least 5 to 10 minutes before Dr. Chapman arrived. Mr. Smith recalls switching from an ambu bag to a non-rebreather mask after Dr. Chapman arrived.

[85] The plaintiff was very upset, and she argued with Dr. Chapman and told him that they did not have consent to withdraw treatment. The plaintiff tried to use the ambu bag herself and, while doing so, she grabbed the phone and tried to call 911. She then tried to reach a hospital administrator. Dr. Chapman said that no one would come. The plaintiff continued to try to support her father's breathing until his head went forward, and she knew that was when he died.

[86] The plaintiff asked Dr. Chapman and Mr. Smith to leave her father's room. The plaintiff was angry and shouting. The plaintiff remained alone with her father for some time, then gathered a few of her father's belongings and left the hospital without speaking with anyone.

[87] The plaintiff discovered that her father's resuscitation code status had been changed when she reviewed her father's chart the following day after being asked to come to the hospital to sign a consent to an autopsy.

Agreement regarding the conduct of the trial

[88] The parties entered into an agreement with respect to certain matters regarding the conduct of the trial. They agreed:

(a) The defendants will not argue that liability should be apportioned to Sunnybrook Hospital or any of its employees, or any other party not named as a defendant in the action.

(b) Neither Dr. Chapman nor Dr. Livingstone is vicariously liable for any alleged breach in the standard of care by Sunnybrook Hospital or any of its employees or any other physician.

(c) The parties' experts will confine their opinion evidence to the standard of care exercised by the defendants in the timeframe from Dr. Chapman's assessment of Mr. DeGuerre on September 22, 2008 through to Mr. DeGuerre's death, and the damages caused by any breach thereof.

(d) With these exceptions, the parties do not intend to limit, restrict or prejudice the ability of any party to lead evidence or make argument at trial on any relevant issues or facts.

PART III - ANALYSIS

[89] The plaintiff claims:

(a) Damages pursuant to the *FLA* in compensation for the loss of guidance, care and companionship that the plaintiff might reasonably have expected to receive from Mr. DeGuerre if his death had not occurred by the fault or neglect of the defendants in breach of duties owed to Mr. DeGuerre.

(b) Damages for severe and lasting mental injuries caused by breaches of a duty of care and fiduciary duty owed by the defendants to Mr. DeGuerre.

(c) Damages for severe and lasting mental injuries caused by breaches of the duty of care and the fiduciary duty owed by the defendants directly to the plaintiff.

[90] The parties settled the quantum of these damages before trial. The issues of liability remain to be decided.

[91] In her Amended Fresh as Amended Statement of Claim, the plaintiff also pleads that the defendants are liable for abuse of power and intentional infliction of mental anguish. The plaintiff did not pursue these causes of action at trial.

[92] The defendants accept that they owed a duty of care to Mr. DeGuerre. In respect of the plaintiff's *FLA* claim, a derivative claim, the following issues are raised:

(a) Did the defendants fail to meet the required standard of care and thereby breach a duty of care owed to Mr. DeGuerre?

(b) Did Mr. DeGuerre die by the defendants' fault or neglect?

[93] In respect of the plaintiff's indirect claim for damages caused by alleged breaches of a duty of care or fiduciary duty owed to her father, the following issues are raised:

(a) Did the defendants fail to meet the required standard of care and thereby breach the duty of care owed to Mr. DeGuerre? Did they breach their fiduciary duty owed to him?

(b) Is the plaintiff entitled to recover damages caused by a breach of the duty of care or fiduciary duty owed to her father?

(c) Did the plaintiff suffer damage that was caused by a breach or breaches by the defendants of the duty of care or fiduciary duty owed to the plaintiff's father?

[94] In respect of the plaintiff's direct claim for damages caused by alleged breaches of a duty of care owed by the defendants to the plaintiff, the following issues are raised:

(a) Did the defendants owe a duty of care to the plaintiff?

(b) Did the defendants fail to meet the required standard of care and thereby breach the duty of care? Did they breach their fiduciary duty?

(c) Did the plaintiff suffer damage that was caused by a breach or breaches by the defendants of the duty of care or fiduciary duty owed to the plaintiff?

(d) Is the plaintiff entitled to damages for her injuries that are compensable at law?

[95] In respect of the plaintiff's direct claim for damages caused by alleged breaches of a fiduciary duty owed to her, I must decide whether the defendants owed such a duty and, if so, whether it was breached and whether the plaintiff is entitled to recover damages as a result.

[96] When I use the term "DNR order" in my reasons, I refer to the order made by Dr. Chapman and Dr. Livingstone on September 22, 2008 in which they ordered that further aggressive therapy, e.g., CPR and intensive care unit ("ICU") care, will not be offered as a therapeutic option, and that resuscitation was not to be attempted in the event of cardiac arrest. When I refer to the defendants' decision not to offer CPR as a therapeutic or treatment option, I include their decision not to offer a transfer to the ICU. When I use the words "offer" or "propose" in respect of a treatment, I use these words interchangeably.

A. The Plaintiff's *FLA* Claim

[97] The plaintiff claims damages under the *FLA* for her pecuniary loss resulting from the death of her father who, she alleges, died by the defendants' fault or neglect in circumstances where he would have been entitled to recover damages if he had not died. The plaintiff claims an amount to compensate her for the loss of guidance, care and companionship that she might reasonably have expected to receive from her father if he had not died. This is a derivative claim.

[98] The plaintiff claims that her father's death was caused by the defendants' negligence. The plaintiff's *FLA* claim raises several questions:

(a) Did the defendants fail to meet the applicable standard of care in their assessments of Mr. DeGuerre on September 22, 2008? Specifically, did they fail to meet the applicable standard of care by failing to diagnose him as suffering from the treatable and reversible condition of sepsis due to pneumonia, with the result that the defendants deprived Mr. DeGuerre of the opportunity to recover?

(b) Did the defendants fail to meet the applicable standard of care through non-compliance with the *HCCA* by failing to obtain the plaintiff's informed consent as Mr. DeGuerre's substitute decision-maker before administering a "treatment" (as defined in the *HCCA*), including by deciding not to offer CPR to Mr. DeGuerre as a treatment option and writing the DNR order, and by changing Mr. DeGuerre's plan of treatment which included cardiopulmonary resuscitation ("CPR") as a treatment option?

(c) At common law, did the defendants fail to meet the applicable standard of care on September 22, 2008 by deciding not to offer CPR to Mr. DeGuerre as a treatment option?

(d) Did Mr. DeGuerre die by the defendants' fault or neglect?

[99] I address each of these questions in turn.

a. Did the defendants fail to meet the applicable standard of care in their assessments of Mr. DeGuerre on September 22, 2008?

[100] The defendants, as physicians, owed a duty of care to Mr. DeGuerre, their patient.

[101] To meet the standard of care owed to a patient, a physician must exercise the degree of skill and care expected of a normal, prudent physician of comparable training and experience in the same circumstances: *Wilson v. Swanson*, [1956] S.C.R. 804 at p. 10. An error of judgment will not constitute negligence unless that error also amounts to a failure to meet the standard of care: *Wilson* at p. 6.

[102] The question of whether the defendants failed to properly examine and assess Mr. DeGuerre on September 22, 2008 is an important part of the medical context in which the defendants' decision not to offer CPR was made. This is so because it bears on the criteria for decision-making at the end of life as set out in the College of Physicians and Surgeons of Ontario policy and the Sunnybrook policies which were then in place (as they relate to three categories of benefit to the patient from CPR described in these policies), policies which informed the standard of care and applied to the defendants in relation to their care of Mr. DeGuerre on September 22, 2008.

<u>Policies of the Ontario College of Physicians and Surgeons and Sunnybrook Hospital on September 22, 2008</u>

[103] The OCPS had a published policy statement in place on September 22, 2008 with respect to decision-making for the end of life (the "CPSO policy"). Each of Dr. Livingstone and Dr. Chapman was aware of the CPSO policy in September 2008, and each testified that this policy guided his practice and informed his understanding of the standard of care.

[104] The CPSO policy states that its purpose is to "assist physicians in providing medically and ethically appropriate care to patients at the end of life; specifically, care that aims to reduce suffering, respect the wishes and needs of patients and their families, and lessens conflict and distress". The CPSO policy states that the requirements of informed consent at the end of life are the same as the requirements in other situations, and it references a separate policy for Consent to Medical Treatment. The CPSO Consent to Medical Treatment policy that was in effect on September 22, 2008 states that the duties set out in the policy are codified in the *HCCA*, and that physicians are encouraged to consult with the *HCCA* in order to familiarize themselves with all the legislative provisions.

[105] The CPSO policy states that physicians should advocate for meaningful and/or realistic goals of care and, where appropriate for the patient or substitute decision-maker, this will involve an early discussion of diagnoses and prognosis, and of the potential benefits, burdens, and risks associated with various therapies and with the refusal of therapy. The CPSO policy states that physicians should strive to ensure that there is communication with patients or substitute decision-makers when treatment can no longer prevent death and help them to reassess and revise priorities.

[106] The CPSO policy outlines three categories of potential benefit to end-of-life care which are described as criteria which should be used to guide decision-making for the end of life:

(a) Patient is likely to benefit: There is a reasonable likelihood that CPR and other life-support will restore and/or maintain organ function. The likelihood of the person's returning to his or her pre-arrest and life-support condition is at least moderate.

(b) Benefit to patient is unlikely or uncertain: It is unlikely that or uncertain whether CPR and other life-support will restore organ function. The subsequent prognosis is poor or uncertain and the likelihood of adverse consequences is high.

(c) Patient almost certainly will not benefit: There is almost certainly no chance that the person will benefit from CPR and other life-support, either because the underlying illness or disease makes recovery or improvement virtually unprecedented, or because the person will be unable to experience any permanent benefit.

[107] The CPSO policy states that patients have the right to receive life-sustaining treatments that may be a benefit to them and that take into account their goals, values and beliefs. According to the CPSO policy, when it is not clear whether treatment might be a benefit, the choice should be made on the side of providing life-sustaining treatment. The CPSO policy states that when it is clear from available evidence that treatment will almost certainly not be a benefit or may be harmful to the patient, the physician should refrain from beginning or maintaining such treatment. It provides that a decision not to initiate CPR or other life-sustaining treatments does not necessarily mean that any other treatment or intervention should be withheld or withdrawn. Palliative care should continue to be provided. The CPSO policy states that physician should recognize that decisions concerning resuscitation and other life-sustaining treatments might change over time, and these decisions should be reassessed whenever it is appropriate to do so; in particular, when the condition of the patient changes and when the patient or substitute decision-maker indicates that he or she has changed the decision about such treatment.

[108] The CPSO policy states that physicians are not obliged to provide treatments that will almost certainly not be of benefit to the patient.

[109] The conflict resolution measures in the CPSO policy are stated to apply where it becomes evident in the course of making decisions for end-of-life that there is disagreement over appropriate treatment between patients or substitute decision-makers and healthcare providers.

The CPSO policy statement refers to the *HCCA* as a statute which provides a structure for managing conflicts about treatment decisions for incapable patients that cannot be resolved in other ways. Physicians are told that they should be aware of the relevant legislative processes.

[110] The CPSO policy statement addresses the circumstance where consensus is not achieved:

> If the patient or substitute decision-maker, or family if there is consent, insists on a course of treatment that the physician feels will not be of benefit to the patient, the physician may offer to transfer care of the patient to another facility or care provider who is willing to provide that treatment. This option should be considered only after alternative methods of conflict resolution have been exhausted. In following such a course, the physician must comply with the College's policy on Ending the Position-Patient Relationship.

[111] Sunnybrook Hospital had two relevant policy statements in place on September 22, 2008 which were put into evidence.

[112] The first is entitled "Decision-making and Conflict Resolution Regarding Futility in the Use of Life Support" (the "Sunnybrook life support policy"). This policy states that it is Sunnybrook's policy to respect life and human dignity by providing care to patients that is medically and ethically appropriate. This policy includes a statement that acknowledges that when a patient or substitute decision-maker of an incapable patient requests that life-support be initiated or continued, healthcare providers involved sometimes consider this request to be unjustifiable because of the patient's medical status. The Sunnybrook life-support policy states that in deciding whether life-support including admission to an intensive care unit is consistent with Sunnybrook's basic commitment to care that respects human dignity, considerations will be given to the wishes of patients or their substitute decision makers, the standard of medical care, and existing laws and guidelines. This policy states that while there is no clearly established framework for this situation, there are clearly established ethical and legal principles in Ontario for situations where patients or their substitute decision makers decline treatment proposed by healthcare providers, and it states that in this situation, principles in the *HCCA* supersede this policy. The Sunnybrook life-support policy states that the *HCCA* covers all the elements of consent to health services and treatment provided in all settings by health practitioners specified in the *HCCA*.

[113] The Sunnybrook life-support policy, like the CPSO policy, describes three levels of benefit from life-support treatment:

(a) Likely to Benefit: There is a good chance that life-support and accompanying therapies will restore and/or maintain acute organ function. The likelihood of the person's being discharged from an acute care hospital is high.

(b) Benefit is Uncertain: It is unknown or uncertain whether life-support and accompanying therapies will restore functioning. The subsequent prognosis or the likelihood of adverse consequences is also unknown or uncertain.

(c) Almost Certainly Will Not Benefit: There is almost certainly no chance that the person will benefit from life-support, either because the underlying illness or disease makes recovery or improvement virtually unprecedented, or because the person will be permanently unable to experience any benefit.

[114] The Sunnybrook life-support policy contains a section which includes principles for appropriate use of life-support. These principles state that people who are likely to benefit from life-support and people for whom benefit is uncertain should normally be made aware life-support will be instituted if the need arises, if they have no objection. The Sunnybrook life-support policy states that people who almost certainly will not benefit from life-support are not candidates for life-support, and life-support should not be proposed. In general, the decision not to propose life-support should be discussed with the patient or their substitute decision-maker. The Sunnybrook life-support policy includes a section that describes a process for addressing conflict and, in this section, the policy states that it is recognized that the patient's condition may not permit completion of this process.

[115] The second relevant Sunnybrook policy which was introduced into evidence is entitled "No Cardiopulmonary Resuscitation (No CPR)" (the "Sunnybrook No CPR policy") which was maintained in Sunnybrook's Patient Care Policy Manual. The Sunnybrook No CPR policy states that a standing order exists to initiate CPR in case of cardiac or respiratory arrest and that a specific instruction is necessary if CPR is not to be initiated. The Sunnybrook No CPR policy states that a "No CPR" order precludes the otherwise automatic initiation of CPR and when a No CPR order is written, nursing staff must ensure that it is placed as the first page in the patient's hospital file. The Sunnybrook No CPR policy expressly refers to the *HCCA* which, it states, establishes the right of people in Ontario to make informed decisions about health treatment. The policy states that the *HCCA* covers all elements of consent to health services and treatment provided in all settings by the health practitioner specified in the *HCCA*.

[116] The Sunnybrook "No CPR" policy states that interventions anticipated to be futile or non-beneficial lie outside the standard of care and that healthcare providers are not obliged to propose or provide futile or non-beneficial interventions. In such cases, this Sunnybrook policy recommends that a "No CPR" order be written on the patient's order sheet and that the patient and/or substitute decision-maker be informed, and their perspectives documented. This policy states that patients for whom CPR will almost certainly not be beneficial should not have CPR presented as a treatment option.

[117] The plaintiff called Dr. Sangita Sharma to give expert opinion evidence. Dr. Sharma is an emergency physician at St. Joseph's Hospital in Hamilton. She graduated from medical school in 2000 and has been practising in the field of emergency medicine since 2005. Dr. Sharma was qualified to give opinion evidence with respect to (1) the standard of care in making DNR orders in 2008; (2) the role of critical care physicians in assessing hospital patients requiring or potentially requiring critical care and as conduits to intensive care; and (3) critical illnesses and their reversibility.

[118] Dr. Sharma testified that the CPSO policy in respect of decision-making at the end of life which was in effect in 2008 applied to all doctors in Ontario and that she followed these

guidelines in her practice. Dr. Sharma testified that the Sunnybrook policy about how to make decisions about resuscitation at end-of-life corresponds with the CPSO policy. Dr. Sharma testified that the three levels of benefit in the Sunnybrook life-support policy correspond with the three categories of benefit in the CPSO policy. Dr. Sharma testified that the CPSO policy on decision-making for the end of life which was in place on September 22, 2008 speaks to the circumstances in which it is appropriate for a physician to make a DNR order. Dr. Sharma testified that the statements in the Sunnybrook policy about dispute resolution are in line with the conflict resolution processes in the CPSO policy.

[119] The defendants called Dr. Scott Anderson to give expert opinion evidence. Dr. Anderson is a critical care and emergency medicine physician practising at London Health Sciences Centre in London, Ontario. He completed his residency in emergency medicine in 1996 and his fellowship program in critical care medicine in 1997. Since 2000, he has been an attending and admitting physician at the Critical Care Trauma Centre at the University of Western Ontario's School of Medicine, a multidisciplinary 26-bed intensive care unit. He has been the site chief of this intensive care unit since 2014. By September 2008, Dr. Anderson had been an attending physician for 12 years with extensive experience working in intensive care units in dealing with patients at the end of their life. Dr. Anderson was qualified to give expert opinion evidence with respect to the standard of care applicable in 2008 and causation regarding resuscitation as it relates to Mr. DeGuerre.

[120] Dr. Anderson also testified that the CPSO policy reflected the standard of care applicable to physicians in Ontario in September 2008.

[121] Dr. Sharma and Dr. Anderson each agreed that when Dr. Livingston and Dr. Chapman were considering CPR as a treatment, they were required to exercise their clinical judgment and decide which category or level of benefit applied to Mr. DeGuerre under the CPSO and Sunnybrook policies when he was under their care.

[122] I accept this evidence and find that the CPSO policy and the Sunnybrook policies which are to similar effect informed the standard of care which applied to the defendants on September 22, 2008. These policies include the need for compliance with the *HCCA*, and I accept that compliance with the *HCCA* was required by the standard of care which applied on September 22, 2008.

<u>Clinical judgments made by Dr. Chapman and Dr. Livingstone on September 22, 2008 with respect to likely benefit to Mr. DeGuerre from CPR</u>

[123] Dr. Chapman and Dr. Livingstone testified that they followed the CPSO policy and the Sunnybrook policies when, following their assessments of Mr. DeGuerre on September 22, 2008, they exercised their clinical judgments and decided that Mr. DeGuerre was near death and would almost certainly not benefit from CPR and that administration of CPR would only cause him harm.

[124] Dr. Chapman assessed Mr. DeGuerre at approximately 11:00 a.m. He was struck by Mr. DeGuerre's physical appearance, noting that he appeared cachectic and frail, although his vital

signs were normal. When he conducted his physical assessment, Mr. DeGuerre was exhibiting delirium, drowsiness and agitation. Dr. Chapman formed the opinion that Mr. DeGuerre was in the final phase of his life and the time that he had remaining seemed short. Dr. Chapman thought Mr. DeGuerre's death was imminent, not in the next few hours, but in days, not months or years. Dr. Chapman thought Mr. DeGuerre's largest threat to life was respiratory compromise, as this is a common pathway at the end of a person's life.

[125] Dr. Chapman explained that CPR is a package of interventions including cardiac massage or chest compression, intubation, mechanical ventilation, and aggressive drug therapy. ICU care would be invasive intervention for organ support, mostly involving mechanical ventilation, which was only available in the level 3 ICU at Sunnybrook.

[126] Dr. Chapman wrote a note on September 22, 2008 that "[f]urther aggressive therapy eg. CPR, ICU care, would almost certainly not provide any lasting benefit to his health, only increased suffering". Dr. Chapman explained that the "increased suffering" to which he referred in his note was suffering which would follow from CPR. He explained that the administration of CPR is very physical, and the consequences would be fractures of ribs and the sternum and dislocation of rib cartilages. The suffering would be amplified because Mr. DeGuerre was on anti-coagulating medication (so that the fractures bleed more). The effects would be worse for patients like Mr. DeGuerre who was on dialysis, because their bones are more fragile. Dr. Chapman explained that airway injuries are common from being intubated and ventilated, as is intra-abdominal trauma from the chest compressions.

[127] Dr. Chapman concluded that Mr. DeGuerre was in the "almost certainly would not benefit" category in the CPSO policy because he was at the end of his life and there are limits to what modern health care can provide. Dr. Chapman's clinical judgment was that Mr. DeGuerre had a terminal condition and further aggressive therapy including CPR would almost certainly not provide any lasting benefit to Mr. DeGuerre's health, and only increase his suffering.

[128] Dr. Livingstone also performed an assessment of Mr. DeGuerre that day. Dr. Livingstone testified that Mr. DeGuerre looked "dreadful" and did not rouse to voice. He was unable to clear his secretions and he was peripherally constricted (that is, the blood vessels in his arms were restricted in order to shunt blood to the core of his body to protect his vital organs). He also had a dark blue left stump, which indicated that it was already dying due to lack of blood supply despite his recent surgery. Dr. Livingstone testified that Dr. Chapman's description of Mr. DeGuerre's condition in his note written on September 22, 2008 was an accurate description and coincided with what he had also observed. Dr. Livingstone felt that Dr. Chapman's note was comprehensive and there was nothing else he could add. He made a notation in the chart that he agreed with Dr. Chapman's assessment.

[129] Dr. Livingstone testified that he thought that the probability of Mr. DeGuerre's death was close to absolute. He explained that CPR is associated with an extensive list of potential injuries, with a high risk of rib fractures and breast bone fractures. Dr. Livingstone testified that Mr. DeGuerre's bones were particularly fragile and that he thought there was virtually a one hundred per cent chance that Mr. DeGuerre would have fractures to his ribs and breast bone, with a high probability of bleeding. There was a significant risk of damage to his airways because of the

insertion of tubes into his trachea, and this risk was higher for Mr. DeGuerre because he was on two anti-coagulant medications. Mr. DeGuerre was at significant risk of injury to the internal organs, notable the liver and the spleen. If there was injury to Mr. DeGuerre's ribs from CPR, there would potentially be a need for blood transfusions and potentially a protracted period of managing blood loss into the belly and a series of cascading events that would follow. Dr. Livingstone testified that he did not think any of these interventions would provide benefit to Mr. DeGuerre because the probability of his death was close to absolute, and the probability of very significant injury from interventions causing pain in his final moments was virtually one hundred per cent.

[130] Dr. Tasnim Sinuff also testified about her involvement in the decision that was made on September 22 not to offer resuscitation to Mr. DeGuerre. Dr. Sinuff is a scientist at Sunnybrook's Research Institute. She has a staff position at Sunnybrook in the department of critical care medicine and respirology, and she is a professor in the interdepartmental division of critical care and respirology at the University of Toronto. Dr. Sinuff was qualified as a participant expert in critical care and respirology to provide evidence concerning the opinion which she reached on September 22, 2018 regarding whether resuscitation would have almost certainly not provided a benefit if attempted on Mr. DeGuerre on that day. Dr. Sinuff testified that she formed the opinion on September 22, 2008 that resuscitation in the form of CPR and ventilation would not have provided any benefit to Mr. DeGuerre if administered on that day. Her opinion was based upon the fact that Mr. DeGuerre had a number of underlying comorbidities that contributed to his trajectory, which was inevitable death.

[131] Dr. Chapman testified that on the late afternoon of September 22 when he entered Mr. DeGuerre's room it was an emergency situation. He testified that Mr. DeGuerre was actively dying. Dr. Chapman testified that Mr. DeGuerre was cyanotic (had a bluish discolouration of the skin), did not have a radial pulse, and only had agonal breath. Dr. Chapman testified that he still felt that subjecting Mr. DeGuerre to what he described as "a very physical, brutal, injurious procedure" would not help him but would only increase his suffering at the end of his life.

[132] Ryan Smith was the respiratory therapist member of the Rapid Response Team on September 22, 2008 who was paged to Mr. DeGuerre's bedside that afternoon. Mr. Smith has been a registered respiratory therapist since 2004. By September 2008, he estimated that he had assisted with approximately 400 "code blue" situations. Mr. Smith was qualified as a participant expert in respiratory therapy to provide an opinion on what would have happened to Mr. DeGuerre if resuscitation had been attempted on the evening of September 22, 2008.

[133] Mr. Smith testified that if a decision had been made to resuscitate Mr. DeGuerre, intubation and ventilation would not been adequate - chest compressions would also have been required. He stated that it would have been very likely that he would have had to start chest compressions because in order to place a breathing tube for mechanical ventilation, he would have had to administer sedation drugs which would cause Mr. DeGuerre to lose his pulse. He described the likely consequence of administration of CPR on an elderly person such as Mr. DeGuerre as including ribs cracking and breaking from the sternum and pulmonary hemorrhage involving bleeding from the person's lungs into his or her airways, typically within 10 to 15 compressions or sometimes 20 to 25 compressions.

[134] Dr. Sharma testified that it was not within the standard of care for the defendants to place a DNR order on Mr. DeGuerre's chart on September 22. She explained that the reasons for her opinion are primarily centred on the issue of consent and the fact that a treatment plan had been offered to Mr. DeGuerre which included full resuscitation, with all of its associated risks, which had been accepted. Dr. Sharma testified that changing this plan required consent, and that the DNR order was a significant change which required consent. She explained this opinion by reference to the three categories of benefit that, according to the CPSO policy, should be used to guide decision-making at the end of life.

[135] Dr. Sharma's testified that she believes that Mr. DeGuerre fell into one of the first two categories of likely benefit in the CPSO policy: that the patient is likely to benefit, or that benefit is unlikely or uncertain. This evidence was given in the context of her opinion that Mr. DeGuerre's respiratory arrest on September 22, 2008 was secondary to a reversible cause, sepsis induced by pneumonia, and that it was possible that he could have survived for an indefinite period of time had appropriate steps been taken earlier in the course of his sepsis and again later in the course of his sepsis. Dr. Sharma did not express an opinion with respect to which category she believes would have applied to Mr. DeGuerre if he was not suffering from a reversible illness, pneumonia.

[136] Dr. Anderson explained the process that the standard of care in 2008 required when a physician was called upon to decide which of the categories from the CPSO policy a patient fell into. He explained that a physician would have to assess the patient, which would involve assessing the patient's medical condition and illness trajectory. Using that information, a physician was required to exercise his or her clinical judgment, experience and training to assess whether the patient was likely to benefit from resuscitation. This evidence was not challenged by Dr. Sharma, and I accept Dr. Anderson's evidence with respect to the process that should be followed for physicians to decide which category of benefit applies to a patient under the CPSO policy in respect of decision-making for the end-of-life.

[137] Dr. Anderson testified that, in his opinion, as at September 22, 2008, Mr. DeGuerre's death was imminent. Dr. Anderson's opinion was that on that day, performing resuscitation in the event of an arrest would almost certainly not have benefited Mr. DeGuerre. He testified that Mr. DeGuerre was in grave condition and his heart could not mount the metabolic requirements or do the work that was required to sustain him, given all of his medical conditions. As a result, his heart was under increasing strain. According to Dr. Anderson, resuscitation would have put further stress on his heart. Dr. Anderson testified that as at September 22, 2008, Mr. DeGuerre would have been in the third category set out in the CPSO policy - resuscitation would almost certainly not have benefited him. Dr. Anderson described an additional category, where the physician believes that resuscitation would provide no benefit but would also certainly harm the patient. He testified that Mr. DeGuerre fit into that category as well.

[138] Dr. Anderson testified that, in his opinion, performing resuscitation on September 22 in the event of an arrest would have caused Mr. DeGuerre to suffer and that there was a 100% chance of resuscitation inflicting harm on Mr. DeGuerre in this case. This was consistent with the evidence given by the defendants. Dr. Anderson explained that resuscitation is always a painful and difficult experience for a patient, especially one who is elderly and, perhaps,

cachectic. He explained that in this situation, CPR would almost certainly break the patient's ribs and sternum, which might also injure the patient's internal organs. The Heparin medication which Mr. DeGuerre was on would compound his internal injuries by causing more internal hemorrhaging.

[139] In order to determine whether Dr. Chapman and Dr. Livingstone failed to meet the required standard of care when they formed their clinical judgments on September 22, 2008 that Mr. DeGuerre would almost certainly not benefit from CPR, I address whether they failed to meet the applicable standard of care by failing to diagnose that Mr. DeGuerre was suffering from a treatable and reversible illness on September 22, 2008, sepsis induced by pneumonia, from which he could have recovered had CPR been administered.

Did the defendants fail to diagnose that Mr. DeGuerre was suffering from sepsis or pneumonia on September 22, 2008?

[140] Dr. Sharma testified that she agreed that Mr. DeGuerre's overall health was poor, however, given that Mr. DeGuerre had a significant amount of time that he was pre-arrest, followed by a respiratory arrest secondary to a reversible cause, that is, pneumonia, it is possible that Mr. DeGuerre could have survived for an indefinite period of time had appropriate steps been taken earlier in the course of his sepsis and again later in the course of his sepsis. Dr. Sharma testified that temporary hemodynamic and respiratory support could have been provided to aid his condition until his pneumonia was treated. This specific support was not provided due to the change in Mr. DeGuerre's code status by Dr. Chapman and Dr. Livingstone. Dr. Sharma confirmed that her opinion in this respect applied on September 22, 2008.

[141] Dr. Sharma did not provide an opinion with respect to whether the defendants failed to meet the applicable standard of care by not diagnosing sepsis and/or pneumonia or by failing to adequately treat those conditions.

[142] Dr. Sharma had reviewed the medical records of Mr. DeGuerre and expressed her professional opinions based upon these records and other documents. Dr. Sharma formed an impression based upon the notes in Mr. DeGuerre's chart, including (i) notes showing increases in his white blood cell count from September 19 to 22, (ii) notes recording congestion, wheezing, and gurgling sounds, and (iii) recommendations from the nephrology service that Mr. DeGuerre's antibiotic medication be changed, that Mr. DeGuerre was suffering from pneumonia on September 22, 2008 which was not adequately treated and that Mr. DeGuerre suffered from sepsis as a result. Dr. Sharma addressed in her evidence three factors upon which her conclusion that Mr. DeGuerre was septic was based: a change in his mental status; his respiratory status (requiring increased oxygen); and an elevated white blood cell count.

[143] Dr. Sharma referred to the policy at Sunnybrook Hospital that administration of CPR was the default treatment that was to be provided unless there was a physician's order to the contrary. She noted that the plaintiff had given a direction, which Dr. Sharma agreed was "consent", to administration of CPR on a "full code" basis. Dr. Sharma noted that Dr. Bellini had made an order which was a reiteration of the default treatment of CPR. Dr. Sharma was shown Dr. Chapman's note on September 22 in which he states that the largest threat to Mr. DeGuerre's life

is respiratory compromise, and she considered this to be a fair assessment. Dr. Sharma agreed that respiratory compromise was an active issue on September 21 and 22.

[144] Dr. Sharma's opinion that Mr. DeGuerre was suffering from sepsis and pneumonia on September 22, 2008 was very significantly undermined on cross-examination.

[145] With respect to sepsis, Dr. Sharma was presented a chapter on severe sepsis and septic shock from a textbook for internal medicine, *Harrison's Principles of Internal Medicine, 17th Edition*, that was current as at September 2008, and she agreed that she would have used it during her residency rotation in internal medicine and that it was authoritative. Dr. Sharma agreed that in order to be diagnosed with sepsis, a patient must have both "systemic inflammatory response syndrome" ("SIRS") and a suspected or proven infection. Dr. Sharma agreed that there is a degree of clinical judgment involved in deciding whether a patient is septic or not. Dr. Sharma agreed that there is no consensus on the definition of sepsis, and that in 2008 a diagnosis of sepsis would involve the application of clinical judgment. Dr. Sharma agreed that the best person to diagnose sepsis would be a physician with direct interactions with the patient over a longitudinal period of time.

[146] With respect to Mr. DeGuerre's mental status, Dr. Sharma agreed that to be diagnosed with sepsis, the change in a patient's mental status must have been an acute change. Dr. Sharma agreed that Mr. DeGuerre's confusion was not new on September 18, and she agreed that he had become increasingly confused while at K-Wing and that, because he had just had major surgery on September 17, it would not be uncommon for a patient in these circumstances to experience some drowsiness. Dr. Sharma also failed to refer in her evidence in chief to a note from September 19 describing Mr. DeGuerre's condition which stated "agitated/confused not new", although she did reference in her report a note from that day that indicated that Mr. DeGuerre "was refusing all medications and that he was confused". However, the note states that Mr. DeGuerre was "refusing all meds"; it does not state that he was confused. Dr. Sharma agreed that this statement in her report was incorrect.

[147] With respect to Mr. DeGuerre's respiratory status, Dr. Sharma testified that Mr. DeGuerre's oxygen saturations had decreased on September 18. This was based on progress notes from September 18 in which the oxygen saturation remained the same (although oxygen delivery changed from 2 L to 3 L). Dr. Sharma agreed that this was a mistake in her report. Dr. Sharma did not mention in her report that on September 21 Mr. DeGuerre's respiratory status had improved (as he was able to maintain his oxygen saturation at 96% and 97% on room air). Dr. Sharma agreed that this had been an improvement from the prior day.

[148] With respect to Mr. DeGuerre's white blood cell count, Dr. Sharma had referred in her report to a note from an orthopedic resident stating that Mr. DeGuerre's white blood cell count was up from the previous day. However, in the same note, the resident noted that Mr. DeGuerre was stable, with stable vital signs. There is also another note from the nephrology service from that day stating that Mr. DeGuerre was stable. Dr. Sharma agreed that she did not refer to either of these notes in her report and focused only on the note stating that Mr. DeGuerre's white blood cell count was elevated. Dr. Sharma failed to include any information from September 20 in her report, although she agreed that it would have been important to consider his status on that day.

The notes from that day described Mr. DeGuerre as stable and comfortable, and noted that his white blood cell count had actually decreased. Mr. DeGuerre was also able to maintain his oxygen saturation within the same range on room air on September 20.

[149] In her evidence in chief, Dr. Sharma failed to refer to Mr. DeGuerre's blood culture test results, which were relevant to determination as to whether he was septic. The notes document that Mr. DeGuerre's blood culture samples taken on September 16 had come back negative. Dr. Sharma stated that the infectious process that she was explaining was the pulmonary infection that occurred later on. However, Dr. Sharma also did not refer to the blood cultures that were taken on September 22, although she agreed those would have been relevant. Those blood culture test results were also negative for infection.

[150] Dr. Sharma testified that Mr. DeGuerre was "febrile" (showing signs of a fever) throughout his admission at Sunnybrook, relying upon her interpretation of a note from the infectious diseases service. It was put to Dr. Sharma that, in fact, the note reads that he was "afebrile" (without a fever) throughout his hospital stay. Dr. Sharma acknowledged that she had read this note as "febrile". She agreed that she had failed to reference in her report other notes that read "still afebrile" and "afebrile [over the weekend]". Dr. Sharma agreed that she had written in her report that the infectious disease service had noted that Mr. DeGuerre had been "febrile" throughout the duration of his hospital admission "despite the above knee amputation for source control of infection". She agreed that even if Mr. DeGuerre had been febrile on this day, this would not have been unexpected because the amputation had just taken place. The suggestion in Dr. Sharma's report that such an observation would have been unexpected and would support a diagnosis of post-surgery infection from another source causing a fever, was shown to be incorrect.

[151] When it was put to Dr. Sharma that there was only one reference throughout Mr. DeGuerre's entire admission at Sunnybrook to an elevated temperature (of 39.2°C on September 13), Dr. Sharma testified that the fever was treated with acetaminophen. However, when she was presented with the medications administration record for that day, she agreed that all doses of acetaminophen were refused, and the fever resolved without any medication. Dr. Sharma finally agreed that Mr. DeGuerre did not have a fever at any point in time during his hospital stay, before or after September 13, 2008, other than on this one occasion.

[152] Dr. Sharma agreed that according to the definition of SIRS in the Harrison's text, Mr. DeGuerre did not meet the requirements to be diagnosed with sepsis on September 22, 2008 when he was assessed by Dr. Chapman.

[153] With respect to her opinion that Mr. DeGuerre was suffering from pneumonia on September 22, Dr. Sharma agreed on cross-examination that if pneumonia is suspected but not certain, the appropriate next step would be to order a chest x-ray and that, generally, a chest x-ray is the most important test in diagnosing pneumonia. Dr. Sharma agreed that a radiologist would have additional training and experience in interpreting chest x-rays in comparison with an emergency room physician, and that internal medicine and critical care physicians would have significant experience diagnosing hospital acquired pneumonia, as well as reviewing chest x-rays themselves.

[154] Dr. Sharma did not mention in her report that a chest x-ray was completed on September 22, 2008 and that it did not show signs of pneumonia.

[155] The defendants tendered evidence from Dr. Scott Anderson. Dr. Anderson testified that, in his opinion, neither Dr. Livingstone nor Dr. Chapman fell below the standard of care in not diagnosing pneumonia or sepsis on September 22.

[156] Dr. Anderson defined sepsis as a condition that is often life-threatening in which an infection causes dysregulation in the body's response to infection. He testified that sepsis is caused by an infection that can be either bacterial, viral or fungal but that 95% of the time it is caused by a bacterial infection. Dr. Anderson defined septic shock as the hemodynamic effects of sepsis, that is, when sepsis progresses to the point where it may cause, for example, very low blood pressure that may be life-threatening.

[157] Dr. Anderson testified that, in his opinion, Mr. DeGuerre did not have sepsis between September 18 and September 22, 2008. He testified that his conclusion was based upon Mr. DeGuerre's entire illness trajectory, in addition to clinical markers, hemodynamic markers and the results of lab investigations. Dr. Anderson emphasized that to make a diagnosis, it is important to look at a constellation of parameters and that one cannot consider one parameter in isolation to reach a conclusion. Dr. Anderson noted that throughout the majority of his stay, Mr. DeGuerre's blood pressure remained within normal parameters. He testified that although Mr. DeGuerre did on occasion have an elevated respiratory rate, making a decision based on one reading in isolation can lead to an erroneous conclusion and that it is necessary to look at the whole picture. He testified that Mr. DeGuerre had a history of COPD, which can affect respiratory rate, and that some patients have a higher baseline respiratory rate than that of a normal, healthy person.

[158] Dr. Anderson noted that Mr. DeGuerre's oxygen saturations fluctuated throughout his admission but were generally good throughout his stay. Dr. Anderson noted that Mr. DeGuerre's heart rate was also within normal limits on September 22. Dr. Anderson was asked about the recorded heart rate of 131 in the physiotherapy service's note on September 22. He testified that this was not significant to him because Mr. DeGuerre was receiving physiotherapy at the time, which may have included high frequency vibration therapy or manual percussions to mobilize secretions which would have been perceived as painful or aggressive to a patient who was confused.

[159] Dr. Anderson testified that temperature can be an indicator of sepsis, but Mr. DeGuerre's temperature during his admission did not indicate that he had sepsis. Notably, on September 22, Mr. DeGuerre did not have a fever at any time. When he was referred to Mr. DeGuerre's vital signs as recorded in the note Dr. Chapman wrote in his chart at the time of his assessment on the morning of September 22, Dr. Anderson testified that these vital signs were not concerning and did not indicate that Mr. DeGuerre had pneumonia or sepsis.

[160] Dr. Anderson explained that an elevated white blood cell count is a non-specific marker and that 90% of the time, it has nothing to do with an infection. He testified that Mr. DeGuerre had an elevated white blood cell count throughout his entire admission with very little to no

evidence of infection at any point. Dr. Anderson testified that he believed that the elevated white blood cell count was more a reflection of the stress on Mr. DeGuerre's body in the post-operative period, as stress is a cause of an elevated white blood cell count.

[161] Dr. Anderson testified about the blood cultures drawn on September 16 and September 22. He testified that with serious infections, bacteria might grow sooner than five days, however any bacterial growth within 1 to 5 days is significant. Dr. Anderson explained that the September 16 and the September 22 results were both negative. In the September 22 results, the only organism identified was coagulase - negative staphylococci (which is a common contaminant when taking blood samples). Dr. Anderson testified that his clinical interpretation of those blood culture results was that they were negative. A negative result means that there was not a bacterial infection in the blood at the time. Dr. Anderson explained that a negative result is not an exclusive test for ruling out infection, but that it is further corroboration that Mr. DeGuerre was not suffering from an infection at the time the blood was drawn. Dr. Anderson explained that if a patient is on an antibiotic when a negative blood culture result is obtained, this means either that the patient is not infected or that the patient is infected, but the antibiotic is the correct one and the organism has been eradicated.

[162] Dr. Anderson defined pneumonia as an infection of the lung, caused by bacterial, and sometimes viral, and rarely fungal infection. Dr. Anderson testified that pneumonia is not an uncommon disease and it is something that he diagnoses in his practice daily. Dr. Anderson testified that when looking at the constellation of information, Mr. DeGuerre did not have pneumonia on September 22. Dr. Anderson explained that the x-ray results from September 22 did not indicate that Mr. DeGuerre had pneumonia. The results indicated that Mr. DeGuerre's pleural effusion had improved since his last x-ray on September 8. Dr. Anderson explained that pleural effusion is a collection of fluid between the lung and the chest wall, which was a chronic condition for Mr. DeGuerre, and did not represent an infection. The x-ray report noted that the size and shape of the cardio pericardial silhouette was unchanged, and Dr. Anderson testified that this result would be expected given Mr. DeGuerre's comorbidities.

[163] Dr. Anderson explained that if a patient had pneumonia, a radiologist would report "infiltrates" (or areas in the lung that are not air) and that significant infiltrates would suggest pneumonia. Dr. Anderson explained that although it is common for patients to have infiltrates on an x-ray report but no infection, the absence of infiltrates indicates that the patient does not have pneumonia. Dr. Anderson explained that if there were enough infiltrates to cause pneumonia that would typically be picked up by a chest x-ray. He explained that pneumonia is the first thing a radiologist would look for when reviewing the chest x-ray of a hospitalized patient. Dr. Anderson confirmed that the radiologist's report did not indicate pneumonia.

[164] Dr. Anderson testified that observations of upper airway secretions and gurgling were not indications that Mr. DeGuerre had pneumonia. Dr. Anderson explained that secretions in the upper airways have nothing to do with the lower lungs or lower airways. Dr. Anderson testified that the observations of Mr. DeGuerre from the morning of September 22 of "gurgling, secretions and sounds 'wet'" were not an indication that Mr. DeGuerre had pneumonia, and that this description could be attributed to Mr. DeGuerre's confusion, agitation and his inability to clear or spit up secretions.

[165] Dr. Anderson's evidence with respect to whether Mr. DeGuerre had sepsis or pneumonia on September 22 was not successfully challenged on cross-examination. He was clearly very experienced and knowledgeable with respect to what is needed in order to make a diagnosis of sepsis or pneumonia. Dr. Anderson thoroughly reviewed the medical records and explained how they supported his opinion that Mr. DeGuerre was not suffering from sepsis or pneumonia on September 22.

[166] On the other hand, Dr. Sharma's opinion given in her evidence in chief did not withstand cross-examination. She acknowledged on cross-examination that she made a number of errors in her report and in her testimony in chief, which I have described above. I have noted a number of occasions where Dr. Sharma did not refer to medical records which did not support her opinion. Dr. Sharma did not satisfactorily explain why she did not refer to these records. Dr. Sharma resiled significantly on cross-examination from her opinion that Mr. DeGuerre had pneumonia or sepsis on September 22, 2008 and the preceding days. I do not accept Dr. Sharma's opinion that Mr. DeGuerre was suffering from sepsis or pneumonia on September 2, 2008. I accept Dr. Anderson's evidence and find that Mr. DeGuerre did not have pneumonia or sepsis on September 22, 2008.

[167] Although the plaintiff pleads that her father had treatable sepsis and pneumonia on September 22, 2008, counsel for the plaintiff did not submit in his closing submissions that I needed to find that Mr. DeGuerre was suffering from sepsis or pneumonia on September 22. He submitted that this question might be a "red herring", and that the true question is whether it was unreasonable for the plaintiff to have expected that her father's condition was untreatable and that efforts to treat him would be of no benefit. Counsel submitted that from the plaintiff's perspective that day, pneumonia was a reasonable possibility, even though the defendants may have had superior information, and she had no reason on September 22 to believe that his condition was not reversible.

[168] I do not regard the question of whether Mr. DeGuerre had sepsis or pneumonia on September 22, 2008 to be a "red herring". The plaintiff's pleading put this fact squarely in issue in this action. There was a considerable amount of evidence directed to this question. If the plaintiff had successfully proven the facts that were pleaded, that Mr. DeGuerre was suffering from an undiagnosed, treatable, illness on September 22, sepsis or pneumonia, from which he may have recovered if resuscitation had been administered, this would have materially affected whether the defendants breached their duties of care to Mr. DeGuerre that day.

[169] I find that the plaintiff has failed to prove that Mr. DeGuerre had sepsis or pneumonia on September 22, 2008 or the several preceding days.

[170] I find that each of Dr. Chapman and Dr. Livingstone followed proper procedures when they conducted their examinations of Mr. DeGuerre on September 22, 2008. Their professional assessment that Mr. DeGuerre's death was imminent and that the administration of CPR would almost certainly not benefit Mr. DeGuerre and only cause harm is amply supported by the evidence.

[171] The defendants did not fail to meet the required standard of care on September 22, 2008 by failing to properly examine and assess Mr. DeGuerre.

b. Did the defendants fail to meet the applicable standard of care through non-compliance with the HCCA?

[172] The plaintiff's primary submission with respect to the defendants' alleged failure to satisfy the required standard of care is based upon inclusion in the standard of care of the requirement for compliance with the *HCCA*.

[173] Section 10(1)(b) of the *HCCA* provides that 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 he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent, or 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 the *HCCA*.

[174] The plaintiff submits that the defendants failed to comply with s. 10(1)(b) of the *HCCA* when they failed to seek and obtain the plaintiff's consent (as Mr. DeGuerre's substitute decision-maker) before they decided to change Mr. DeGuerre's full code status and no longer offer resuscitation and a transfer to the ICU to Mr. DeGuerre, and when they wrote the DNR order and acted on this order. The plaintiff submits that the defendants thereby failed to meet the required standard of care.

[175] In response, the defendants submit that the decision with respect to whether a medical intervention will be offered to a patient is governed by the standard of care and that the requirement of consent under the *HCCA* does not arise in cases where a physician has decided in the exercise of his or her clinical judgment not to offer a given medical intervention. The defendants submit that, therefore, before even considering whether consent is required for a medical intervention, the court must determine whether the standard of care required the intervention to be offered.

[176] In support of her submission that the defendants contravened s. 10 of the *HCCA* and thereby failed to meet the required standard of care, the plaintiff relies upon the decision of the Supreme Court of Canada in *Rasouli (Litigation Guardian of) v. Sunnybrook Health Sciences Centre*, 2013 SCC 53. In *Rasouli*, the Supreme Court of Canada addressed whether the proposed withdrawal of life support to Mr. Rasouli, an incapable patient, is a "treatment" under the *HCCA* which could not be administered by physicians without the consent of the patient's wife, his substitute decision-maker. The majority of the Supreme Court of Canada made it clear that their decision does not stand for the proposition that consent is required under the *HCCA* for withdrawals of medical services other than life support services or in other medical contexts: *Rasouli* at para. 70.

[177] The analysis by the Supreme Court of Canada, including the interpretation of provisions of the *HCCA* which bear upon the meaning of the term "treatment" in the context of the statute as a whole, informs my analysis of whether the defendants proposed and administered a

"treatment" under the *HCCA* on September 22, 2008 when they decided not to offer CPR and wrote the DNR order and when they acted on this decision and order, including when Dr. Chapman refused to administer CPR at Mr. DeGuerre's bedside.

[178] On September 22, 2008, the standard of care with which the defendants were required to satisfy in relation to the care of Mr. DeGuerre included compliance with the *HCCA*. The question is whether the defendants were required by the *HCCA* to obtain the plaintiff's consent as her father's substitute decision-maker before making the decision not to offer CPR as a treatment option and writing the DNR order, and before Dr. Chapman decided not to administer CPR to Mr. DeGuerre at his bedside on September 22.

Statutory framework under the *HCCA*

[179] The *HCCA* provides a framework for resolving the difficult issues surrounding treatment of patients who lack capacity by giving effect to the patient's autonomy interest insofar as possible: *Rasouli* at para. 23. If this autonomy is compromised by lack of capacity, the *HCCA* seeks to balance it against considerations related to the best interests of the patient, as well as providing for resolution of disputes by specialized tribunals instead of the courts.

[180] Whether the *HCCA* required the defendants to obtain the plaintiff's consent (as Mr. DeGuerre's substitute decision-maker) before making the DNR order is, like the question in *Rasouli*, a matter of statutory interpretation. I will follow the approach to statutory interpretation that was expressed by the Supreme Court of Canada in *Rasouli*:

> 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": R. Sullivan, *Sullivan on the Construction of Statutes* (5th ed. 2008), at p. 1. Every statute "shall be given such fair, large and liberal interpretation as best ensures the attainment of its objects": *Legislation Act, 2006*, S.O. 2006, C. 21, Sch. F, s. 64(1).

[181] Section 1 of the *HCCA* sets out its purposes:

> 1. The purposes of this Act are,
>
> (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 well capable and after attaining 16 years of age, be adhered to; and

(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 her treatment, admission to a care facility or a personal assistant 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.

[182] Section 2(1) provides that in the *HCCA*:

"treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include,

[(a)-(f) and (h) are not applicable]

(g) a treatment that in the circumstances poses little or no risk of harm to the person,

[183] Section 10(1) of the *HCCA* provides:

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.

[184] Section 10 of the *HCCA* requires a physician to obtain consent to the administration of a treatment. The requirement for consent applies to a physician who "proposes a treatment". The question of consent under the *HCCA* does not arise unless a treatment is proposed. Where a treatment is proposed, s. 10 of the *HCCA* provides that a health practitioner "shall not administer the treatment and shall take reasonable steps to ensure that it is not administered", unless consent has been given (subject to emergencies which are addressed in ss. 25-28 of the *HCCA*). The absence of consent operates to prohibit the physician from administering a treatment regardless of the medical benefit to the patient: *Rasouli* at para. 25.

[185] The plaintiff submits that on September 22, 2008, Dr. Livingstone and Dr. Chapman were required by the *HCCA* to obtain the plaintiff's consent before changing Mr. DeGuerre's plan of treatment and withholding CPR as a treatment option, writing the DNR order, placing it on Mr. DeGuerre's chart, and refusing to administer CPR to Mr. DeGuerre. The plaintiff makes four arguments in support of this submission:

(i) First, the plaintiff contends that when the defendants wrote the DNR order, placed it on Mr. DeGuerre's chart, and when Dr. Chapman refused to administer CPR at Mr. DeGuerre's bedside (where the plaintiff had consented to administration of CPR to Mr. DeGuerre by directing that he be "full code") they did things for a preventive or other health-related purpose which qualified as a "treatment" under the HCCA. The plaintiff submits that this treatment was proposed and administered without the plaintiff's consent, contrary to the HCCA, and the defendants thereby failed to meet the required standard of care.

(ii) Second, the plaintiff contends that administration of CPR on a "full code" basis was included in Mr. DeGuerre's "plan of treatment", to which the plaintiff had consented, and that the HCCA required the plaintiff's consent to a change to this plan of treatment. The plaintiff submits that by deciding not to offer CPR and writing the DNR order, the defendants changed Mr. DeGuerre's plan of treatment without her consent in contravention of the HCCA, and thereby failed to meet the required standard of care.

(iii) Third, the plaintiff relies upon the practice of the Consent and Capacity Board (the "Board") to reinforce the submission that the defendants' actions on September 22, 2008 in deciding not to offer CPR, writing the DNR order, and Dr. Chapman's decision not to administer CPR at Mr. DeGuerre's bedside were the administration of "treatment" under the HCCA which required the plaintiff's consent.

(iv) Fourth, the plaintiff submits that the CPSO policy and the Sunnybrook policies with respect to decision making at the end of life, including with respect to CPR, reinforce the requirement of consent to the placement of a DNR order.

[186] I address each of these arguments in turn.

(i) Did the defendants do anything for a preventive or other health-related purpose according to the definition of "treatment" in the *HCCA*, without consent, when they wrote the DNR order, placed it on Mr. DeGuerre's chart, and when Dr. Chapman decided not to administer CPR at Mr. DeGuerre's bedside?

[187] In the *HCCA*, subject to certain specified exclusions, "treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan. The terms "course of treatment", "plan of treatment" and "community treatment plan" are defined terms in the *HCCA*.

[188] Whether the defendants' making of the DNR order and Dr. Chapman's decision not to administer CPR to Mr. DeGuerre constituted a "treatment" under the *HCCA* must be determined by answering two questions. First, whether the DNR order and Dr. Chapman's decision were done for a "preventive ... or other health-related purpose" under the *HCCA*. Second, whether the DNR order and Dr. Chapman's decision constituted "anything that is done" for a health-related purpose within the definition of "treatment" in the *HCCA*.

[189] With respect to the first question, in *Rasouli*, McLachlin C.J.C., writing for the majority, held that the term "health-related purpose" is a legal term used in the *HCCA* to set limits on when actions taken by health practitioners will require consent under the statute and "only acts undertaken for a health-related purpose" constitute treatment, and therefore require consent. McLachlin C.J.C. held that "treatment" was intended to have a very broad meaning and, given the breadth of the definition of this term in the *HCCA*, withdrawal or discontinuance of a given treatment clearly may be something done for a therapeutic, preventive, palliative, or other health-related purpose": *Rasouli* at paras. 37, 47-49.

[190] Dr. Livingstone and Dr. Chapman testified that the DNR order was made following their assessments of Mr. DeGuerre on September 22 and that it was based upon their clinical judgment that CPR would almost certainly not benefit Mr. DeGuerre and would only cause harm. They testified that Mr. DeGuerre would certainly suffer from the administration of resuscitative measures, including through painful fractures of bones, bleeding, hemorrhaging, and injuries to his internal organs. I am satisfied that the decision taken by Dr. Livingstone and Dr. Chapman not to offer of CPR and to make the DNR order, and Dr. Chapman's decision not to offer CPR as a treatment option for Mr. DeGuerre at his bedside, were not only for health related purposes generally but, particularly, for a preventive purpose.

[191] The second question requires a more nuanced analysis, one that takes into account the need to balance the sometimes competing values of patient autonomy and providing a meaningful role for family members in respect of treatments and of ensuring appropriate care for incapable patients: See *Rasouli* at para. 51.

[192] The plaintiff submits that although the "treatment" which she contends was proposed and administered - the defendants' acts of writing of the DNR order, placing it on Mr. DeGuerre's

chart, and Dr. Chapman's refusal to administer CPR at Mr. DeGuerre's bedside - did not require interventions which involved physical interference with Mr. DeGuerre's body, they were things that were "done for a ... health-related purpose" within the meaning of "treatment" in the *HCCA*, and the plaintiff's consent as her father's substitute decision-maker was required to the administration of this treatment.

[193] In *Rasouli*, McLachlin C.J.C., writing for the majority, confirmed that the concept of health-related purpose in the *HCCA* "does not interfere with a physician's professional assessment of whether a procedure offers a medical benefit", and its only function is to determine when the actions of health practitioners require patient consent. McLachlin C.J.C. described the term "medical benefit" to be a clinical term used by physicians to determine whether a given procedure should be offered to a patient. McLachlin C.J.C. noted that this clinical term has legal implications for the physician's standard of care, and that if a treatment would be of medical benefit to the patient in this sense, the physician may be required to offer that treatment in order to comply with his standard of care. McLachlin C.J.C. held that whether a given treatment offers a medical benefit requires a contextual assessment of the patient's circumstances, including the patient's condition and prognosis, the expected result of treatment for that patient, and any risks of treatment for that patient. McLachlin C.J.C. explained that the concept of "health-related purpose", by contrast, is a legal term used in the *HCCA* to set limits on when actions taken by health practitioners will require consent under the statute. The *HCCA* does not limit "health-related purpose" to what the physician considers to medically benefit the patient. See *Rasouli* at paras. 36-37.

[194] These passages from *Rasouli* are directly relevant to whether the DNR order and Dr. Chapman's decision at Mr. DeGuerre's bedside not to offer CPR as a treatment option qualify as a "treatment" which was proposed and administered to Mr. DeGuerre without the consent required by the *HCCA*. This is so because McLachlin C.J.C. held that the clinical term "medical benefit" has implications for the physician's standard of care, and she accepted that a physician may be required to offer a treatment to comply with the standard of care if the treatment would be of medical benefit to the patient. It follows that a physician is not always required to offer a treatment, and whether a physician is required to offer a treatment depends on the physician's professional assessment of whether the treatment offers a medical benefit. Whether a treatment offers a medical benefit requires a contextual assessment of the patient's circumstances, including the patient's condition and prognosis, the expected result of treatment for that patient, and any risks of treatment for that patient.

[195] In *Rasouli*, the physicians argued that the *HCCA* distinguishes between administering a particular type of care, which is "treatment" requiring consent, and removing that care, which is not "treatment" and does not require consent. Consequently, the physicians argued, withdrawal of Mr. Rasouli's life support did not require the consent of his substitute decision-maker. McLachlin C.J.C. concluded at para. 45 that this argument cannot succeed, "essentially because withdrawal of life support involves - indeed may be viewed as consisting of - a series of acts that serve health-related purposes, and because the critical interests at stake where withdrawal of life support is concerned go to the heart of the purposes of the *HCCA*": *Rasouli* at para. 45.

[196] The defendants submit that if a physician's medical decision not to offer a treatment and his or her acts to record and enforce this decision qualify as "treatment" requiring consent, this would shift from the physician to the patient the right to decide whether a treatment is or is not medically appropriate. The defendants use the opioid crisis as an example. They submit that a physician may rely on his or her clinical judgment to reach a conclusion that narcotics are not appropriate for a given patient, even if that patient has been prescribed the same medication in the past and, in that case, the physician could not be compelled to prescribe the narcotic medication even if the patient requested it, because to do so would be medically inappropriate and constitute a failure to meet the applicable standard of care.

[197] On cross-examination, Dr. Sharma was asked hypothetical questions in relation to prescribing narcotic medications that addressed whether a patient or substitute decision maker could compel a physician to offer medications that the physician considered to be medically inappropriate. Dr. Sharma agreed that prescribing narcotic medications is a treatment for which (in a non-emergency setting) informed consent is required. Dr. Sharma agreed that in an outpatient setting, she would explain the benefits and the risks of the opioid medication treatment with the patient and obtain consent to the administration of this treatment if it was offered. She testified that she would not prescribe narcotics to a patient, even one to whom they had been prescribed in the past, if she felt that this treatment was medically inappropriate. Dr. Sharma agreed that a patient cannot compel a physician to prescribe narcotic medications simply because another physician had done so in the past. Dr. Sharma agreed that if she believed that prescribing the medication would almost certainly not provide a benefit, and would cause harm, she would not offer the medication, even if directed to do so by her patient.

[198] The physicians in *Rasouli* made a similar argument which was addressed by McLachlin C.J.C. as it related to withdrawal of life support, at paras. 58-60:

> The second argument against regarding treatment as including withdrawal of life support is that it could lead to deeply undesirable results. If consent is required for withdrawal of life support, patients could arguably compel the continuation of any treatment, regardless of its medical implications. The legislature cannot have intended this. Common sense suggests that many withdrawals of treatment - for example, refusal to renew a prescription for a drug that may harm a patient - must be excluded from the definition of "treatment" under the Act.
>
> The difficulty with this argument is that it treats everything that can be termed a withdrawal of treatment - from refusal to refill a prescription to ending life-support - as equivalent for purposes of consent under the *HCCA*. A more nuanced view that withdrawal of treatment may sometimes, although not always, constitute "treatment", better fits the provisions of the *HCCA* and the realities of medical care.
>
> At a minimum, if the processes involved in withdrawal of care are health-related, they do not cease to be treatment merely because one labels them cumulatively as "withdrawal of treatment". This applies to withdrawal of life support, as described in this case. The reality is that in Mr. Rasouli's situation, the distinction between

> "treatment" and "withdrawal of treatment" is impossible to maintain. The withdrawal consists of a number of medical interventions, most if not all done for health-related purposes. Viewed globally, a series of distinct acts may be viewed as "withdrawal" of treatment. But viewed individually, each act may be seen as having a health-related purpose, and hence constitute "treatment" requiring consent.

In *Rasouli*, the court focused on the reality of the situation, and examined the "processes" involved in the withdrawal of care for Mr. Rasouli. McLachlin C.J.C. noted at para. 62-63 that many of the processes involved in withdrawal of life support entailed physical interference with the patient's body and, under the *HCCA*, as at common law, physical interference requires consent.

[199] In Mr. DeGuerre's situation on September 22, 2008, in contrast, the processes involved in the defendants' decision not to offer of CPR and make the DNR order were those that Dr. Chapman and Dr. Livingstone followed in the course of making a clinical assessment of the likely benefit of CPR to Mr. DeGuerre. Dr. Chapman and Dr. Livingstone drew upon their education, training, and years of experience and concluded that Mr. DeGuerre would almost certainly not benefit from CPR and, if CPR were attempted, it would be harmful. These processes were those identified by McLachlin C.J.C. in *Rasouli* at para. 36 as necessary for a physician to decide whether a given treatment offers a medical benefit: a contextual assessment of the Mr. DeGuerre's circumstances including his condition and prognosis, and the risks of the treatment for him. None of these processes involved medical interventions or physical interference with Mr. DeGuerre's body, as they did in *Rasouli*. The relevant processes did not involve "anything that is done" or, as these words were paraphrased in *Rasouli*, "acts undertaken", for a health-related purpose – they involved the physicians' professional assessment of whether CPR would or would not be of medical benefit to Mr. DeGuerre.

[200] After they made the medical decision that Mr. DeGuerre's death was imminent and that CPR would almost certainly not benefit him and would only cause him harm, the defendants took steps to record and enforce their medical decision. These steps involved writing the DNR order (to preclude the otherwise automatic initiation of CPR according to Sunnybrook's policy) and, in Dr. Chapman's case, deciding not to offer CPR at Mr. DeGuerre's bedside that evening. These steps are not "anything that is done" for a health related purpose within the meaning of "treatment" in the *HCCA*. They were processes followed by Dr. Chapman and Dr. Livingstone to comply with the applicable standard of care by deciding whether administration of CPR to Mr. DeGuerre on September 22, 2008 would be medically inappropriate and whether a medical decision should be made not be offer CPR to Mr. DeGuerre as a treatment option.

(ii) <u>On September 22, 2008, were the defendants required to obtain the plaintiff's consent before deciding not to offer CPR as a treatment option because CPR had previously been offered as part of a "plan of treatment" for Mr. DeGuerre under the *HCCA* to which the plaintiff had consented?</u>

[201] The plaintiff's second argument is that administration of CPR on a "full code" basis was included in Mr. DeGuerre's "plan of treatment", to which the plaintiff had consented, and in

order for the defendants to modify Mr. DeGuerre's "plan of treatment" they required the plaintiff's consent. The plaintiff relies upon s. 2 (1) of the *HCCA* which provides that "treatment" includes a "plan of treatment".

[202] The meaning of "plan of treatment" is found in Section 2(1) of the *HCCA*:

> "plan of treatment" means a plan that,
>
> (a) is developed by one or more health practitioners,
>
> (b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and
>
> (c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition;"

[203] The plaintiff submits that Mr. DeGuerre's "plan of treatment" bound his treatment team, including the defendants, and, if resuscitation was no longer considered appropriate and the plaintiff refused to consent to a DNR order, the only legal recourse available to the defendants was an application to the Consent and Capacity Board pursuant to s. 37 of the *HCCA*.

[204] Dr. Livingstone assessed Mr. DeGuerre on September 10, 2008 but, as I have noted, his progress notes from this assessment and his telephone conversation with the plaintiff that day were misplaced. I accept that Dr. Livingstone, as Mr. DeGuerre's most responsible physician, likely would have recorded that Mr. DeGuerre was to receive various treatments including regular dialysis, medications for pain, other medications, and visits from other hospital services. The hospital had a standing order to initiate CPR in case of cardiac or respiratory arrest which was in effect on September 10. The plaintiff, as Mr. DeGuerre's substitute decision-maker, had consented to these treatments to deal with Mr. DeGuerre's health problems, including the standing order to initiate CPR in case of cardiac or pulmonary arrest, through her instruction that Mr. DeGuerre was to be "full code".

[205] Although the consent was modified on September 12, 2008 before Mr. DeGuerre went for surgery (at least in respect of his care during surgery), Dr. Bellini made an order for CPR on September 18, 2008 that Mr. DeGuerre is now "full code" following a discussion with the plaintiff. This instruction was the plaintiff's consent on her father's behalf to Sunnybrook's standing offer to initiate CPR on a "full code" basis. As at September 18, following Dr. Bellini's order, there was a standing offer to initiate CPR, a treatment under the *HCCA*, to which the plaintiff had consented on her father's behalf, on a "full code" basis.

[206] In the absence of Dr. Livingstone's notes of his assessment of Mr. DeGuerre on September 10 and his telephone discussion with the plaintiff, it is difficult to decide with confidence whether there was a "plan of treatment" that was developed and in place for Mr. DeGuerre from that day forward. This is particularly so given that, as McLachlin C.J.C. observed

in *Rasouli* at para. 56, it is difficult to know what the legislature meant by "plan of treatment". On the evidence in this case and giving the term "plan of treatment" a broad interpretation, I accept that there was a plan of treatment for Mr. DeGuerre on the morning of September 22, 2008 (before Dr. Chapman and Dr. Livingstone decided that CPR would not be offered) that included a proposal for administration of CPR to which the plaintiff had consented on behalf of her father by asking for "full code".

[207] The plaintiff submits that the Supreme Court of Canada determined in *Rasouli* that under the *HCCA* doctors require consent in order to withhold or withdraw a treatment provided for in a "plan of treatment" and, therefore, the defendants required the plaintiff's consent to the withholding or withdrawal of CPR from Mr. DeGuerre's plan of treatment.

[208] In *Rasouli*, the patient did not have a plan of treatment. McLachlin C.J.C. addressed at paras. 56-57 the physicians' textual argument that by including withdrawal of treatment in "plan of treatment" in the *HCCA*, the legislature indicated that it did not intend withdrawal of treatment to be treatment requiring consent, unless the withdrawal is part of a plan of treatment:

> However, it is difficult to draw inferences of legislative intent on point from these provisions. As pointed out by the courts below, measures must be "treatment" to be included within a "plan of treatment", making the necessary process of inference circular. Moreover, it is unclear what the legislature meant by "plan of treatment". A plan of treatment entails obtaining consent to all elements of the plan: s. 13. But the *HCCA* does not clarify whether a plan of treatment is fixed and must be fully specified in advance, or whether it permits flexible alteration in response to changes in the patient's situation - an understanding that might extend to a case such as this. Whatever the correct response to these questions, the point is simply that it is not clear that the legislature intended only withdrawals of treatment that are part of a "plan of treatment" to be "treatment" under the *HCCA*.
>
> Moreover, common sense suggests that the legislature cannot have intended withdrawal of life support to require consent only in the context of a plan of treatment. This would place the issue of consent at the sole discretion of physicians. A plan of treatment is simply a way in which physicians may choose to group and present various treatments to the patient for the purpose of obtaining consent. Allowing physicians to unilaterally determine whether consent is required in any given case cuts against patient autonomy and the statutory objective of providing consent rules that apply consistently in all settings: s. 1(a).

[209] The plaintiff submits that in these passages McLachlin C.J.C. rejected the argument that withdrawal of treatment is not "treatment", and the Supreme Court of Canada was unanimous in determining that doctors require consent in order to withdraw a "treatment" provided for in a "plan of treatment". The plaintiff submits that the same reasoning applies to "withholding" of a treatment provided for in a plan of treatment. I disagree with this characterization of the *Rasouli* decision.

[210] McLachlin C.J.C. rejected the argument that by expressly including withdrawal of treatment in "plan of treatment" the legislature indicated that it did not intend withdrawal of treatment to be treatment requiring consent, unless the withdrawal is part of a plan of treatment. McLachlin C.J.C. held that withdrawal of treatment may sometimes, although not always, constitute "treatment" and that in the situation at issue in *Rasouli*, where the withdrawal involved a number of medical interventions including those involving physical interference with the patient's body, "treatment" under the *HCCA* extended to withdrawal of life support for Mr. Rasouli. See *Rasouli* at paras. 55-63 and 68-70.

[211] In *Rasouli*, because patient did not have a plan of treatment, it was not necessary for the Court to decide whether a plan of treatment which was proposed for a person and to which consent was given could be changed, without the person's or his or her substitute decision-maker's consent, to remove provision for the administration of a treatment included in the plan of treatment because a physician decided that, given the person's then current health condition, administration of this treatment would not benefit the person and would be medically inappropriate: *Rasouli* at para. 56. This question, which was not decided in *Rasouli*, arises in this action.

[212] The plaintiff relies upon ss. 13 and 14 of the *HCCA* in support of her submission that Mr. DeGuerre's "plan of treatment" bound his treatment team, including Dr. Chapman and Dr. Livingstone, and in order for them to modify this "plan of treatment", the plaintiff's consent was required, or the defendants were required to make an application to the Board under s. 37 of the *HCCA*. Section 13 of the *HCCA* provides that one health practitioner may, on behalf of all the practitioners involved in the plan of treatment, propose the plan of treatment, determine the person's capacity with respect to the treatments referred to in the plan of treatment, and obtain a consent or refusal of consent concerning the treatments in accordance with the *HCCA*. Section 14 provides that a consent that has been given by or on behalf of the person for whom the treatment was proposed may be withdrawn at any time.

[213] A plan of treatment is developed by one or more health practitioners, not the patient. There is no requirement in the *HCCA* for a person to have a plan of treatment and, if there is one, there is no requirement that the person's consent (or, if incapable, the person's substitute decision-maker's consent) must be obtained to the inclusion or exclusion of a treatment from the plan of treatment that is proposed for the person. Consent or refusal of consent is required under s. 13 concerning the treatments included in the plan of treatment.

[214] Section 13 of the *HCCA* provides flexibility to health practitioners involved in a plan of treatment (which may involve various treatments overseen and administered by health practitioners in several specialities of health care) by allowing one health practitioner to propose the plan of treatment and obtain consent concerning various treatments on behalf of all practitioners involved in the plan. However, s. 13 does not provide, as the plaintiff contends, that a health practitioner who is involved in a patient's plan of treatment is bound in all circumstances to continue to offer and to administer treatments in a plan of treatment where consent was obtained, or that a health practitioner must obtain the consent of the patient or substitute decision-maker in order to change the plan of treatment to remove provision for the administration of a treatment. Indeed, as McLachlin C.J.C. observed in *Rasouli*, the *HCCA* does

not clarify whether a plan of treatment is fixed and must be fully specified in advance, or whether it permits flexible alteration in response to changes in the patient's situation.

[215] The plaintiff submits that the requirement for consent to the withdrawal of a treatment included in a plan of treatment is reinforced by s. 29(3) of the *HCCA* which provides:

> 29(3) If a treatment is withheld or withdrawn in accordance with a plan of treatment and with a consent to the plan of treatment that a health practitioner believes, on reasonable grounds and in good faith, to be sufficient for the purpose of this Act, the health practitioner is not liable for withholding or withdrawing the treatment.

[216] The plaintiff contends that because this provision expressly protects physicians from liability where a treatment for an incapable person is withheld in accordance with a plan of treatment to which consent was given by the substitute decision-maker, it follows that a treatment which is part of a plan of treatment can only be withheld with the consent of the substitute decision-maker. I disagree that the plaintiff's conclusion follows from this premise.

[217] Section 29(3) provides that a physician is protected from liability where a plan of treatment to which consent was given (which the physician believes on reasonable grounds and in good faith to be sufficient) provides for withholding or withdrawal of treatment, and the physician withholds or withdraws the treatment. Section 29(3) does not provide that a treatment which is included in a plan of treatment to which consent was given must continue to be offered and administered unless the substitute decision-maker withdraws his or her consent.

[218] A "plan of treatment", according to the definition in the *HCCA*, must provide for "the administration to the person of various treatments or courses of treatment". If follows that section 29(3) does not apply to a treatment in respect of which administration is not proposed in a plan of treatment.

[219] For example, s. 29(3) could apply in a situation where a physician determines through the exercise of clinical judgment that the likelihood of benefit of CPR to restore organ function to a very ill and incapable patient is low, and the risk of suffering and harm is high, but the physician does not determine that the patient will almost certainly not benefit from CPR. In this situation, the patient would be in the second category of benefit according to the CPSO policy for decision-making for the end of life and, according to this CPSO policy which informs the standard of care, the choice of whether to offer CPR should be made on the side of providing life-sustaining treatment. In this situation, the substitute decision-maker (acting according to the principles in s. 21 of the *HCCA*) may refuse to consent to the administration of CPR and, if a plan of treatment is developed for this patient, CPR may be withheld as a treatment in the plan, with the consent of the substitute decision-maker, even though CPR was offered. A physician who then withheld administration of CPR for this patient upon the onset of cardiac or respiratory arrest would be protected from liability for doing so.

[220] In *Scardoni v. Hawryluck*, 2004 CarswellOnt 424, Cullity J. decided an appeal by substitute decision-makers from a decision of the Consent and Capacity Board directing them to

consent to withholding of life support treatment. The appellants had refused to consent to a proposal by their mother's physician that life support treatment be withheld. The Board disagreed with the appellants' belief that such treatment was in their mother's best interests and directed them to consent. Cullity J. considered whether s. 10(1)(b) of the *HCCA* imposes an obligation on a health practitioner to obtain the consent of the substitute decision-maker to a decision to withdraw, or withhold, particular treatment.

[221] Cullity J. accepted as generally correct that the *HCCA* should not be interpreted as permitting a patient – or her substitute decision-maker – to choose the health treatment to be administered and wrote at paras. 40 and 42:

> It does not, however, follow that there is no room for a distinction between treatments that should be considered to be withdrawn, or withheld, for the purposes of the statutory definition of a plan of treatment and other treatments that health practitioners would consider to be inappropriate for a patient's medical condition. If consent is required for the former, the statute does confer an important element of choice on a capable patient and requires a consideration of the factors in s. 21 when the patient is incapable.
>
> [...]
>
> The distinction between treatment that is rejected by health practitioners as appropriate on health grounds and treatment that is [*sic*] part of a plan of treatment is withheld may be difficult - and even very difficult - to apply in some cases, but not, I think, here where the application of the treatment in intensive care for specific health problems of [the patient] has been found by her physicians in the past to be medically appropriate and would be administered in the future but for their views of her best interests with that the meaning of s. 21 of the Act and, specifically, s. 21 (2)(c). As a practical matter, where physicians are in doubt whether consent is required, the substitute decision-maker would presumably be asked to consent and recourse to the Board would be available if consent is refused.

Cullity J. decided that it was not necessary for him to interpret s. 10(1)(b) of the *HCCA* and decide whether it imposes an obligation on a health practitioner to obtain consent of the substitute decision-maker to a decision to withdraw or withhold particular treatment, and that this should be decided if and when a case arises in which the correct interpretation of the section is directly in issue: *Scardoni* at para. 44.

[222] I regard the distinction drawn by Cullity J. between, on one hand, treatments that are withdrawn or withheld for purposes of the statutory definition of "plan of treatment" and, on the other hand, treatments that health practitioners consider to be inappropriate for a patient's medical condition to be critical. In *Scardoni*, the treatments in question were offered to the patient in the past, and they continued to be offered in the future. The physicians in *Scardoni* had not made a medical decision that the treatments should not be offered. Consent was given to the administration of the treatments and, unless consent was withdrawn pursuant to s. 14 or an order

was made by the Board under s. 37, the physicians were required to administer the treatments when needed.

[223] In this case, in contrast, Dr. Livingstone and Dr. Chapman exercised their professional judgment and concluded that administration of CPR would be medically inappropriate given Mr. DeGuerre's health condition on September 22, 2008. They changed Mr. DeGuerre's plan of treatment by writing the DNR order and removing an offer for administration of CPR on the onset of cardiac or respiratory arrest. When they did so, this treatment was no longer offered, and Mr. DeGuerre's plan of treatment no longer provided for administration of CPR. When Dr. Chapman decided not to administer CPR to Mr. DeGuerre at his bedside on September 22, he did not withhold a treatment that was provided for in Mr. DeGuerre's plan of treatment.

[224] In her decision on the application in *Rasouli*, 2011 CarswellOnt 1650, Himel J. considered the decision of Cullity J. in *Scardoni* at paras. 44-45 when she addressed the physicians' submission that the *HCCA* should not be interpreted in a way that would result in patients being able to pick and choose their own treatment:

> Cullity J.'s comments indicate that a distinction can be made between treatment that has been withdrawn as part of a plan of treatment and treatments that cannot be considered part of a plan of treatment because they were rejected from the onset as being medically inappropriate. While this distinction may be difficult to apply, the wording of the *HCCA* forecloses the possibility of patients picking and choosing their own treatment on the basis of this distinction.
>
> Since a plan of treatment is by definition a plan that is "developed by one or more health practitioners", patients themselves cannot develop it. Medical services or treatments desired by patients could only be included in a plan of treatment under the *HCCA* if one or more health practitioners adopted it into the plan. In other words, treatment cannot be included in any plan of treatment for the purposes of the *HCCA* until it is proposed by a health practitioner. This condition prevents a patient from picking and choosing their own treatment as the only treatment a doctor would require consent to withhold or withdraw would be one proposed by the doctor or by another health practitioner.

I adopt these statements by Himel J. including, specifically, her conclusion that under the *HCCA*, "the only treatment a doctor would require consent to withhold or withdraw would be one proposed by the doctor or by another health practitioner".

[225] I would add to the statements made by Himel J. the refinement that it is not necessary that a treatment that is not considered part of a plan of treatment be one that was "rejected from the onset" as being medically inappropriate. The *HCCA* does not provide that a plan of treatment which is developed at one time in the course of a person's care and deals with health problems that a person then has or is likely to have in the future (given the person's current health condition) is fixed and cannot be altered without the patient's consent. This is supported by the definition of "plan of treatment" in the *HCCA* which provides that a plan of treatment may deal with a health problem that the person is likely to have in the future given the person's current

health condition. A person's health condition during the course of medical care for a serious illness is likely to change over time and a physician must adjust the treatment options which are offered to a person during the course of care to reflect his or her clinical judgment. This may involve proposing additional treatments, recommending the withholding or withdrawal of a treatment that was and is being offered (or that has already been administered), or deciding that a treatment that had been offered as part of a plan of treatment will almost certainly not benefit a patient and making the medical decision that this treatment will no longer be offered.

[226] Section 1(a) of the *HCCA* provides that one of its purposes is to provide rules with respect to consent to treatment that apply consistently in all settings. McLachlin C.J.C. relied upon this statutory objective at para. 57 in reaching her decision in *Rasouli*. I do not accept that the *HCCA* should be interpreted such that a physician would have a different obligation with respect to his or her decision not to propose a treatment that had been included as part of a person's plan of treatment than the physician's obligation would be in respect of the same treatment where there was no plan of treatment. The standard of care which applies to a physician's decision to offer or not to offer a given treatment, including a requirement for consent, should be the same, regardless of whether the treatment is part of a "plan of treatment". The interpretation of the *HCCA* that the plaintiff advances, insofar as it would lead to a different outcome depending on whether the treatment was included in a plan of treatment, would conflict with this statutory objective.

(iii) Do decisions of the Consent and Capacity Board support the plaintiff's interpretation of the *HCCA*?

[227] The plaintiff's third argument in support of her interpretation of the terms "treatment" and "plan of treatment" in the *HCCA* is that the practice of the Board provides persuasive authority supporting this interpretation.

[228] The plaintiff relies upon the following passage from the *Rasouli* decision in which McLachlin C.J.C. at para. 69 cited the practice of the Board to reinforce her interpretation that "treatment" may include withdrawal of life support:

> The practice of the Board, although not determinative, reinforces the conclusion that treatment under s. 2(1) includes withdrawal of life support. Whether implicit or explicit, a specialized tribunal's interpretation of its home statute constitutes persuasive authority: Sullivan, at 621; P.-A. Côté, in collaboration with S. Beaulac and M. Devinat, *The Interpretation of Legislation in Canada* (4th ed. 2011), at pp. 584-85. The Board has regularly exercised its jurisdiction in cases where physicians proposed to withdrawal life-support, consistent with the view that withdrawal of life support constitutes "treatment" under the *HCCA* [citations omitted]. Courts on review have endorsed this interpretation: [citation omitted].

[229] The plaintiff relies upon a number of decisions of the Board where a substitute decision-maker had refused to consent to withholding of a treatment, such as CPR or dialysis, and the physician applied to the Board for a determination as to whether the substitute decision-maker had complied with s. 21.[1] The plaintiff submits that on September 22, 2008, an application to the Board under s. 37 of the *HCCA*, was the only one available to the defendants when they decided that CPR would not provide a medical benefit to Mr. DeGuerre and they would not offer CPR as a treatment option. The plaintiff submits that unless and until the Board directed the plaintiff to consent to the withholding of CPR, the defendants were required to carry out this treatment and administer CPR to Mr. DeGuerre and, if possible, transfer him to the ICU.

[230] Section 37(1) of the *HCCA* provides:

> If consent to a treatment is given or refused on an incapable person's behalf by his or her substitute decision-maker, and if the health practitioner who proposed the treatment is of the opinion that the substitute decision-maker did not comply with section 21, the health practitioner may apply to the Board for a determination as to whether the substitute decision-maker complied with section 21.

Under s. 37(2), the parties to an application are the health care practitioner who proposed the treatment, the incapable patient, the substitute decision-maker and any other person the Board specifies.

[231] As I have noted, according to the CPSO policy for end of life care that applied on September 22, 2008, the benefit to a patient from CPR or other life-support will be unlikely or uncertain where it is unlikely or uncertain whether CPR and other life-support will restore organ function, the subsequent prognosis is poor or uncertain and the likelihood of adverse consequences is high. If the physician decides that the patient is unlikely to benefit from the treatment, the CPSO policy states that the treatment should still be offered to the patient because the choice should be made on the side of providing life-sustaining treatment. In such circumstances, if the physician who proposed the treatment is of the opinion that the substitute decision-maker did not comply with s. 21 (by acting in accordance with the incapable person's prior capable wish or in the incapable person's best interests), the physician may apply to the Board under s. 37 of the *HCCA* for a determination as to whether the substitute decision-maker complied with s. 21 and the Board may give the substitute decision-maker directions. It is noteworthy that s. 37(1) applies to a health practitioner who "proposed the treatment".

[232] In the Board decisions upon which the plaintiff relies, the Board was not asked to decide whether CPR or other life support treatment would almost certainly not benefit the patient under CPSO policy for treatment at the end of life. This is a medical decision to be made by the physician based upon the exercise of his or her clinical judgment in compliance with the

[1] Section 21 provides that a person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the incapable person's prior capable wish or, if such a wish is not known to the substitute decision-maker or it is impossible to comply with the wish, the incapable person's best interests.

applicable standard of care. The Board decisions do not state that the physician had made a medical decision that the treatment would almost certainly not benefit the patient and would not be proposed, as opposed to a decision that the benefit to the patient is unlikely or uncertain, and the treatment would not be in the patient's best interests according to the factors in s. 21 of the *HCCA*.

[233] The fact that in some of the decisions the Board used words to describe the physician's view that the proposed treatment would not be in the patient's best interests according to the principles in s. 21(2) of the *HCCA*, for example, that it would be "futile", does not allow me to conclude that the physician had made a medical decision that the treatment would almost certainly not benefit the patient, and that the treatment was not offered. In each case, it appears that CPR or other life support treatment had been proposed by the physician and consent to the proposed treatment had been requested and given. In a number of these Board decisions, the physician had recommended that the substitute decision-maker refuse to consent to administration of CPR by consenting to a DNR order. The issue on these applications was whether the patient's substitute decision-maker, in giving consent to CPR or other life support treatment, had acted in the incapable patient's best interests in compliance with s. 21 of the *HCCA*.

[234] The defendants rely on a decision of the Board in *Re (MW)*, 2008 CanLII 119685. In that case, the patient's substitute decision-makers attempted to compel the treating physicians to insert chest tubes to relieve the patient's respiratory distress. Chest tubes had been a proposed and administered treatment for the patient in the past. However, in the then current circumstances, none of the ICU physicians had proposed this medical intervention - they had determined that the patient was dying, and the insertion of the chest tubes would be invasive and accomplish little. The Board determined at p. 10 that it did not have jurisdiction to decide the application:

> In this case, [the substitute decision-maker] is asking the Board to make a determination about consent for a hypothetical treatment. No such treatment has been proposed by any physician treating [the patient]. The Board is asked to consider a treatment that is not and may never be at issue. This is simply not within the Board's authority. It is not within the role of the Board to propose treatment or to determine the appropriateness of the scope of treatment. There is no role for the Board in this matter.

The decision is an example of a Board decision which supports the defendants' submission that the Board's authority under the *HCCA* does not extend to a situation where a treatment has not been proposed.

[235] Each of the Board decisions upon which the plaintiff relies is fact specific. From a review of these Board decisions, it is not possible to determine what, in all of the circumstances, the standard of care required of the physician with respect to the medical decision of whether or not CPR or other life support treatment was required to be offered to the patient. This question was not before the Board. In the decisions upon which the plaintiff relies, the Board did not decide, explicitly or implicitly, that making a DNR order is a "treatment" under the *HCCA* for which

consent is required. These Board decisions are not persuasive authority, one way or the other, on this question of statutory interpretation.

(iv) Do the CPSO policy and the Sunnybrook policies that were in place on September 22, 2008 support the plaintiff's submission that the applicable standard of care required the defendants to obtain the plaintiff's consent before writing and acting on the DNR order?

[236] The plaintiff submits that the CPSO policy and the Sunnybrook policies further reinforce the requirement of consent in placing a DNR order.

[237] With respect to the CPSO policy, the plaintiff submits that there is no basis to support the defendants' evidence that this policy authorized them to place the DNR order without consent from the plaintiff. The plaintiff relies upon statements in the CPSO policy which note that physician should strive to ensure that there is communication with patients or their substitute decision-makers when treatment can no longer prevent death and help them reassess and revise priorities. The policy notes that informed decision-making in the context of end-of-life care includes information about the potential benefits, risks, and consequences of the proposed course of action, including palliative care. The plaintiff submits that substitute decision-makers do not need to reassess priorities or receive information about benefits and risks if the decision of whether CPR should be administered at the end of life is not theirs to make.

[238] Further, the plaintiff relies upon the references in the CPSO policy to conflict resolution measures and submits that if physicians did not require consent to withdraw CPR as a treatment option, the policy would not require any form of conflict resolution and there would be no need to provide information to a substitute decision-maker or to achieve consensus. The plaintiff submits that the same reasoning applies to the Sunnybrook policies.

[239] The CPSO policy is clear with respect to the course of action which should be taken by a physician in circumstances where the physician has made a medical decision that the patient will almost certainly not benefit from CPR:

> When it is clear from available evidence that treatment will almost certainly not be a benefit or may be harmful to the patient, physicians should refrain from beginning or maintaining such treatment. Any recommendation not to support life support, or to withdraw life support, should be discussed with the patient or substitute decision-maker, and family if there is consent. If the patient or substitute decision-maker, or family if there is consent, specifically request the physician to provide or continue the treatment notwithstanding the recommendations of the healthcare team, the position should turn to the conflict resolution measures discussed in Part 4.1 of this policy in an effort to achieve consensus.

[240] The Sunnybrook policies include similar statements. The Sunnybrook life-support policy states:

> In some situations a physician can determine that a treatment is medically futile or non-beneficial because it offers no reasonable hope of recovery or improvement, or because the person is permanently unable to experience any benefit. In other cases the utility and benefit of a treatment can only be determined with reference to the person's subjective judgement about his or her overall well-being. Patients will be offered life-support, if this intervention meets the standard of care as determined by the intervention's anticipated level of benefit. Healthcare providers are not obliged to propose or provide treatments that lie outside of the standard of care; there is no obligation to offer a person futile or nonbeneficial treatment.
>
> Patients and SDM's may question the physicians' judgements regarding decisions about life-support. The process to be followed when these questions arise as described in the **Process For Addressing Conflict**.

[241] The Sunnybrook No CPR policy states:

> Interventions anticipated to be futile or non-beneficial lie outside the standard of care. Although healthcare providers are not obliged to propose or provide futile or non-beneficial interventions, they should consider the patient's or SDM request and reason for wanting CPR. A non-beneficial intervention offers no reasonable hope of recovery or medical improvement, or is non-beneficial because the person is permanently unable to experience any benefit prior to the intervention. In such cases, [Sunnybrook] recommends that a "No Cardiopulmonary Resuscitation" order be written on the patient's order sheet and that the patient and/or SDM be informed. The perspective of the patient and/or SDM should be documented as well as their requests for assistance or comfort measures.
>
> Patients and SDM may question physicians regarding the appropriateness of decisions about resuscitation. The process to be followed when these questions arise is described in Section #7 ("Disagreement") under "Specific Principles".

[242] These policies emphasize the importance of informing the patient, the substitute decision-maker, and the family if there is consent that a decision has been made that CPR will not be offered. I do not accept the plaintiff's submission that the requirement for timely communication is meaningless unless consent is required in advance to a decision not to offer CPR as a treatment option.

[243] The CPSO policy and the Sunnybrook policies do not support the plaintiff's submission that the defendants were required to obtain her consent before writing and acting on the DNR order and before Dr. Chapman decided not to offer and administer CPR at Mr. DeGuerre's bedside. These policies support the defendants' submissions that they were not obliged to do so.

If the defendants' acts of making the DNR order and Dr. Chapman's decision at Mr. DeGuerre's bedside to not to offer or administer CPR would otherwise be "treatment" according to the definition in the *HCCA*, are these acts described in clause (g) of this definition, such that they are excluded from the meaning of "treatment" in the *HCCA*?

[244] If I have erred in my conclusion that the defendants did not propose a treatment on September 22, 2008 which required the plaintiff's consent, I address whether the treatment is described in clause (g) of the definition of "treatment" in s. 2(1), such that it is excluded from the meaning of "treatment" in the *HCCA*.

[245] The definition of "treatment" in the *HCCA* includes a number of specific exclusions. One of these exclusions is found in clause (g) of the definition in s. 2(1) of the *HCCA*: "a treatment that in the circumstances poses little or no risk of harm to the person".

[246] I have concluded that Dr. Livingstone and Dr. Chapman met the required standard of care when they concluded following their assessments of Mr. DeGuerre on September 22, 2008 that the administration of CPR would almost certainly not be of benefit to him and would only cause him harm. It follows that the defendants' medical decision not to offer CPR as a treatment option and to write the DNR order, and Dr. Chapman's decision at Mr. DeGuerre's bedside not to offer or administer CPR, posed little or no risk of harm to Mr. DeGuerre. To the contrary, these decisions and the actions taken to implement them saved Mr. DeGuerre from harm.

[247] If I had concluded that Dr. Livingstone's and Dr. Chapman's acts in writing the DNR order to give effect to their medical decision and Dr. Chapman's actions in deciding not to offer CPR as a treatment option at Mr. DeGuerre's bedside would otherwise fall within the definition of the term "treatment" in the *HCCA*, I would have concluded that these things are described in clause (g) of the definition of "treatment" and are excluded from the meaning of "treatment".

Conclusion on whether defendants failed to meet the required standard of care through non-compliance with the *HCCA*

[248] The steps taken by the defendants to make the DNR order and place it on Mr. DeGuerre's chart, and Dr. Chapman's decision at Mr. DeGuerre's bedside not to offer or administer CPR do not constitute "treatment" within the meaning of this term in the *HCCA*. This conclusion is supported by the words in s. 2(1) of the *HCCA* which define "treatment" and "plan of treatment", and by s. 10 of the *HCCA* which provides that consent is required in circumstances where a health care practitioner "is proposing" a treatment. The "treatment" is CPR, not writing a DNR order to preclude the otherwise automatic initiation of CPR. After the DNR order was written, the defendants were no longer proposing CPR as a treatment option.

[249] The interpretations which I have given to "treatment" and "plan of treatment" are consistent with the provisions of the *HCCA* as a whole and with the purposes of the *HCCA* as set out in s. 1 thereof. The *HCCA* does not provide that a physician is required to propose every conceivable treatment to a patient and allow the patient to choose which treatment or treatments to receive, and if consent is given to a treatment on the menu of choices, to administer the treatment unless directed otherwise on an application to the Board under s. 37(1). To the

contrary, ss. 10 and 37 of the *HCCA* only apply where a health practitioner is proposing or has proposed a treatment. This interpretation is supported by the decision of McLachlin C.J.C. in *Rasouli*, who recognized that the standard of care applicable to physicians requires that they undertake a contextual assessment of the patient for the purpose of deciding whether a given treatment should or should not be proposed. To interpret the *HCCA* as the plaintiff asks would significantly diminish if not eliminate the proper role of a physician in exercising clinical judgment and making the necessary medical decision about whether administration of a given treatment would be medically inappropriate for his or her patient, and whether the treatment should be proposed to the patient.

[250] This interpretation strikes the right balance between the value of providing and facilitating appropriate care for incapable patients and the values of enhancing the autonomy of persons for whom treatment is proposed and providing a meaningful role for supportive family members when a person lacks the capacity to give or refuse consent to a treatment, even at a critical time where life is at stake. The objects and purposes of the *HCCA* are served by this interpretation.

[251] On September 22, 2008, although CPR had been offered as a "treatment" as part of a "plan of treatment" to which the plaintiff had consented on her father's behalf, the defendants were not required by the *HCCA* to continue to offer CPR as a treatment option to Mr. DeGuerre. On that day, the defendants undertook a contextual assessment of the Mr. DeGuerre's circumstances, including his condition and prognosis, the expected result of CPR, and the risks of CPR for him and, following the exercise of their clinical judgment, they made the medical decision not to offer CPR as a treatment option. Under the *HCCA*, they were not required to obtain the plaintiff's consent to this medical decision.

[252] The defendants did not fail to comply with the *HCCA* when they wrote the DNR order and when Dr. Chapman decided not to offer or administer CPR to Mr. DeGuerre at his bedside.

c. At common law, did the defendants fail to meet the applicable standard of care on September 22, 2008 by deciding not to offer CPR to Mr. DeGuerre as a treatment option?

[253] The plaintiff submits that as was the case in *Rasouli*, this is not a case about who, in the absence of a statute, should have the final say in whether resuscitation or admission to the ICU should be withheld from a patient or whether a next-of-kin's decision should trump a physician's decision that administration of resuscitation would not be beneficial and should not be offered as a treatment option to an incapable patient. The plaintiff relies on the *HCCA*.

[254] I have held that the *HCCA* did not apply to the defendants' conduct on September 22, 2008 in writing the DNR order or acting on it. As a result, it is necessary for me to address whether at common law the defendants were required to obtain consent from Mr. DeGuerre or someone authorized to consent on his behalf before making the medical decision not to offer CPR as a treatment option and writing the DNR order to give effect to this decision, and before Dr. Chapman decided not to offer or administer CPR to Mr. DeGuerre at his bedside.

[255] The plaintiff submits that prior to *Rasouli* and the enactment of the *HCCA*, the common law was not settled on the question of when consent to withdrawal or withholding of medical treatment is required. The plaintiff relies upon the decision of Himel J. who heard and decided the application in *Rasouli* in the first instance. In her decision at para. 55, Himel J. concluded that the statutory scheme for consent under the *HCCA* applies to the withdrawal of life support. Himel J. expressed her view that the common law in Canada on this issue was unclear, and she provided an overview of relevant case law and academic commentary to illustrate the status of the common law on consent to withholding or withdrawing treatment in Canada.

[256] In *Rasouli* at the Supreme Court of Canada level, the appeal raised two questions. The first question was whether the *HCCA* governed the issue of withdrawal of life support with the consequence that Mr. Rasouli's substitute decision-maker's consent to withdrawal of life support was required and her refusal could only be challenged before the Board. The second question, which would have been reached only if the Court decided that the *HCCA* does not apply, was whether at common law the Court should order that Mr. Rasouli's life support can be removed without the consent of his wife (his litigation guardian and substitute decision-maker under the *HCCA*). The Supreme Court of Canada decided that the *HCCA* governed the issue of withdrawal of life support and, as a result, it was not necessary for it to decide the second question. See *Rasouli* at paras. 14-16.

[257] McLachlin C.J.C. held at para. 52 that nothing in the *HCCA* suggests that it is merely a codification of the common law and, while the *HCCA* builds on the common law, its consent requirement is in some ways broader and in other ways narrower than the common law, based as it is on the detailed definition of "treatment" in s. 2(1). For anything done which is inside the definition of "treatment", the HCCA applies. For anything done which is outside the definition of "treatment", the common law applies pursuant to s. 8(2) of the *HCCA*.

[258] In the Court of Appeal for Ontario, Moldaver J.A. (as he then was) and Simmons J.A., writing for the Court, observed that given Himel J.'s conclusion that the *HCCA* applied to withdrawal of treatment in that case, she was not obliged to consider whether consent to withdraw life support would also be required at common law. Moldaver and Simmons JJ.A. concluded that the *HCCA* provides a complete answer to the question of consent in the case on appeal and did not address the reasons of Himel J. relating to the common law. See *Rasouli (Litigation Guardian of) v. Sunnybrook Health Sciences Center*, 2011 ONCA 482.

[259] In examining the common law authorities, it is important to focus on the factual circumstances to which the common law principles apply. This is not a case like *Rasouli* where life support treatment had already been administered and the "withdrawal" of life support involved a series of medical interventions, many of which entailed physical interference with the patient's body. This is not a case involving a recommendation by a physician to withhold administration of a life support treatment, which was still being proposed as a treatment option, on the ground that to withhold administration of the treatment would be in the best interests of the incapable patient. This is a case where the physicians exercised their clinical judgment and made a medical decision not to offer life support treatment, CPR, as a treatment option for their incapable patient on the ground that to administer CPR would be medically inappropriate. The question is whether at common law the physicians failed to meet the applicable standard of care

by making and acting on this medical decision without the patient's consent or the consent of someone with authority to give or refuse consent on his behalf.

[260] In *Rasouli* at the court of first instance, Himel J. cited *R. (a minor), Re*, [1991] 4 All E.R. 177 (Eng. C.A.). In that case, the Court held at pp. 184 and 187:

> It is trite law that in general a doctor is not entitled to treat a patient without the consent of someone who is authorized to give that consent. If he does so, he will be liable in damages for trespass to the person and may be guilty of a criminal assault. This is subject to the necessary exception that in cases of emergency a doctor may treat the patient notwithstanding the absence of consent, if the patient is unconscious or otherwise incapable of giving or refusing consent and there is no one else sufficiently immediately available with authority to consent on behalf of the patient. However consent by itself creates no obligation to treat. It is merely a key which unlocks the 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.

Himel J. cited two other U.K. cases and concluded that the U.K. cases consistently hold that doctors do not legally require consent to withdraw or withhold treatment: *Rasouli* (application decision) at paras. 58 to 61.

[261] In her review of the jurisprudence in Canada, Himel J. cited the decision of the Manitoba Court of Appeal in *Child & Family Services of Central Manitoba v. L. (R.)* (1997), 154 D.L.R. (4^{th}) 409. In that case, the parents of an infant who was in a persistent vegetative state appealed from an order authorizing the Child and Family Services agency to provide a "do not resuscitate" direction to the infant's health care providers. The infant had been apprehended by the agency. The infant's parents refused to consent. A Manitoba statute provided that an agency may apply to court for an order authorizing medical treatment for an apprehended child where the parents of the child refuse to consent to such treatment. The Manitoba Court of Appeal held at para. 14-17 that there was no need for a consent from anyone for a doctor to refrain from intervening:

> There is no legal obligation on a medical doctor to take heroic measures to maintain the life of the patient in an irreversible vegetative state. Indeed, the opposite may be true. Consent to the use of heroic measures, they being necessarily intrusive, might technically be required to avoid the intervention amounting to a trespass. The only fear a doctor need have in denying heroic measures to a patient is the fear of liability for negligence in circumstances where qualified practitioners generally would have thought intervention warranted.

[262] In *Rasouli* at the application level, Himel J. cited the decision of Metivier J. in *Children's Aid Society of Ottawa-Carleton v. C. (M.)*, [2008] O.J. No. 3795 in which she found the correct principle to apply in decisions of this nature is that "the decision to withdraw or withhold life-sustaining treatments is inherently a medical one, 'within the sole purview of the patient's treating doctors'". Himmel J. noted that at para. 33 Metivier J. wrote "... consent is not needed for the doctors to make use of their professional judgment and discretion to cease treatment or give only palliative care." Himel J. noted that in *Children's Aid*, the application of the *HCCA* was not considered.

[263] Himel J. also cited at para. 74 the British Columbia decision in *Rotaru v. Vancouver General Hospital Intensive Care Unit*, 2008 BCSC 318 as an authority which provides further support for the proposition that a doctor does not need consent to withhold treatment. In that case, the physician did not believe that dialysis treatment should continue to be provided to a palliative patient. The court surveyed the United Kingdom jurisprudence and concluded that a medical practitioner is not required to act contrary to the fundamental duty which that practitioner owed to his or her patient. The court refused to order the health practitioner to begin re-administration of this treatment.

[264] Himel J. also cited at para. 76 the following passage from the text *Legal Liability of Doctors and Hospitals in Canada*, Ellen I. Picard and Gerald B. Robertson at p. 345:

> 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 reasonable prospect of a therapeutic benefit to 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 healthcare team, be completely ineffective."

Himel J. observed at para. 77 that the absence of a legal duty to perform and provide treatment supports the contention that a common law, doctors do not need consent to withdraw or withhold treatment.

[265] Himel J. referred to three decisions which indicated to her that the common law position on whether consent is needed to withdraw or withhold treatment in Canada is not firmly decided, and which led her to conclude that the law on whether consent is needed to withdraw or withhold treatment in Canada is not well-settled.

[266] The first of these cases is *Sawatzky v. Riverview Health Centre Inc*., [1998] M.J. No. 506, 167 D.L.R. (4th) 359 (Man. Q.B.). In *Sawatzky*, the plaintiff was the patient's wife. She applied for an interlocutory injunction to enjoin the defendant health centre until trial from imposing a "do not resuscitate" order which was issued without her consent. The defendant opposed the requested injunction on the basis that the effect would be to order a doctor to provide medical treatment which she or he feels is not in the patient's interests, putting the physician in conflict with the Code of Conduct of the College of Physicians and Surgeons. Beard J. noted that the "do not resuscitate" order had been in place for 10 or 11 days and, prior to that, the doctor had issued an order to resuscitate which was in effect for five months. Beard J. treated the *status quo* as the situation prior to the "do not resuscitate" order. Beard J. noted that the cases which had dealt with this issue did not consider the effect of rights under the *Charter of Rights and Freedoms* or the Manitoba *Human Rights Code*.

[267] In passages quoted by Himel J. at para. 79, Beard J. noted that courts have expertise in resolving factual disputes and making legal decisions, and there is a role for the courts in making factual determinations and advising of the legality or illegality of disputed medical decisions before the patient is dead. Beard J. considered that there was a public interest aspect involved in some of the issues which needs to be recognized including in the protection of the patient, the reassurance of the patients' families and the reassurance of the public. Beard J. considered several "special and extraordinary" circumstances, including that there was a dispute as to the patient's condition and neither party had obtained another opinion to resolve the dispute. Beard J. granted the interlocutory injunction on terms, including that the Public Trustee represent the interests of the patient and that the Public Trustee and the defendant health centre, and the patient's wife if she so chose, obtain an independent medical opinion as to the patient's current condition and the advisability of the "do not resuscitate" order.

[268] In *Sawatzky*, Beard J. accepted that the doctors have to make the medical decisions. However, Beard J. considered the factual dispute between the patient's wife and the defendant as to the patient's condition and his prognosis for the future to be one that "cries out for some clarification" (para. 33). A central factual issue on the injunction application was, therefore, whether the doctors at the defendant health centre had met the required standard of care when they made the medical decision that resuscitation would be inappropriate. Beard J. did not decide, nor did he cite any authority in which a court had decided, that at common law a physician requires consent from the patient before making a medical decision not to offer a treatment, even in the context of end-of-life care.

[269] The second case cited by Himel J. at paras. 80-81 to support her conclusion that the common law is not well-settled is *Golubchuk (Committee of) v. Salvation Army Grace General Hospital*, 2008 MBQB 49. In *Golubchuk*, the court considered the issue of removal of life support. The substitute decision-maker had not consented to the health practitioner's proposal to remove a ventilator. The application judge, P. Schulman J., allowed an injunction to prevent the doctor from removing the ventilator. The application judge rejected the hospital's argument that the court had no role in the matter because the health practitioner did not need consent to withdraw the medical treatment. The application judge cited passages from a commentary written by Professor B. Sneiderman of the *Child & Family Services* decision in which the commentator focused on the "crucial circumstances" requiring consent – treatment that involves physical contact with the patient's body. Justice Schulman appraised the strength of the plaintiff's case given the facts that removal of the ventilator probably involved some interaction with the plaintiff's body and the providing of narcotics over the plaintiff's objection, and removal of the ventilator will lead to the passing of the plaintiff sooner in time than if he remained on the ventilator. Himel J. noted at para. 81 that in *Children's Aid Societ*y one of the grounds on which *Golubchuk* was distinguished was that the proposed withdrawal of treatment involved physical intervention.

[270] The third case cited by Himel J. to support her conclusion that the common law is not well-settled is *Sweiss v. Alberta Health Services*, 2009 ABQB 691. In *Sweiss*, the patient's family applied for an injunction to discontinue a "do not resuscitate" order and to prevent any doctor from removing the mechanical ventilator support which the patient was receiving. The applicants contended that the actions proposed by the patient's treating physician will end the patient's life and constitute assault and battery and, further, the proposed actions were not consistent with the patient's religious belief. The patient's treating physician's opinion was that it would be devastating to the patient to attempt any form of CPR and that CPR attempts would likely be harmful and make the patient's death less dignified. The application judge approached the application from the perspective of what is in the best interests of the patient having regard to his actual condition, the medical treatment that is recommended, the wishes and directions of the patient, and what is just and equitable in the circumstances. The application judge granted an interim injunction preventing the removal of the ventilator for five days to allow the family to obtain an independent assessment regarding their father's condition. The application judge accepted the treating physician's evidence that active intervention would create substantial harm to the patient and any such procedure would be of no benefit to him, and that the Court should not in the circumstances of this case force the doctor to go against the primary medical principle of doing no harm. The application judge denied the request for an interim injunction that the DNR order be removed or lifted.

[271] In her decision in *Rasouli*, Himel J. at para. 82 wrote that the court in *Sweiss* did not address the hospital's argument that no consent is required for a physician to refrain from intervening. Himel J. inferred that the court clearly did not accept this argument as it granted the injunction. Himel J. regarded *Sweiss* as an example of a case in which the court did not find that health practitioners do not require consent to withdraw treatment. I read the decision in *Sweiss* to support the position at common law that a physician does not need consent to make a medical decision not to offer a treatment, even in the context of end-of-life care, because the injunctive relief sought in respect of the DNR order (which was made without consent) was denied.

[272] None of the three cases upon which Himel J. relied to support her conclusion that the law on whether consent is needed to withdraw or withhold treatment in Canada is not well-settled involved facts that are similar to the facts before me. It seems that Himel J. may have regarded the common law position on the need for consent to the "withdrawal" of treatment to overlap with the common law position on the need for consent to "withholding" of treatment because she did not draw a distinction between them. In my view, there is a vital distinction between a medical decision to "withdraw" a life support treatment which was already administered and which the patient has been receiving (that may involve interventions requiring physical interaction with the patient's body (as was the case in *Rasouli*, *Golubchuk* and, in respect of removal of the ventilator, *Sweiss*)) and a decision not to offer (or, put another way, to withhold) a life support treatment such as CPR that would not involve any physical interaction with the patient's body.

[273] In *Rasouli*, McLachlin C.J.C. concluded that the withdrawal of life support for Mr. Rasouli was inside the definition of "treatment" in the *HCCA*. As a result, it was not necessary for her to address the common law position of whether life support treatment could be withdrawn without the consent the patient or, if the patient is incapable, without the consent of someone with authority to give or refuse consent on his or her behalf. In her dissenting reasons, however, Karakatsanis J. addressed the common law jurisprudence. It was necessary for Karakatsanis J. to do so because, in her view, the *HCCA* does not apply to the withdrawal of treatment.

[274] Karakatsanis J. wrote that even in end-of-life situations, she has not been directed to any Canadian decision ordering that a physician obtain consent to withhold or withdraw treatment that is not medically effective. Karakatsanis J. reviewed the decisions to which Himel J. referred in *L. (R.)*, *Sweiss*, *Sawatzky*, *Golubchuk*, and *Rotaru*, as well as authorities in the U.K. and in the United States and concluded at paras. 185-186:

> Thus, courts throughout Canada, the U.K. and the U.S. have been reluctant to require a doctor to provide or continue life support treatment that was found to be outside the professional medical standard of care. [...]
>
> In my view, even in end-of-life situations, there is no common law right to insist on medical treatment that the doctor and the institution consider medically futile, harmful, and outside professional standards. Consent is not required to withdraw life-sustaining treatment in such circumstances. Patients cannot force doctors to act in violation of the standard of care.

[275] Karakatsanis J. held at paras. 187-189, citing *Sawatzky*, *Golubchuk* and *Rotaru*, that another thread running through the jurisprudence is the court's supervisory role in adjudicating end-of-life decisions; such decisions are not entirely within the discretion of doctors. In this regard, Karakatsanis J. noted that, typically, the courts have become engaged in end-of-life decision-making when a patient's family has sought an injunction to stop the institution from withholding or withdrawing life-sustaining treatment. As she noted, most often, the analysis centres on the factual record and whether the treatment is futile or medically ineffective and, in addition, courts have looked broadly to the best interests of the patient.

[276] Karakatsanis J. concluded at paras. 190-191 that decisions to withdraw life support must be in accordance with the applicable standard of care:

> In my view, Canadian courts should assess whether the decision to withdraw life support accords with the physician's standard of care and her fiduciary duty, as well as considerations of patient autonomy and human dignity. In any review, the doctor's medical diagnosis and view of the implications of continued treatment feature prominently. The wishes, values, and beliefs of the patient should be considered; however, they cannot be determinative. A doctor cannot be required to act contrary to her standard of care.
>
> The common law protects the interests of Canadians in the medical realm - whether doctor or patient - by requiring physicians to act (1) in accordance the conduct of a prudent practitioner of the same experience and standing in her field, including a duty to obtain informed consent [citations omitted] and (2) in the best interests of their patients [citation omitted]. Typically, decisions to provide or to withdraw treatment are made on the basis of medical benefit to the patient. This approach will likely satisfy the standard of care and advanced the patient's best interests where the patient's medical condition is the primary concern.

[277] The conclusions reached by Karakatsanis J. with respect to the common law position in Canada on the need for consent to the withholding of treatment are supported by the authorities she cited and apply to the question before me. When I use the term "withholding of treatment" in this context, I mean not offering a treatment, as opposed to withholding administration of a treatment that is being offered and to which consent was given. I do not need to consider the common law position on the specific question in *Rasouli*, the need for consent to the withdrawal of a treatment that was already administered and that the patient is receiving.

[278] A person does not have a common law right or entitlement which would compel a doctor to offer and, if consent is given, administer a treatment that the doctor has decided would be medically inappropriate or contrary to the professional standard of care. At common law, Dr. Livingstone and Dr. Chapman were not required to obtain the plaintiff's consent (as the person authorized to give or refuse consent to medical treatment on her father's behalf) before making the medical decision not to offer CPR as a treatment option for Mr. DeGuerre and writing and acting on the DNR order.

d. Did the defendants' decision to write the DNR order and not to administer CPR cause Mr. DeGuerre's death?

[279] In order to succeed on her *FLA* claim, the plaintiff must show that the defendants' fault or neglect by not administering CPR caused the death of Mr. DeGuerre. If a breach of a legal duty did not cause the injury on a balance of probabilities, the physician is not liable: *Clements v. Clements*, 2012 SCC 32 at para. 37.

[280] Although I have concluded that the plaintiff has not proven that the defendants failed on September 22, 2008 to meet the applicable standard of care in relation to the duty of care owed

to Mr. DeGuerre, I go on to address the question of whether, had I concluded otherwise, the plaintiff has proven that Mr. DeGuerre's death was caused by the defendants' neglect.

[281] The "but for" test has long been the legal test for causation. This was confirmed by the Supreme Court of Canada in *Clements* at para. 46:

> As a general rule, a Plaintiff cannot succeed unless she shows as a matter of fact that she would not have suffered the loss "but for" the negligent act or acts of the defendant. A trial judge is to take a robust and pragmatic approach to determining if a Plaintiff has established that the defendant's negligence caused her loss. Scientific proof of causation is not required.

In *Clements*, the Supreme Court of Canada confirmed at para. 46 that the "material contribution" test for causation may only be used where the plaintiff's loss would not have occurred but for the negligence of two or more tortfeasors and the plaintiff is unable to show that any one of the possible tortfeasors in fact was the necessary or "but for" cause of his or her injury. This situation does not arise in this case. The appropriate test is the "but for" test. The onus is not met simply by demonstrating that there is the possibility of a causal connection between the alleged negligence and the damage: *Rothwell v. Raes* (1990), 2 O.R. (3d) 332 (C.A.) at pa. 4.

[282] The standard of care is an objective one. What a physician would or would not do himself or herself in a particular situation does not establish the standard of care. This was stated in *Bafaro v. Dowd*, [2008] O.J. No. 3474 at para. 36:

> To the extent that an expert testifies as to what he himself would do in a situation, rather than what the standard of care requires, his testimony does not establish the standard of care nor demonstrate that the defendant doctor breached a standard of care.

[283] The plaintiff must prove on the balance of probabilities that, but for the defendants' negligence, the unfavourable outcome (in this case, Mr. DeGuerre's death) would have been avoided. Loss of a chance of a better outcome is not compensable in medical malpractice cases: *Salter v. Hirst*, 2011 ONCA 609 at para. 14.

[284] The plaintiff relies upon the evidence of Dr. Sharma in support of her submission that the defendants' negligence caused the death of her father. As I have noted, Dr. Sharma testified that it is possible that Mr. DeGuerre could have survived for an indefinite period of time had appropriate steps been taken earlier in the course of his sepsis (induced by pneumonia) and again later in the course of his sepsis. Dr. Sharma testified that she believed that on September 22, 2008 Mr. DeGuerre was in one of the "likely benefit" or "uncertain benefit" categories of benefit in the CPSO policy. In the context of her belief in this respect, Dr. Sharma testified that the defendants failed to meet the required standard of care when they made the DNR order without the plaintiff's consent.

[285] Dr. Anderson testified that, in his opinion, Mr. DeGuerre would have suffered harm as a result of attempted resuscitation, including rib and sternal fractures, injury to his organs and

internal hemorrhaging, particularly because of his condition and comorbidities and the fact that he was on anticoagulant medications. Dr. Anderson testified that, in his opinion, Mr. DeGuerre would almost certainly have died during an attempt at resuscitation. I accept Dr. Anderson's evidence which is supported by the evidence of Dr. Sinuff and by the evidence of Dr. Chapman and Dr. Livingstone.

[286] In any event, Dr. Sharma did not provide an expert opinion on the question of causation upon which I can rely to conclude that Mr. DeGuerre's death was caused by the defendants' negligence. Dr. Sharma testified that, given that Mr. DeGuerre had a significant amount of time that he was pre-arrest, followed by a respiratory arrest secondary to a reversible cause (that is, pneumonia) it is *possible* that Mr. DeGuerre could have survived for an indefinite period of time had appropriate steps been taken earlier in the course of his sepsis and again later in the course of his sepsis. Dr. Sharma testified that temporary hemodynamic and respiratory support could have been provided to aid his condition until his pneumonia was treated and this specific support was not provided due to the change in Mr. DeGuerre's code status by Dr. Chapman and Dr. Livingston.

[287] The plaintiff submits that this is not a case where the evidence needed to prove that Mr. DeGuerre's death was caused by the defendants' negligent failure to administer CPR was equally available to the parties. The plaintiff submits that because her father died two hours after the onset of respiratory distress without CPR having been administered, it became impossible for her to prove that her father's death was caused by the defendants' fault. The plaintiff submits that she adduced some affirmative evidence that the defendants' fault was linked to the loss, the evidence of Dr. Sharma with respect to reversible sepsis and pneumonia, and that it is open to me as the trier of fact to determine whether an inference of causation should be made in these circumstances which would discharge the plaintiff's burden of proving causation. The plaintiff submits that I should draw such an inference. In support of this submission, the plaintiff relies upon *Benhaim v. St-Germain*, 2016 SCC 48.

[288] In *Benhaim*, the plaintiff's partner died of lung cancer at the age 47, leaving behind the plaintiff and their young son. The plaintiff brought an action for damages against two of her partner's physicians. The trial judge held that while the physicians were negligent, the evidence did not establish on a balance of probabilities that their negligence caused the death of the plaintiff's partner. The Québec Court of Appeal reversed that decision, and the majority held that the trial judge erred in law by failing to draw an adverse inference of causation. The question on the appeal to the Supreme Court of Canada was whether the trial judge was required to draw an adverse inference of causation and whether she committed an error of law in her causation analysis or made a palpable and overriding error of fact. Wagner J., writing for the majority, held that the trial judge was not required to draw an adverse inference of causation which is permissive because it is a component of the fact-finding process. Wagner J. concluded that the trial judge did not commit an error of law in applying the rules of evidence and that she did not commit a palpable and overriding error in her appreciation of the facts. The appeal was allowed.

[289] In his decision in *Benhaim*, Wagner J. referred to previous decisions of the Court in *Snell v. Farrell*, [1990] 2 S.C.R. 311 and *St. Jean v. Mercier*, [2002] 1 S.C.R. 491 upon which the

plaintiff had relied, and he held that in these decisions, the Court held that ordinary rules of causation must be applied in medical malpractice cases. He concluded at para. 54:

> In sum, the Court held in *Snell* that "the plaintiff in medical malpractice cases - as in any other case - assumes the burden of proving causation on a balance of probabilities": *Ediger* [*Ediger (guardian ad litem of) v. Johnston*, 2013 SCC 18], at para. 36. Causation need not be proven with scientific or medical certainty, however. Instead, courts should take a "robust and pragmatic" approach to the facts, and may draw inferences of causation on the basis of "common sense": *Snell*, at p. 330-331; *Clements*, at paras. 10 and 38. The trier of fact may draw an inference of causation even without "positive or scientific proof", if the defendant does not lead sufficient evidence to the contrary. If the defendant does adduce evidence to the contrary, then, in weighing that evidence, the trier of fact may take into account the relative ability of each party to produce evidence: *Ediger*, at para. 36.

Wagner J. held at para. 55, citing Allen M. Linden and Bruce Feldthusen in *Canadian Tort Law* (10th ed. 2015), at p. 129, that an inference can be drawn in causation fact-finding just as in other fact-finding situations, and that for a trial judge to do so is not a retreat from the "but for" analysis, but an example of it, using ordinary logic and reasoning as in other contexts.

[290] Wagner J. addressed at para. 66 the question raised by the plaintiff in this case, that if she proves that the defendants were negligent, without an adverse inference she may be unable to prove causation in the absence of complete information, and he explained how this question should be resolved:

> In cases of causal uncertainty, both parties face the difficulty of attempting to establish facts in the absence of complete information. This case raises the issue of how that difficulty ought to be distributed between plaintiffs and defendants in cases involving what Prof. Lara Koury calls "negligently created causal uncertainty": *Uncertain Causation and Medical Liability* (2006), at p. 223 (emphasis deleted). That distribution must balance two considerations: ensuring that defendants are held liable for injuries only where there is a substantial connection between the injuries and their fault, on the one hand, and preventing defendants from benefiting from the uncertainty created by their own negligence, on the other. In *Snell*, this Court struck a balance by clarifying that an adverse inference may be available in such circumstances, while leaving the decision on whether to draw that inference to the trial judge as part of the fact-finding process, which is governed by ordinary principles of causation.

[291] In my analysis of whether the plaintiff has proven that her father was suffering from sepsis secondary to pneumonia on September 22, 2008, I considered the evidence in relation to this question, including the expert evidence of Dr. Sharma and Dr. Anderson. As I have noted, Dr. Sharma's evidence that Mr. DeGuerre was suffering from undiagnosed sepsis and pneumonia on September 22, 2008 was significantly undermined on cross-examination, and I do not accept

her evidence in this respect. For reasons I have given, I accept the evidence of Dr. Anderson and find that Mr. DeGuerre was not suffering from sepsis or pneumonia on September 22, 2008.

[292] The evidence given by Dr. Chapman, Dr. Livingston, Dr. Sinuff and Dr. Anderson amply supports my finding that on September 22, 2008 Mr. DeGuerre was very ill and suffering from numerous comorbidities, and he was close to death. In the circumstances, there is no proper basis for me to draw an adverse inference against the defendants based upon the fact that CPR was not administered, and Mr. DeGuerre died that day. If the defendants were required by the *HCCA* to administer CPR, even though they had concluded that to do so would be medically inappropriate, the plaintiff has failed to prove that there is a substantial connection between the failure to administer CPR and Mr. DeGuerre's death.

[293] With respect to the issue of causation, the defendants rely upon a power of attorney which was executed by Mr. DeGuerre on November 9, 2007 in which he appointed the plaintiff to be his attorney for personal care pursuant to the *Substitute Decisions Act*. The power of attorney includes the following statements under the heading Specific Instructions:

> If at any time I should have a terminal condition and my attending physician has determined that there can be no recovery from such condition and my death is imminent, where the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medications or the performance of any other medical procedure deemed necessary to provide me with comfortable care or to alleviate pain.
>
> In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this Declaration shall be honoured by my family and physician as a final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

[294] This power of attorney was not provided to the defendants before Mr. DeGuerre's death. The defendants discovered that it existed only afterwards.

[295] The defendants submit that the power of attorney is an expression of Mr. DeGuerre's prior capable wish concerning his treatment and that the plaintiff was under an obligation to disclose it to them. Dr. Livingstone and Dr. Chapman testified that if the plaintiff had disclosed the power of attorney, they would have engaged in further discussions with the plaintiff about Mr. DeGuerre's end-of-life care sooner and throughout Mr. DeGuerre's admission at Sunnybrook.

[296] The plaintiff testified that she had discussed with her father his wishes with respect to end of life care after this document was signed, and that her instructions that his code status should be "full code" corresponded with his wishes. The plaintiff did not agree with the proposition put to her on cross-examination that she was obliged to disclose the power of attorney to her father's treating physicians.

[297] It is not necessary for me to decide whether the plaintiff was obliged to disclose the power of attorney document to her father's health care team. The fact that the plaintiff did not provide notice to the defendants of the power of attorney does not affect my conclusion with respect to whether administration of CPR would have prolonged Mr. DeGuerre's life.

[298] I conclude that the plaintiff has failed to prove that had CPR been administered to Mr. DeGuerre on September 22, 2008, his life expectancy would have changed. The plaintiff has not proven that Dr. Chapman's failure to administer CPR caused Mr. DeGuerre's death. As a result, even if I had held that the defendants failed to meet the required standard of care in writing the DNR order and deciding not to offer CPR to Mr. DeGuerre on September 22, 2008 without the plaintiff's consent, there is no basis to award any damages to the plaintiff for her *FLA* claim.

[299] The defendants are not liable to the plaintiff in respect of her *FLA* claim.

B. The Plaintiff's indirect claim for damages caused by alleged breaches of the duty of care and fiduciary duty owed by the defendants to Mr. DeGuerre

[300] The plaintiff also claims damages as a close family member who was very involved with her father's care for breach of the defendants' duty of care or fiduciary duty owed to her father.

[301] The plaintiff submits that if the plaintiff's consent to the DNR order was not required pursuant to the *HCCA*, on September 22, 2008 Dr. Livingston and Dr. Chapman were, nevertheless, required to discuss with the plaintiff, as Mr. DeGuerre's substitute decision-maker, their intention to make a DNR order before doing so.

[302] The plaintiff submits that the defendants owed a duty of care to Mr. DeGuerre to bring new information to his attention when they decided to change his plan of treatment and, because of Mr. DeGuerre's incapacity, this information should have been provided to the plaintiff. The plaintiff contends that the defendants failed to do so and thereby breached their duty of care they owed to Mr. DeGuerre. As a result, the plaintiff suffered damages from nervous shock because she witnessed her father's death in shocking circumstances where she expected that CPR would be administered on a full code basis and she was deprived of information possessed by the defendants that they had decided that her father would almost certainly not benefit from CPR which would only cause him harm, and that they intended to make, or did make, a DNR order.

[303] The plaintiff also submits, citing *Norberg v. Wynrib*, [1992] 2 S.C.R. 226 at para. 64, that the defendants owed a fiduciary duty to Mr. DeGuerre to act with the utmost good faith and loyalty which included a duty to make proper disclosure of information to him. She submits that the defendants' fiduciary duty required them to inform Mr. DeGuerre or his substitute decision-maker as soon as they were considering making a DNR order and that they breached this duty by acting unilaterally which caused him to suffer and deprived him of treatment options that would have permitted him a dignified death.

[304] In *Norberg*, a physician gave drugs to a chemically dependent woman patient in exchange for sexual contact. The central issue was whether the defence of consent can be raised against the intentional tort of battery in the circumstances. In her concurring decision, McLachlin J. (as she then was) held at para. 64 that the relationship of physician to patient falls into the special

category of relationships which the law calls fiduciary. She also cited at para. 69 the decision of La Forest J. in *McInerney v. MacDonald*, [1992] 2 S.C.R. 138 who noted at p. 11 that "not all fiduciary relationships and not all fiduciary obligations are the same; these are shaped by the demands of the situation. A relationship may properly be described as 'fiduciary' for some purposes, but not for others." McLachlin J. identified the question to be asked on appeal as whether, assuming a fiduciary relationship did exist between the doctor and the patient, is it properly described as fiduciary for the purposes relevant to the appeal?

[305] McLachlin J. went on to address at paras. 85-100 the reasons that had been advanced for why the doctrine of breach of fiduciary duty cannot apply in that case. One of these reasons was the contention that nothing would flow from categorizing the duty as fiduciary because a fiduciary obligation would add nothing except, perhaps, a duty of confidence and non-disclosure, to an action in tort or contract. McLachlin J. noted at para. 96 that tort and contract can provide a remedy for a physician's failure to provide adequate treatment but only with considerable difficulty can they accommodate the wrong of a physician abusing his or her position to obtain sexual favours from his or her patient. McLachlin J. concluded that without characterizing the duty as fiduciary, the wrong done to the plaintiff can neither be fully comprehended in law nor adequately compensated in damages.

[306] In *Arndt v. Smith*, [1997] 2 S.C.R. 539 McLachlin J. (as she then was), concurring in part, addressed the argument that the case should be analyzed as one involving fiduciary obligations as opposed to negligence. In that case, the patient contracted chicken pox while pregnant and her physician did not disclose the risk of brain damage to the fetus. The baby was born with brain damage and the plaintiff sued for damages including the costs of raising a child. The plaintiff alleged that she had been deprived of the choice to have an abortion. In the British Columbia Court of Appeal, one of the justices had suggested that the physician's breach should be considered as a breach of fiduciary duty to disclose, depriving the plaintiff of a choice. At para. 37, McLachlin J., citing *Reibl v. Hughes*, [1980] 2 S.C.R. 880 at pp. 891-92, rejected the approach that loss of choice is itself compensable, and she accepted that a failure to disclose attendant risks should go to negligence because it arises as the breach of an "anterior duty of care". McLachlin J., at para. 38, applied the reasoning in *Reibl v. Hughes* to reject the approach of analyzing the plaintiff's claim as a breach of fiduciary duty:

> For the same reasons, I would reject the alternative approach of fiduciary obligation proposed by the respondent. As with battery, the effect would be to replace the factual analysis of standard of care and causation appropriate to negligence actions with a choice-based analysis that makes recovery virtually automatic upon proof of failure to provide relevant information. I see no reason to depart from the approach which considers the failure of a physician to advise of medical risks under the law of negligence relating to duty of care, absent special circumstances like fraudulent misrepresentation or abuse of power for an unprofessional end; see *Reibl v. Hughes, supra*; *Norberg v. Wynrib*, [1992] 2 S.C.R. 226 (S.C.C.). Such conduct is neither alleged nor proven in the case at bar.

[307] This case is one where the plaintiff asserts that the defendants breached the duty of care owed to Mr. DeGuerre by failing to provide relevant information to him (or to the plaintiff as his

substitute decision-maker), thereby depriving him of a choice to consent or refuse consent to CPR. There are no special circumstances that would make it more appropriate to analyze the plaintiff's claim as one based on a breach of a fiduciary duty. There is no reason to depart from the approach under the law of negligence.

[308] The plaintiff submits that courts in Canada have recognized claims for damages for nervous shock in circumstances where health practitioners have failed to properly communicate with family members respecting the patient's condition or to warn family members of foreseeable harm or obtain proper consent.

[309] In support of this submission, the plaintiff relies on *Lew v. Mount Saint Joseph Hospital Society*, [1997] B.C.J. No. 2461. In that case, the plaintiff brought an action against the hospital for damages for nervous shock sustained when he saw his wife who had suffered from catastrophic brain injury caused by the negligence of the anesthetist during routine surgery. The hospital brought an application to strike out the statement of claim which was dismissed. In this case, however, Newbury J.A. noted at para. 4 that the plaintiff alleged a breach of a direct and independent duty of care owed to the plaintiff himself. Newbury J.A. dismissed an application for leave to appeal on the basis that the ultimate question is one of law which should not be decided in a factual vacuum on the pleadings alone. Newbury J.A. expressed her view that the legal and policy issues that will inform the question of duty of care require a factual foundation and that the application judge properly exercised his discretion in declining the hospital's application. This decision does not stand for the proposition that a patient's family member who suffers from nervous shock caused by a breach of a duty of care owed to a patient may recover damages.

[310] The plaintiff also relies upon *Dawe (Guardian ad litem of) v. British Columbia Children's Hospital*, 2003 BCSC 443. In *Dawe*, the plaintiff was pregnant with twins and one was born with severe brain damage and later died. The plaintiff brought an application to amend her statement of claim to make claims in relation to the manner in which a hospital communicated with her. The court held that the proposed amendments represent particulars of a claim already made in the statement of claim and that the amendments relate to the same events as those already pleaded. The plaintiff was permitted to amend her pleading to make the claims, including for negligent misrepresentation. I do not regard this case as a helpful authority on the question before me. The duty of care was owed to the plaintiff and the damages were allegedly suffered by the plaintiff.

[311] The plaintiff also relies on *Anderson v. Wilson*, [1999] O.J. No. 2494, a class action by persons exposed to Hepatitis B during treatment where class members included non-infected persons who claimed damages for nervous shock after being informed that they might have been exposed. The Court of Appeal held that, given the uncertain state of the law on tort relief for nervous shock, it was not appropriate for it to reach a conclusion at the pleadings stage without a complete factual foundation. It was not plain and obvious that the claim for the tort of mental distress standing alone will fail. The court did not decide that plaintiffs to whom a duty of care was not owed could recover damages. This decision was made on a pleadings motion and does not set out legal principles that assist me.

[312] Other than the three authorities to which I have referred, the plaintiff did not cite authorities on the legal question of whether a close family member of a patient, including the substitute decision-maker for an incapable patient, is entitled to claim damages for nervous shock caused to the family member by a health practitioner's breach of a duty of care or fiduciary duty owed to the patient. In *Lew*, decided in 1997, Newbury J.A. referred to the thoughtful analysis of Henderson J. in the court below involving a question of law that Newbury J.A. described as one "apparently not decided anywhere in the Commonwealth". Newbury J.A. wrote that the cases cited to Henderson J. had all involved claims by a "secondary victim" rather than, as in *Lew*, an allegation of breach of a direct and independent duty of care owed to the plaintiff himself.

[313] In respect of the plaintiff's indirect claim against Dr. Livingstone and Dr. Chapman, she makes this claim as a "secondary victim". Because of the decision I have reached on whether the defendants breached their duty of care or fiduciary duty owed to Mr. DeGuerre, I do not find it necessary to answer the legal question of whether a "secondary victim" may recover damages for nervous shock caused by a breach of a duty owed by a doctor to his or her patient.

[314] A physician's conduct is judged in light of the medical knowledge that ought to have been reasonably possessed at the time of the alleged act of negligence. The court should not attribute to a physician knowledge that the physician did not have: *Grass (Litigation Guardian of) v. Women's College Hospital*, [2005] O.J. No. 1403 (C.A.) at paras. 95-98.

[315] In *Lapointe v. Hôpital Le Gardeur*, 1992 CarswellQue 47, the Supreme Court of Canada cautioned against the use of hindsight in determining whether a physician met the standard of care:

> ...courts should be careful not to rely upon the perfect vision afforded by hindsight. In order to evaluate a particular exercise of judgment fairly, the doctor's limited ability to foresee future events when determining a course of conduct must be borne in mind. Otherwise, the doctor will not be assessed according to the norms of the average doctor of reasonable ability in the same circumstances, but rather will be held accountable for mistakes that are apparent only after the fact.

[316] In *St. Jean v. Mercier*, [2002] S.C.J. No. 17, the Supreme Court of Canada addressed at para 53 the standard of care applicable to physicians and held:

> To ask, as the principal question in the general inquiry, whether a specific positive act or an instance of omission constitutes a failure is to collapse the inquiry and may confuse the issue. What must be asked is whether that act or omission would be acceptable behaviour for a reasonably prudent and diligent professional in the same circumstances. The erroneous approach runs the risk of focusing on the result rather than the means. Professionals have an obligation of means, not an obligation of result.

[317] Dr. Livingstone and Dr. Chapman testified that when they examined Mr. DeGuerre on September 22, 2008 each believed that Mr. DeGuerre would die soon, although they did not

expect that he would die in the next few hours or before there was an opportunity to discuss the DNR decision with the plaintiff. Dr. Chapman testified that it was important to him to write the DNR order and place it on Mr. DeGuerre's chart as soon as he could, even though the order had not been discussed with the plaintiff, as part of his duty of care to Mr. DeGuerre, so as not to expose him to needless attempts at resuscitation. Dr. Livingstone testified that he did not wait to write the DNR order until after someone had spoken with the plaintiff because his duty of care to Mr. DeGuerre was paramount.

[318] Dr. Chapman noted that resuscitation would not be offered to Mr. DeGuerre in the event of an arrest and he wrote the DNR order on Mr. DeGuerre's chart, which Dr. Livingstone co-signed. Immediately afterwards, Dr. Chapman called the plaintiff at home to inform her of the decision and the DNR order, but he was unable to reach her. He left a voicemail message at 1:58 p.m. asking her to contact Dr. Livingstone or the ward. The plaintiff testified that she listened to the voicemail message and called the ward at 3:08 p.m. that afternoon, but she could not recall with whom she spoke. When the plaintiff attended in her father's room at the hospital later that afternoon and experienced the traumatic events which ended with her father's death, she did not know that Dr. Chapman and Dr. Livingstone had written the DNR order to record and give effect to their medical decision not to offer CPR.

[319] In her evidence in chief, Dr. Sharma accepted that the CPSO policy informs the standard of care which applied to the defendants. She read at length from the CPSO policy in her evidence in chief. Dr. Sharma also referred to the Sunnybrook No CPR policy which states that a specific instruction is necessary if CPR is not to be initiated, and she agreed that the term "instruction" means "consent". As I have noted, this policy also states that patients for whom CPR will almost certainly not be beneficial should not have CPR presented as a treatment option, and that No CPR orders may be written by a staff physician without the agreement of the patient or the substitute decision-maker. Dr. Sharma did not address these statements of the Sunnybrook No CPR policy in her evidence. Dr. Sharma testified that the section on "Disagreement" in the No CPR policy is consistent with the CPSO policy concerning conflict resolution. Dr. Sharma testified that the Sunnybrook policy in relation to "futility in the use of life support" states "levels of benefit" which correspond with the levels, or categories, of benefit in the CPSO policy, and that there is a process for addressing conflict that is similar to the conflict resolution processes in the CPSO policy. Dr. Sharma read from the Sunnybrook No CPR policy where it states that physicians' decisions as to whether CPR is appropriate for a particular patient should consider the wishes of the patient, the standard of medical care, the likely benefit of CPR, and existing laws and guidelines.

[320] Dr. Sharma referred to the section of the Sunnybrook life-support policy with respect to communication which states that communication about life-support should take into account the clinical condition of the person. This policy states that people who almost certainly will not benefit from life-support are not candidates for life-support, and life-support should not be proposed. However, in general, the decision not to propose life-support should be discussed with the patient or their substitute decision-maker. Dr. Sharma referred to the section of this policy dealing with processes for addressing conflict, and she stated that this section overlaps with the conflict resolution section in the Sunnybrook no CPR policy, and that communication is a repeated theme in each of the three policies.

[321] Dr. Sharma testified that the standard of care in September 2008 required the physician to communicate with the patient or substitute decision-maker prior to writing a DNR order, discuss alternative treatment options, and obtain the consent of the patient or substitute decision-maker. Dr. Sharma testified that she was relying on the three policies as being consistent with this as the standard, and that these policies are in keeping with the *HCCA* which also applied to physicians in September 2008.

[322] Dr. Anderson testified that the standard of care in 2008 did not require a physician to communicate with a substitute decision-maker before writing a DNR order. He explained that as at September 2008, it was common for a physician to be unable to reach or communicate with a substitute decision-maker or family member before a patient's condition deteriorated. He stated that in Dr. Livingstone's and Dr. Chapman's situation, where the plaintiff was not at the bedside when they made their decision, it was within the standard of care to attempt to reach her by telephone. Dr. Anderson explained that it would not have been an appropriate to leave detailed patient information in a voicemail message, due to patient confidentiality concerns. He testified that he would not have left information about a change in code status in a voicemail message, because this information is important and serious and warrants a face-to-face discussion, although an in person discussion is not always possible. Dr. Anderson testified that Dr. Chapman's voice mail message to the plaintiff on September 22, 2008 met the standard of care in terms of the content of the information conveyed.

[323] Dr. Anderson testified that when dealing with issues relating to the care of patients at the end of their life, there is not always time to pursue dispute resolution mechanisms to resolve disagreements between the physician and the substitute decision-maker. Dr. Anderson testified that the Sunnybrook policies reflected the standard of care at the time and that they did not require dispute resolution mechanisms to be exhausted before a physician wrote a DNR order. He explained that it would be inappropriate to impose such a requirement because a physician who was required to wait while these processes were being carried out would be subject to administering treatment to a patient that he or she believed to be non-beneficial and/or harmful.

[324] The CPSO policy and the Sunnybrook policies emphasize the importance of timely, clear, thoughtful, and sensitive communications with patients or substitute decision-makers with respect to end-of-life care. However, the CPSO policy is clear that the prior consent of a substitute decision-maker is not required for a No CPR order in circumstances where the patient will almost certainly not benefit from CPR. The Sunnybrook policies similarly so state, and the Sunnybrook No CPR policy specifically states that a DNR order may be written by a physician without the agreement of the patient or the substitute decision-maker. The standard of care did not require Dr. Chapman or Dr. Livingstone to seek the plaintiff's consent to the DNR order before making it. The standard of care did call for the defendants to attempt to discuss with their patient through his substitute decision-maker, the plaintiff, the decision not to offer CPR as a treatment option and to make the DNR order and, if practicable, engage in the dispute resolution procedures provided for in the Sunnybrook policies, before making the medical decision not to offer CPR.

[325] In this case, Dr. Livingstone and Dr. Chapman made the decision to write a DNR order and each explained that, having done so, it was important to place it on Mr. DeGuerre's chart in

order to preclude the administration of inappropriate medical treatment because of Sunnybrook's standing order to administer CPR in the absence of a DNR order. Dr. Chapman quickly acted to attempt to inform the plaintiff that this decision had been made but he was not successful. Dr. Anderson testified that Dr. Chapman's voicemail message on September 22, 2008 met the standard of care in terms of the content of the information conveyed. I accept Dr. Anderson's evidence that Dr. Chapman was justified in not leaving a more detailed voice mail message for the plaintiff because of patient privacy and confidentiality concerns.

[326] The plaintiff submits that the circumstances which arose on September 22, 2008 when the defendants wrote a DNR order without obtaining the plaintiff's prior consent were those of their own making because they withheld information from the plaintiff about her father's medical condition and his prospects for recovery, and thereby deprived her of the right to make the decision of whether to consent to withholding of CPR as a treatment option. As an example, the plaintiff points to a note from the geriatrics service on September 15, 2008 which states that Mr. DeGuerre is "looking much worse today" and is a "very high mortality risk". The note records a recommendation of palliation.

[327] The evidence does not support the plaintiff's contention that the defendants withheld information from her. Dr. Livingstone spoke with the plaintiff on September 10 and told her that her father was in the process of dying and that his death was likely to occur within days and almost certainly less than two weeks. The plaintiff told him that she wanted her father to be full code, and they agreed that the discussion about whether to proceed with surgery would be deferred since he was too unwell for surgery at that time. When Dr. Livingstone assessed Mr. DeGuerre on September 12, his condition appeared to have improved slightly, and Dr. Livingstone concluded that this improvement raised the slight possibility that Mr. DeGuerre might live longer than Dr. Livingstone had anticipated. Dr. Livingstone supported proceeding with the bilateral amputation which occurred on September 17. Mr. DeGuerre was discharged from the intensive care unit on the evening of September 20, and Dr. Livingstone again became his most responsible physician. Throughout this time, Mr. DeGuerre was very ill. The plaintiff was actively involved with her father's care and discussed his condition with Dr. Bellini on September 18 and with Dr. Aoun on the evening of September 21. Dr. Chapman would have assessed Mr. DeGuerre on September 21 as part of his standard practice as a member of the rapid response team to do a brief end-of-bed assessment of patients. There is no evidence that Dr. Chapman made a medical decision that CPR should not be offered to Mr. DeGuerre because of his condition at the time of this assessment.

[328] The defendants' assessments of Mr. DeGuerre that led to the DNR order were only made on September 22, and Dr. Chapman tried to reach the plaintiff immediately after this decision was made. I do not accept the plaintiff's submissions that Dr. Livingstone and Dr. Chapman "starved" her of information and deprived her of her right to decide whether CPR should be administered to her father.

[329] In these circumstances, the duty of care owed by Dr. Chapman and Dr. Livingstone to Mr. DeGuerre was paramount. I accept that on the afternoon of September 22, 2008, the defendants were justified in writing the DNR order before discussing it with the plaintiff for the reason they gave. Unfortunately, Mr. DeGuerre's health condition declined on the afternoon of

September 22, 2008, before the plaintiff spoke with either Dr. Livingstone or Dr. Chapman, and the plaintiff experienced profoundly upsetting circumstances when she arrived at her father's bedside in the late afternoon without knowing of the medical decision which had been made, and over the ensuing course of events that evening which ended with her father's death.

[330] With the benefit of hindsight, should Dr. Chapman and Dr. Livingstone have taken different or additional actions to try to reach the plaintiff to discuss the DNR order with her after it was made? Perhaps. Had Dr. Chapman and Dr. Livingstone known that Mr. DeGuerre would experience respiratory arrest within a few hours of the DNR order, and not in days, perhaps Dr. Chapman would have left a more detailed voice mail message, notwithstanding any concerns about patient confidentiality, or at least conveyed more urgency in his message. Perhaps Dr. Chapman would have left his cell phone number for the plaintiff to call him back, or Dr. Livingstone's cell phone number. Perhaps Dr. Chapman would have ensured that the hospital administration desk would contact him to speak to the plaintiff when she called at 3:08 p.m. Without the benefit of hindsight, however, I am unable to conclude that actions taken by Dr. Chapman and Dr. Livingstone to communicate with the plaintiff about the DNR order would not be acceptable behaviour for a reasonably prudent physician in the same circumstances.

[331] I accept Dr. Anderson's evidence that the defendants met the applicable standard of care in the manner in which they communicated with the plaintiff. I conclude that the plaintiff has failed to prove that Dr. Chapman and Dr. Livingstone did not meet the standard of care which applied on September 22, 2008 in respect of the duty of care owed to Mr. DeGuerre by failing to inform the plaintiff, in her capacity as Mr. DeGuerre's substitute decision-maker, prior to writing the DNR order, of their intention to do so, or by failing to take reasonable steps after the DNR order was written to notify the plaintiff of this medical decision and discuss it with her.

[332] With respect to Dr. Chapman's communications with the plaintiff when she was at her father's bedside that afternoon, the plaintiff testified that Mr. Smith had been providing Mr. DeGuerre with breathing support for at least 5 to 10 minutes before Dr. Chapman arrived. When Dr. Chapman entered her father's room he told Mr. Smith to stop using the bag valve mask, which he did. Mr. Smith recalls switching from an "ambu" bag to a "non-rebreather" mask after Dr. Chapman arrived. The plaintiff was very upset. She argued with Dr. Chapman and said that her father was full code. The plaintiff testified that Dr. Chapman responded by saying "ta ta", and that this was for her father's own good. The plaintiff found Dr. Chapman's choice of words and tone to be inappropriate. The other members of the healthcare team who were present, Dr. Ahmed (resident), Ms. Weaver (nurse), Mr. Smith (respiratory therapist) and Dr. Chapman himself, testified that Dr. Chapman did not say "ta ta". I do not need to decide whether Dr. Chapman used this phrase or not because, even if he did, this would not amount to a failure to meet the required standard of care.

[333] The plaintiff testified that Mr. Smith did not place the non-rebreather mask on her father because she grabbed the ambu bag and began providing her father with breathing support. She estimated that she continued to use the ambu bag for 10 minutes while she dialled 911 and the hospital operator. After approximately 10 minutes, the plaintiff knew her father had died. She did not make further attempts to resuscitate her father. The plaintiff asked the clinical team to leave the room and slammed the door behind them. The plaintiff agreed that she was angry and

screaming. The plaintiff remained in her father's room for some time. She then gathered a few of her father's belongings and left the hospital.

[334] The plaintiff testified that she remained unaware of the DNR order on her father's chart until the following day when she returned to the hospital to review her father's chart and request an autopsy.

[335] With respect to Dr. Chapman's communications to the plaintiff at Mr. DeGuerre's bedside on the evening of September 22, 2008, Dr. Anderson testified that the explanation provided to the plaintiff (as outlined in Dr. Chapman's note of that day) as to why resuscitation was not being offered met the standard of care.

[336] Before the plaintiff entered her father's room on September 22, 2008, she had understood that CPR would be administered to her father in the event of the onset of cardiac or respiratory arrest, on a "full code" basis. This had been confirmed by Dr. Bellini on September 18, 2008. No one had informed her otherwise. There is no question that the circumstances with which the plaintiff was confronted on the afternoon and evening of September 22, 2008 were unexpected and shocking to her. The plaintiff was distraught and angry when Dr. Chapman would not allow CPR to be administered to her father. Nevertheless, in respect of Dr. Chapman's dealings with the plaintiff at Mr. DeGuerre's bedside on September 22, 2008, I accept Dr. Anderson's evidence and conclude that Dr. Chapman did not fail to meet the required standard of care in the circumstances.

[337] The defendants' duties to Mr. DeGuerre were to exercise the degree of skill and care expected of a normal, prudent physician of comparable training and experience in the same circumstances. When I assess the actions taken by Dr. Chapman and Dr. Livingstone after they made the DNR order without the benefit of hindsight, I conclude that the plaintiff has failed to prove that the defendants did not meet the applicable standard of care by failing to communicate their medical decision to their patient (by informing the plaintiff of this decision as his substitute decision-maker).

[338] I address the issues of whether, if I had decided that the defendants breached the duty of care owed to Mr. DeGuerre, the plaintiff would be entitled to recover damage for psychological injury and whether the damages were caused by breaches of a duty of care when I address the plaintiff's claim for damages for alleged breach of duties owed to her.

[339] The defendants are not liable to the plaintiff for breach of a duty of care or a fiduciary duty owed by the defendants to the Mr. DeGuerre.

c. <u>The Plaintiff's direct claim for damages caused by alleged breaches of a duty of care and fiduciary duty owed by the defendants to her</u>

[340] The plaintiff has alleged that the defendants are liable to her for damages arising from negligent infliction of nervous shock and breach of fiduciary duty. In respect of these claims, the plaintiff contends that the defendants owed her a duty of care and a fiduciary duty.

Are the defendants liable to the plaintiff for negligent infliction of nervous shock?

[341] Liability for negligent infliction of mental harm is conditioned upon the claimant showing (i) that the defendant owed a duty of care to the claimant to avoid the kind of loss alleged; (ii) that the defendant breached that duty by failing to observe the applicable standard of care; (iii) that the claimant sustained damage; and (iv) that such damage was caused, in fact and in law, by the defendant's breach: *Saadati v. Moorhead*, 2017 SCC 28 at para. 13.

a. Did the defendants owe a duty of care to the plaintiff?

[342] The first question is whether a duty of care was owed by the defendants to the plaintiff. This question is answered by first determining whether the proposed cause of action fits within an established category of relationships giving rise to a duty of care. Where the relationship between the plaintiff and defendant is of a type that has already been judicially recognized as giving rise to a duty of care, or is analogous to a recognized duty, a court may usually infer that sufficient proximity is present and that if the risk of injury was foreseeable, a *prima facie* duty of care will arise. See *Paxton v. Ramji*, 2008 ONCA 697 at para. 30 and authorities cited.

[343] The plaintiff submits that the defendants owed her a duty of care in her capacity as Mr. DeGuerre's close family member who was informed about and involved in her father's care to avoid the kind of loss suffered by the plaintiff. The plaintiff does not assert that the duty is owed to the plaintiff as her father's substitute decision-maker. The plaintiff submits that the defendants breached their duty of care which caused her to suffer damages which are compensable at law.

[344] The plaintiff cites *Paxton* and *Healey v. Lakeridge Health Corp*., [2006] O.J. No. 4277 in support of her submission that the proposed duty of care falls within a category which is analogous to a recognized category.

[345] In *Paxton*, the physician prescribed a medication to his patient before the patient's child's conception. At the time, the physician was under the impression that his patient would not become pregnant while on the drug because her husband had a vasectomy. However, the vasectomy failed, and the patient became pregnant. The child was born with significant defects as a result of the medication and sued the physician for her injuries. The question before the court was whether the physician owed the future child of his patient a duty of care. The Court of Appeal addressed whether the claim falls within, or is analogous to, a recognized duty of care. In addressing this question, the Court of Appeal wrote:

> A third potentially analogous category is the duty of care that a doctor may owe to a non-patient third party for harm arising out of the doctor's treatment of a patient: [citations omitted]. In these cases, however, the nature of the doctor's duty of care to the third party and the legal basis for imposing a duty of care are not fully developed. For that reason, I would not view these cases as establishing the basis for an analogous category between a doctor and a future child, if viewed as a third party non-patient. Even if these cases could be considered as establishing a potentially analogous category, once again, the unique policy

> considerations that arise in the context of the relationship between a future child of a female patient and the patient's doctor tell against drawing an analogy.

The Court of Appeal considered the proposed duty to be a novel one and proceeded with the two-stage *Anns*/*Cooper* analysis to determine whether the proposed duty of care should be recognized in law.

[346] In *Healey v. Lakeridge Health Corp*., [2006] O.J. No. 4277, the plaintiff was the proposed representative plaintiff in a class action against a hospital and a respirologist. The plaintiff sought to represent a class of persons who were exposed to tuberculosis by reason of their contact with an individual or with other persons who had been in contact with him. Cullity J., who heard the motion for certification, addressed the question of whether there was a sufficiently proximate relationship between the plaintiff, who was not a patient at the hospital, and the hospital to justify imposition of a *prima facie* duty of care owed by the hospital to the plaintiff. Cullity J. noted at paras. 43 and 68 that "there is no doubt that hospitals and physicians can owe duties of care to persons who suffer harm as a foreseeable consequence of a breach of duty owed to a patient" and that "a breach of duty owed to one person may, itself, breach a duty of care owed to others".

[347] In *Paxton*, Feldman J.A. noted in the passage I have quoted that in cases where a duty of care was owed by a doctor to a non-patient third party for harm arising out of the doctor's treatment of a patient, the nature of the doctor's duty of care to the third party and the legal basis for imposing a duty of care were not fully developed. Feldman J.A., when she made this observation, also referred at footnote 11 to the discussion of these cases and others by Cullity J. in *Healey*. I am not satisfied that the proposed duty of care owed by a physician to a patient's close family member who was informed about and involved with the patient's care is one which falls within an established category of relationships (or a category that is analogous to an established category) giving rise to a duty of care.

[348] Where a proposed duty of care does not fall within an established category (or one that is analogous), it is necessary to proceed with the two-stage *Anns/Cooper* analysis to determine whether the proposed duty of care should be recognized in law.

[349] The first stage of the analysis involves a two-part inquiry into whether (a) the harm that occurred was the reasonably foreseeable consequence of the defendant's act; and (b) sufficient proximity existed between the plaintiff and the defendant, based on factors arising from the relationship between the parties, to render the recognition of a duty just and fair: *Design Services Ltd. v. Canada* (2008), 293 D.L.R. (4th) 437 at paras. 48-50 (S.C.C.).

[350] In *Syl Apps Secure Treatment Centre v. B.D.*, [2007] 3 S.C.R. 83 the Supreme Court of Canada addressed the inquiry into reasonable foreseeability and proximity at the first stage of the *Anns/Cooper* analysis and held:

> The basic proposition underlying "reasonable foreseeability" is that everyone "must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour" (*Donahue v. Stevenson*, [1932]

> A.C. 562 (H.L.), per Lord Atkin, at p. 580). The question is whether the person harmed was "so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected" (*Donahue v. Stevenson*, at p. 580).
>
> There must also be a relationship of sufficient proximity between the plaintiff and the defendant. The purpose of this aspect of the analysis was explained by Alan Linden and Bruce Feldthusen in *Canadian Tort Law* (8th ed. 2006) as being to decide "whether, despite the reasonable foresight of harm, it is unjust or unfair to hold the defendant subject to a duty because of the absence of any relationship of proximity between the plaintiff and the defendant (p. 304).

[351] Policy considerations are relevant not only at the second stage of the analysis, but also at the first stage when determining whether a relationship of sufficient proximity exists between the parties. As explained in *Syl Apps* at para. 32:

> This means, the Court [in *Cooper v. Hobart*, [2001] 3 S.C.R. 537] recognized, that policy is relevant at both the "proximity" stage and the "residual policy concerns" stage of the *Anns* test. The difference is that under proximity, the relevant questions of policy relate to factors arising from the particular relationship between the plaintiff and the defendant. In contrast, residual policy considerations are concerned not so much with "the relationship between the parties, but with the effect of recognizing a duty of care on other legal obligations, the legal system and society more generally".

[352] With respect to the inquiry at the first part of the first stage of the *Anns/Cooper* analysis, the question is whether the plaintiff has offered facts to persuade the court that the risk of the type of damage that occurred was reasonably foreseeable to the class of plaintiff that was damaged. The foreseeability question must be framed in a way that links the impugned act to the harm suffered by the plaintiff. See *Rankin (Rankin's Garage & Sales) v. J.J.*, 2018 SCC 19 at paras. 24-25.

[353] The defendants submit that it was not reasonably foreseeable to either of them that Mr. DeGuerre would experience an arrest before they had a chance to communicate their decision with respect to his code status to the plaintiff. The defendants rely upon the evidence of Dr. Livingston and Dr. Sinuff that it is very difficult to predict when a patient's death will actually occur, even if it is imminent.

[354] I do not agree that it was not reasonably foreseeable that Mr. DeGuerre would experience an arrest before Dr. Chapman or Dr. Livingston were able to communicate to the plaintiff that they had made a medical decision that CPR would not be offered as a treatment option for her father. Dr. Chapman and Dr. Livingston testified that the DNR order was written in order for them to discharge the duty of care owed to Mr. DeGuerre and to preclude the administration of CPR according to the standing offer in Sunnybrook's policy to initiate CPR in case of cardiac or respiratory arrest. Dr. Livingston and Dr. Chapman testified that Mr. DeGuerre's death was imminent. Although neither Dr. Chapman nor Dr. Livingston expected that Mr. DeGuerre would

experience an arrest within hours, it was reasonably foreseeable that he could suffer from an arrest at any time, given his health condition. It was reasonably foreseeable that the plaintiff would visit her father on September 22, 2008, and that her father would suffer from an arrest in her presence. It was reasonably foreseeable that Mr. DeGuerre could die in the plaintiff's presence in circumstances where the plaintiff had expected CPR to be administered on a "full code" basis.

[355] In order the plaintiff to satisfy the *Anns/Cooper* test at the first part of the first stage of the analysis, she must show that the type of damage that occurred to the class of plaintiff who was injured was reasonably foreseeable. The impugned act must be linked to the harm suffered by the plaintiff. The type of damage that the plaintiff claims occurred is, as it is described in *Mustapha v. Culligan*, 2008 SCC 27, psychological disturbance which is "serious and prolonged and rise[s] above the ordinary annoyances, anxieties and fears that people living in society routinely, if sometimes reluctantly, accept". The class of plaintiff of which Mr. DeGuerre's daughter is a member is the class of Mr. DeGuerre's close family members who knew that CPR had been offered and that consent to administration of CPR was given. The impugned act is Dr. Chapman's decision not to administer CPR to Mr. DeGuerre when he was suffering from a respiratory arrest (because of the defendants' medical decision that to do so would be medically inappropriate) in circumstances where the plaintiff had previously been informed that CPR would be offered as a treatment and, as her father's substitute decision-maker, she had consented to administration of this treatment on a "full code" basis.

[356] The plaintiff has adduced evidence of facts which persuades me that the risk of the type of damage from the defendants' impugned act that the plaintiff claims occurred, serious and prolonged psychological disturbance, was reasonably foreseeable damage to the class of plaintiffs which included the plaintiff.

[357] The proximity analysis requires the court to determine whether there was a sufficiently close and direct relationship between the parties that the defendant was under a duty to be mindful of the plaintiff's interest. The proximity inquiry involves examination of the relevant factors arising from the relationship between the plaintiff and the defendant including the expectations, representations, reliance, and the property or other interests involved as between the parties. See *Rankin* at para. 23.

[358] The plaintiff submits that the defendants were in a relationship with her by which they owed her a legal duty to be mindful of her interest, and that this duty was not in any way inconsistent with the defendants' duty to their patient.

[359] With respect to the proximity inquiry undertaken at the second part of the first stage of the *Anns*/*Cooper* analysis, in *Paxton* the Court of Appeal addressed at paras. 66, 68 and 76 the policy considerations that are implicated in the physician-patient relationship in the context of whether a duty of care was owed to the future child of a physician's patient:

> If a doctor owes a duty of care to a future child of a female patient, the doctor could be put in an impossible conflict of interest between the best interests of the

> future child and the best interests of the patient in deciding whether to prescribe a teratogenic drug or to give the patient the opportunity to choose such a drug.
>
> [...]
>
> These conflicting duties could well have an undesirable chilling effect on doctors. A doctor might refuse to prescribe Accutane to a female patient, even where it is indicated and the patient agrees to fully comply with the PPP [a manufacturer developed program that doctors are to implement before prescribing the drug to women of childbearing potential], in order to avoid the risk of a lawsuit brought by a child who is conceived despite compliance with the PPP or because the mother fails to comply with the PPP. Thus, imposing a duty of care on a doctor to a patient's future child in addition to the existing duty to the female patient creates a conflict of duties that could prompt doctors to offer treatment to some female patients in a way that might deprive them of their autonomy and freedom of informed choice in their medical care.
>
> [...]
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> The conflicting duties that would be owed by a doctor to a female patient and to her future child (whether conceived or not yet conceived) and prescribing medication to the female patient, together with the indirect relationship between a doctor and a future child, reflect two aspects of the same reality. Because the woman and her fetus are one, both physically and legally, it is the woman whom the doctor advises into makes the treatment decisions affecting herself and her future child. The doctor's direct relationship and duty are to the female patient. That relationship and that duty of care prevent a relationship of the requisite proximity between the doctor and future child because the interests of the mother and her future child may possibly conflict, as noted by the Supreme Court of Canada in *Winnipeg Child and Family Services*, at p. 949.

[360] Similarly, in *Bovingdon v. Hergott*, 2008 ONCA 2, leave to appeal refused [2008] S.C.C.A. No. 92, the defendant physician prescribed a fertility drug to his patient without providing full information to her regarding the increased risk of having twins, the risk of premature birth with twins, and the possible problems related to premature delivery. The mother and her twins sued the physician for the disabilities the twins suffered as a result of premature birth. The Court of Appeal held that the physician could not owe a co-extensive duty to both the children and their mother. To recognize co-extensive duties could create a potential conflict of interest for the physician. The Court of Appeal held that the policy of ensuring that women's choice of treatment be preserved supports the conclusion that the doctor owed no legal duty to the unborn children in that case. See *Bovingdon* at paras. 68, 70, 71.

[361] In *Syl Apps*, a child was apprehended by the Children's Aid Society and placed in foster care in circumstances where the child had alleged that her parents had physically and sexually abused her. The child was sent to a treatment centre where she was treated by a social worker/case coordinator. The child, with her consent, was made a permanent ward of the Crown.

The child's parents, grandparents and three siblings sued the treatment centre and the social worker, and their allegations revolved around their assertion that the child was treated by the treatment center and the social worker as if her parents had physically and sexually abused her, that this was negligent conduct, and that the negligence caused the child not to return to her family, thereby depriving the family of a relationship with her. At the Court of Appeal for Ontario, the majority held that the treatment centre and the social worker may owe a duty of care to the family of the child, and that the action should proceed to trial. Sharpe J.A. in his dissenting reasons held that the potential for conflicting duties as well as the residual policy considerations negated a duty of care. The question for the Supreme Court of Canada was whether, on the facts as pleaded, the treatment centre and the social worker owed the child's family a duty of care.

[362] Abella J., writing for the court, agreed with Sharpe J.A. that to recognize a legal duty to the family of the child in the care of the treatment centre and the social worker would pose a real risk that a secure treatment centre and its employees would have to compromise their overriding duty to the child. Abella J. also agreed with Sharpe J.A. that "the duty of care pertaining to the relationship between children in need of protection and those who are charged with their care should be clearly defined on a categorical basis, rather than being left in a fluid state to be resolved on a case-by-case basis" and held that the new duty of care should not be recognized. See *Syl Apps* at paras. 20-21.

[363] Abella J. held at para. 41 that the deciding factor for her in the proximity analysis was the potential for conflicting duties because imposing a duty of care on the relationship between the family of the child in care and that child's court-ordered service providers creates a genuine potential for serious and significant conflict with the service providers' transcendent statutory duty to promote the best interests, protection and well-being of the children in their care. Abella J. held that the fact that the interests of the parents and of the child may occasionally align does not diminish the concern that in many, if not most of the cases, conflict is inevitable.

[364] Abella J. addressed at para. 50 the policy implications of holding that the service providers owe a corresponding duty of care to the family of a child in care:

> If a corresponding duty is also imposed with respect to the parents, service providers will be torn between the child's interests on the one hand, and parental expectations which may be unrealistic, unreasonable or unrealizable on the other. This tension creates the potential for a chilling effect on social workers, who may hesitate to act in pursuit of the child's best interests for fear that their approach could attract criticism - and litigation - from the family. They should not have to weigh what is best for the child on the scale with what would make the family happiest, finding themselves choosing between aggressive protection of the child and a lawsuit from the family.

[365] Abella J. held at paras. 54-55 that the services provided by the treatment centre and the social worker are provided in a treatment context which invokes medical paradigms of confidentiality and privacy and noted that "[n]umerous courts have recognized that a doctor does not owe a duty of care to the parent of his or her patient because that would create a situation of conflicting duties of care". Abella J. held that recognizing a duty to the parents in this context

could result in conflicting duties in the provision of medical treatment to children who have been removed from their parents' custody.

[366] In his dissenting reasons in the Court of Appeal in *Syl Apps*, Sharpe J.A. held at para. 74, citing *Cooper* at para. 44, that if the duty claimed "would *potentially* conflict with the [defendant's] overarching duty" (emphasis added by Sharpe J.A.), proximity is not made out.

[367] The plaintiff submits that it was known to the defendants through her discussions with Dr. Livingstone and the Sunnybrook treatment team that she was advocating for a plan of treatment that respected her father's wish that he receive a full range on resuscitative interventions, through her request that her father be treated as "full code". She submits that the defendants ought to have known that the plaintiff, as a loving daughter and an experienced nurse, had an interest in preventing her father from experiencing a painful death in her presence, and that the defendants owed her a duty of care, compliance with which included not disregarding her decisions as Mr. DeGuerre's substitute decision-maker. The plaintiff submits that the close and direct relationship between her and the defendants was reinforced by the statutory requirements of the *HCCA*, and that she expected Dr. Livingstone to follow the *HCCA* and not change her father's plan of treatment without her consent. The plaintiff contends that she relied on Dr. Livingstone throughout her father's admission at Sunnybrook to adequately care for him and to communicate with her in respect of any material changes in his conditions or expected outcomes.

[368] The defendants accept that Mr. DeGuerre did not have capacity to make treatment decisions and, therefore, in certain respects the *HCCA* was operative. Under s. 21 of the *HCCA*, a person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the incapable person's prior capable wish, if it is known and it is possible to comply with the wish, or in accordance with the incapable person's best interests. The defendants submit that under the *HCCA*, the patient's interests are paramount to those of the substitute decision-maker.

[369] The defendants submit that, like in *Syl Apps*, policy considerations weigh against recognizing a duty of care owed by the defendants to the plaintiff, as their patient's daughter or as his substitute decision-maker, to be mindful of the plaintiff's interests. The defendants submit that imposition of such a duty would have required them to either (i) communicate with the plaintiff prior to deciding not to offer CPR as a treatment option and writing a DNR order, or (ii) obtain the plaintiff's consent prior to writing a DNR order. The defendants contend that to recognize a duty of care in such circumstances would have an undesirable chilling effect on the way in which physicians treat their patients, in particular, incapable patients. They submit that recognition of such a duty would force physicians to attempt to balance the best interests of their patient while, at the same time, considering the corresponding duty to the patient's substitute decision-maker which might require them to act in a way to avoid a lawsuit. The defendants submit that this would unacceptably interfere with the duty of care owed by a physician to his or her patient.

[370] I accept that recognition of such a duty of care owed by a physician to a family member or substitute decision-maker of an incapable patient would have the potential to put the physician

in a conflict of interest because the wishes of the close family member or substitute decision-maker may not align with the physician's medical opinion of what is in the patient's best interests. The imposition of a duty of care owed by a physician to a patient's family members or a substitute decision-maker might influence the physician, in attempting to comply with competing and potentially conflicting duties of care, to act in ways in which he or she would not otherwise act and put the patient at risk of harm. The dissenting decision of Sharpe J.A. of the Court of Appeal for Ontario and the decision of Abella J. of the Supreme Court of Canada in *Syl Apps* are authorities which support the conclusion that where the duty claimed would potentially conflict with the defendant's overarching duty (in this case the duty owed by the defendants to their patient, Mr. DeGuerre), proximity is not made out.

[371] I conclude that proximity is not made out because a duty of care owed to a person in the position of the plaintiff would potentially conflict with the doctors' overarching duty of care owed to their patient. The plaintiff has failed to establish that the defendants owed her a *prima facie* duty of care to be mindful of her interests as her father's daughter who was closely involved with his care or as his substitute decision-maker. Unless a duty of care is found, no liability will follow: *Rankin* at para. 17.

[372] The defendants submit in the alternative that if a physician owes a duty of care to the patient's family member or substitute decision-maker, the scope of the duty should be limited such that it only operates in circumstances where the duty would not put the physician in a position where compliance with this duty may conflict with the physician's primary duty to his or her patient. The defendants submit that the scope of the duty of care should be limited such that it does not interfere with the physician's role as a healthcare practitioner to rely on his or her clinical judgment when determining what treatments are indicated for patients.

[373] In support of this submission, the defendants rely on the following passage from the decision of the Supreme Court of Canada in *Ryan v. Victoria (City)*, [1999] 1 S.C.R. 201 at paras. 25-26:

> In addition to negating a duty of care entirely, policy considerations may also serve to "limit" the "scope" of an existing duty under the second step of the *Anns/Kamloops* test. It is necessary to be clear about what this means. The purpose of the *Anns/Kamloops* test is to establish the existence of a legal duty, not to determine the standard of care required to establish liability. Policy considerations do not give rise to "greater" or "lesser" duties in different cases. A duty of care either exists or it does not. As discussed below, when the language of "duty" is framed in terms of its degree or content, what is really at issue is not duty but the applicable standard of care. While the distinction is obvious, courts from time to time seem to lose sight of that principle. [Citations omitted]
>
> The "scope" of a duty of care can be "limited" under the *Anns/Kamloops* test only in the sense that the duty will arise in certain situations and not in others. Such limitations may be based on broad policy considerations such as efficiency and economic fairness or on specific principles of law which operate in particular cases. The ultimate determination of whether a duty of care arises or not is an

> issue properly framed within the second step of the *Anns/Kamloops* test and its answer depends on the factual and legal context of each case. In that sense, the test is highly flexible.

[374] I regard the defendants' alternative submission as one which goes to the degree or content of what would be required to comply with the duty of care, in other words, the standard of care required to establish liability. If I had held that the defendants owed a duty of care to the plaintiff to be mindful of her interests, I would not rely on policy considerations to limit the scope of the duty. It would still be necessary to address the content of the applicable standard of care, whether the defendants breached the duty by failing to observe the applicable standard of care, whether the plaintiff suffered psychological injuries which qualify as damage, and whether the damage was caused by the defendants' breach of their duty of care.

b. <u>If the defendants owed a duty of care to the plaintiff, did they fail to meet the applicable standard of care?</u>

[375] I next address the question of whether, if I erred in deciding that the defendants did not owe a duty of care to the plaintiff, the defendants failed to meet the applicable standard of care.

[376] A duty of care owed by the defendants to the plaintiff could not conflict with their paramount duty of care owed to their patient, Mr. DeGuerre. The standard of care that applied on September 22, 2008 required the defendants to make a medical decision as to whether CPR should not be offered as a treatment option because it would almost certainly not benefit him and would only cause him harm. If they met the applicable standard of care, the defendants were entitled to decide not to offer CPR as a treatment option. If a duty of care was owed to the plaintiff, the applicable standard of care could not be one that would require the defendants to offer and administer CPR to Mr. DeGuerre, a treatment that they had decided was medically inappropriate. This would require them to act in a way that would conflict with their duty to their patient.

[377] In relation to the standard of care that applied on September 22, 2008 with respect to the duty of care owed by the defendants to Mr. DeGuerre, I have held that the plaintiff has not proven that the defendants failed to meet the applicable standard of care by failing to effectively communicate to her, as her father's substitute decision-maker, either that they were considering making a DNR order, or that such an order had been made and CPR would not be offered to her father. If I had found that the defendants owed a duty of care to the plaintiff, I would reach the same conclusion and hold that the plaintiff has failed to prove that the defendants failed to meet the applicable standard of care.

c. <u>Did the plaintiff suffer psychological injuries which qualify as compensable damage?</u>

[378] Although I have held that the defendants did not owe a duty of care to the plaintiff, I go on to address the issues that arise with respect to the plaintiff's claim for damages. The first question is whether the plaintiff has proven that she suffered compensable damage.

[379] In *Mustapha*, the Supreme Court of Canada described the nature of psychological disturbance that rises to the level of compensable personal injury at para. 9:

> This said, psychological disturbance that rises to the level of personal injury must be distinguished from psychological upset. Personal injury at law connotes serious trauma or illness: [citations omitted]. The law does not recognize upset, disgust, anxiety, agitation or other mental states that fall short of injury. I would not purport to define compensable injury exhaustively, except to say that it must be serious and prolonged and rise above the ordinary annoyances, anxieties and fears that people living in society routinely, if sometimes reluctantly, accept. The need to accept such upsets rather than seek redress in tort is what I take the Court of Appeal to be expressing in its quote from *Vanek v. Great Atlantic & Pacific Co. of Canada* (1999), 48 O.R. (3d) 228 (Ont. C.A.): "Life goes on" (para. 60). Quite simply, minor and transient upsets do not constitute personal *injury*, and hence do not amount to damage. [Emphasis in original]

[380] In *Saadati*, the Supreme Court of Canada elaborated on this description at paras. 37-38:

> None of this is to suggest that mental injury is always as readily demonstrable as physical injury. While allegations of injury to muscular tissue may sometimes pose challenges to triers of fact, many physical conditions such as lacerations and broken bones are objectively verifiable. Mental injury, however, will often not be as readily apparent. Further, and as *Mustapha* makes clear, mental injury is not proven by the existence of mere psychological *upset*. While, therefore, tort law protects persons from negligent interference with their mental health, there is no legally cognizable right to happiness. Claimants must, therefore, show much more - that the disturbance suffered by the claimant is "serious and prolonged and rise[s] above the ordinary annoyances, anxieties and fears" that come with living in civil society (*Mustapha*, at para. 9). To be clear, this does not denote distinct legal treatment of mental injury relative to physical injury; rather, it goes to the prior legal question of what constitutes "mental injury". Ultimately, the claimant's task in establishing a mental injury is to show the requisite degree of disturbance (although not, as the respondents say, to show its classification as a recognized psychiatric illness).
>
> Nor should any of this be taken as suggesting that expert evidence cannot assist in determining whether or not a mental injury has been shown. In assessing whether the claimant has succeeded, it will often be important to consider, for example, how seriously the claimant's cognitive functions and participation in daily activities were impaired, the length of such impairment and the nature and effect of any treatment [citation omitted]. To the extent that claimants did not adduce relevant expert evidence to assist triers of fact in applying these and any other relevant considerations, they run the risk of being found to have fallen short. As Thomas J. observed in *van Soest* (at para. 103), "[c]ourts can be informed by expert opinion of modern medical knowledge", "without needing to address the question whether mental suffering is a recognisable psychiatric illness or not". To

> be clear, however: while relevant expert evidence will often be helpful in determining whether the claimant has proven a mental injury, it is not required as a matter of law. Where a psychiatric diagnosis is unavailable, it remains open to a trier of fact to find on other evidence adduced by the claimant that he or she has proven on a balance of probabilities the occurrence of mental injury. And, of course, it also remains open to the defendant, in rebutting a claim, to call expert evidence establishing that the accident cannot have caused any mental injury, or at least *any* mental injury known to psychiatry. While, for the reasons I have given, the lack of a diagnosis cannot on its own be dispositive, it is something that the trier of fact can choose to weigh against evidence supporting the existence of mental injury.

[381] The plaintiff testified that after all these years, she is still in disbelief over what occurred. She was very close to her father and grieved his loss but internalized a lot of guilt for not being able to protect him, thinking she could have prevented what happened by staying overnight at the hospital on September 21. She still thinks about the events and some nights she is not able to sleep because memories of the events creep in, including memories of her father and the events that occurred at the hospital. She had no trouble sleeping before the September 22, 2008 incident, although now she does. The plaintiff testified that her sleeping problems are not constant but come and go. She testified that preparing for significant steps in the litigation would lead to memories that interfered with her ability to sleep. The plaintiff described herself as a "sentimental person", who would cry even watching an old movie, but testified she becomes teary more so than before especially if she thinks about her father.

[382] The plaintiff testified that she sought help from professionals for her mental health. The first time that the events surrounding her father's death are mentioned in her family physician's chart is in May 2011. She saw a psychologist, Dr. Fraser, for a number of sessions. There was a delay of a year for the plaintiff to obtain a referral from her family doctor to a psychiatrist. The plaintiff saw a psychiatrist, Dr. Mohammed Sohail, on August 9, 2012 who diagnosed the plaintiff with "complicated grief reaction to her father's death". The plaintiff testified that Dr. Sohail declined to continue treatment while she was still involved in litigation and offered to treat her once the litigation was over.

[383] The plaintiff found Dr. Anna Baranowsky, a clinical psychologist, and began to see her as a patient. The plaintiff began to see Dr. Baranowsky weekly in 2013 and these sessions continue to the present. The plaintiff has found her treatment with Dr. Baranowsky to be helpful.

[384] The plaintiff called Dr. Baranowsky to give expert evidence as a treating physician with respect to the damage suffered by the plaintiff. Dr. Baranowsky is a registered clinical psychologist licensed to practice in Ontario and has been in private practice since 1998. She specializes in the area of trauma. Dr. Baranowsky was qualified as a participant expert to give evidence about the impact of the events surrounding her father's death on the plaintiff.

[385] Dr. Baranowsky testified that as a result of the circumstances in which the plaintiff's father died on September 22, 2008, the plaintiff suffered trauma. She testified that throughout their sessions, the source of the plaintiff's injury and trauma comes back to the events of that

evening. Dr. Baranowsky listed symptoms of lasting trauma including loss of sleep and depressed mood, and she found that the plaintiff experienced these symptoms. Dr. Baranowsky testified that the plaintiff is a strong person who showed signs of resiliency, yet the pain and suffering from this incident stand out and endure. She testified that the plaintiff has encountered a number of other setbacks in her life and difficult experiences which she brought to their counselling sessions, particularly with respect to her employment, and these have resolved. Dr. Baranowsky testified that the plaintiff continues to experience the effects of her reaction to the events of September 22, 2008, but she cannot say whether these continue at the same frequency as in the past. Dr. Baranowsky testify that her mandate was not to diagnose the plaintiff but, instead, to provide her with support and therapy.

[386] On cross-examination, Dr. Baranowsky agreed that she had discussed with the plaintiff on numerous occasions other sources of stress including the police complaints the plaintiff filed concerning these events, stresses at work, in particular, bullying and harassment by managers, the plaintiff's retirement, a physical assault, sexual assault and other unwanted sexual experiences, a delayed CT scan at Sunnybrook ordered by another physician, and not having a lot of close friends or people in her life. Dr. Baranowsky agreed that her opinion of how the DNR decision impacted the plaintiff was based purely on the plaintiff's self-reporting. Dr. Baranowsky agreed that she had not seen Mr. DeGuerre's medical records, spoken with his clinical team, or seen the statement of defence or transcripts from the discoveries of this action. What she heard about the events at Sunnybrook came from the plaintiff, five years after the fact. Dr. Baranowsky agreed that she took what the plaintiff had said at face value and did not weigh the stress of the litigation against the underlying events. She did not conduct an analysis to understand how the various stressors that she described impacted the plaintiff. Dr. Baranowsky agreed that she did not regard her role as a support person for the plaintiff to be unbiased and objective, and this was one of the reasons why she would not have felt comfortable acting as an independent expert in this case.

[387] Dr. Baranowsky was referred to her notes and records and she agreed that she recorded in one note that the plaintiff had described herself as experiencing "complicated bereavement" as a result of the "presenting problem" described as "Father died at Sunnybrook as a result of DNR that doctors assigned without permission". It is clear from this record that the plaintiff's "complicated bereavement" did not simply follow from the loss of her father but focused on the fact that he died in circumstances where he was not offered what she considered to be needed lifesaving support to which he was entitled. Dr. Baranowsky agreed that on other occasions, she recorded that the plaintiff had described herself as suffering from grief from her father's loss, and that she misses him dearly.

[388] Dr. Baranowsky agreed that grief was normal, and she was asked about symptoms of normal grief which may be apparent from the loss of a loved one. She agreed that these symptoms may include depressed mood, numbness, yearning for the deceased loved one, anger, sleeplessness, guilt, fatigue, and poor concentration. She agreed that the intensity and duration of grief can depend on many factors, and that normal grief may last for months or even several years, especially when the deceased loved one is very close. Dr. Baranowsky agreed that even after many years, waves of grief can pop up unexpectedly, and reminders of the deceased loved one may lead to sadness and grief.

[389] The defendants submit that the evidence shows that the plaintiff has been suffering from a grief reaction from the death of a very close loved one, and that grief is not compensable in law. In support of this submission the defendants cite *Logan v. Lovesy*, [1983] O.J. No. 262 where the court held that "neither sorrow nor the immediate emotional response to a stressful situation attracts damages" and *Scamolla v. Tenax Ltd.*, 1995 CarswellOnt 2894 (C.A.) in which damages for what the court described as "the enormous grief and mental anguish" of family members of the deceased were held not to be recoverable as a matter of law. They also submit that stress associated with litigation is not recoverable.

[390] These authorities do not stand for the proposition that psychological disturbance associated with a complicated grief reaction from the loss of a beloved family member will not, under any circumstances, qualify as compensable damage as described in *Mustapha*. The nature of the disturbance in each case must be considered in order to determine whether it rises to the level of personal injury as opposed to ordinary, minor, and transient psychological upset that falls short of injury.

[391] The plaintiff testified that her sadness and guilt, and the symptoms associated with the circumstances in which she lost her father have been ongoing, and still continue, and I accept her evidence in this regard. Although Dr. Baranowsky was challenged on cross-examination in respect of certain parts of her evidence, I do not find that she failed to provide truthful evidence when she testified about how the plaintiff had described her mental and emotional state during the counselling sessions. I accept Dr. Baranowsky's evidence of how the plaintiff described her ongoing symptoms and that the plaintiff attributed her feelings of sadness and sorrow to the events of September 22, 2008, although Dr. Baranowsky accepted that other stressful situations, including this litigation, have also contributed to the plaintiff's mental health conditions over the years. Dr. Baranowsky was candid that she was not an objective expert and that she did not offer a clinical diagnosis of the plaintiff's mental health.

[392] Dr. Souhail provided a diagnosis of "complicated grief reaction to her father's death". He did not give evidence at trial to explain how a "complicated" grief reaction differs from an uncomplicated or normal grief reaction.

[393] I accept the plaintiff's evidence in which she described her feelings and her mental health over the years since her father died. The grief which the plaintiff has experienced goes beyond normal grief, in the way it was described by Dr. Baranowsky on her cross-examination. I accept that the symptoms which the plaintiff described are serious, and they have continued far longer than a period of several years. I am satisfied that the plaintiff has met her burden of proving that she has suffered, and continues to suffer, from profound sadness and related symptoms, including sleep difficulties, associated with a grief reaction to her father's death and the circumstances in which it happened. The conditions which the plaintiff describes rise above the ordinary annoyances, anxieties and fears that people in society routinely accept.

[394] The plaintiff has proven that the nature of her injury rises to the level of compensable damage.

d. Did the plaintiff suffer damage which was caused, in fact and in law, by the defendants' breach of duty?

[395] I have decided that the defendants did not owe a duty of care to the plaintiff and, if a duty of care was owed, they did not fail to meet the applicable standard of care. If I am held to have erred in so deciding, I go on to consider whether the plaintiff has proven that the damage she suffered was caused, in fact and in law, by the defendants' breach of duty.

[396] The defendants submit that if they owed a duty of care to the plaintiff, she has failed to prove that their conduct was the factual and legal cause of any loss she suffered. They submit that the plaintiff experienced various stressors, including the litigation and its costs, and that the plaintiff has failed to prove that the defendants' breach of duty by not administering CPR was the cause in fact of her damage. I disagree.

[397] Although the plaintiff acknowledged that she suffered from other stressful events during her life, and she and Dr. Baranowsky acknowledged that they discussed other stressors during the course of the counselling sessions, both the plaintiff and Dr. Baranowsky testified that the events which the plaintiff experienced on September 22, 2008, when her father died in her presence while she was frantically trying to save his life and he was not offered what she regarded as lifesaving support which he was entitled to receive, were the main cause of the psychological injuries of which the plaintiff complains. It was clear from the plaintiff's evidence that the trauma that she experienced on September 22, 2008, and from which she has continued to suffer, was caused by the decision of the health care team at Sunnybrook not to administer CPR to Mr. DeGuerre when he was experiencing respiratory arrest because of the DNR order written by the defendants and Dr. Chapman's bedside direction. This evidence supports my finding that the plaintiff would not have suffered serious psychological injury had CPR been administered to her father on September 22, 2008, even if it did not save his life.

[398] The defendants also submit that the plaintiff has failed to establish that the outcome would have been any different if she had been consulted prior to the refusal to provide resuscitation or if resuscitation had indeed been provided. The defendants rely upon the plaintiff's evidence that even if the defendants had expressed their views with respect to the imminence of Mr. DeGuerre's death, and that providing resuscitative measures would almost certainly not have been a benefit and only increased his suffering, she would still not have consented to their decision not to offer CPR as a treatment option. The defendants submit that, in the emergency situation which would then have ensued, Dr. Chapman would have made the same decision not to perform CPR or, if he had acquiesced and performed CPR, there is no evidence to suggest that the plaintiff would not have experienced the same reaction to her father's death.

[399] I do not accept these submissions. I must decide the question of whether the plaintiff has proven causation in fact if the defendants owed the plaintiff a duty to administer CPR to her father on September 22, 2008. When I consider the evidence in a robust, common sense fashion, I am satisfied that the plaintiff has proven that the denial of CPR at her father's bedside in circumstances where she had been told that CPR would be administered on a "full code" basis,

which led to his death in her presence while she was desperately trying to save his life, was a necessary cause of her serious psychological injury.

[400] I also conclude that the defendants' failure to administer CPR to Mr. DeGuerre caused the plaintiff's damage in law and that the damage is not too remote to warrant recovery.

[401] In *Mustapha*, the Supreme Court of Canada held that the plaintiff's psychiatric injury from seeing dead flies in a bottle of water supplied by the defendants was too remote to be recoverable because the defendants would not reasonably have foreseen that a person of ordinary fortitude would suffer serious and prolonged psychiatric injury from the breach. Consequently, the plaintiff was unable to recover, even though he had proven that the defendant's breach caused his psychiatric injury. The Supreme Court of Canada described at para. 13 the degree of probability that would satisfy the reasonable foreseeability requirement of the remoteness inquiry as a "real risk", that is, "one which would occur to the mind of a reasonable man in the position of the defendant ... and which he would not brush aside as far-fetched". In judging whether the personal injury was foreseeable, one looks at a person of ordinary fortitude, unless the evidence demonstrates that the defendant knew that the plaintiff was of less than ordinary fortitude: *Mustapha* at paras. 14-17.

[402] In this case, the defendants knew that the plaintiff had expressed that the code status that was to apply to her father on the onset of cardiac or respiratory arrest was "full code". They had decided that Mr. DeGuerre was close to death, and that the onset of respiratory arrest was expected soon. The plaintiff frequently visited her father, almost every day. The defendants knew that they had decided to make the DNR order to satisfy their duty to their patient without first consulting with the plaintiff as their patient's substitute decision-maker. The defendants would have known that the plaintiff would expect CPR to be administered to her father upon the onset of respiratory arrest if they were not able to discuss with her, in advance, that they had made a medical decision not to offer CPR as a treatment option.

[403] There was a real risk, one which could not be brushed off as far-fetched, that a person of ordinary fortitude in the plaintiff's position would experience significant and serious shock and trauma that could be prolonged, if she witnessed her father suffering and dying from respiratory arrest in circumstances where (i) she reasonably expected that CPR would be administered on a full code basis, (ii) she was crying for help and desperately trying to save her father's life, and (iii) CPR was being withheld by health care providers at the direction of the responsible physician.

[404] If, contrary to my decision, plaintiff had proven that the defendants owed her a duty of care and they failed to meet the required standard of care, I would conclude that the plaintiff has shown that her damages are recoverable in law and not too remote.

[405] The defendants are not liable to the plaintiff for breach of a duty of care owed by the defendants to the plaintiff.

Are the defendants liable to the plaintiff for breach of fiduciary duty?

[406] The plaintiff submits that the defendants owed her an independent fiduciary duty to bring new information to Mr. DeGuerre's attention when they decided to change his treatment plan and, due to Mr. DeGuerre's incapacity, this information should have been provided to the plaintiff as his substitute decision-maker. The plaintiff submits that the hallmarks of a fiduciary duty are evident on the evidence in this case because (i) there was a scope of discretion in the defendants' actions; (ii) the defendants had the ability to unilaterally exercise that discretion (shown by Dr. Chapman's ability to prevent hospital staff from assisting to resuscitate Mr. DeGuerre); and (iii) the plaintiff was vulnerable vis-à-vis the defendants' decision-making. The plaintiff cites *Frame v. Smith*, [1987] 2 S.C.R. 99 at p. 136.

[407] The defendants submit, citing *Alberta v. Elder Advocates of Alberta Society*, 2011 SCC 24 at para. 29, that while the hallmarks identified in *Frame* are useful in explaining the source of fiduciary duties, they are not a complete code for identifying fiduciary duties, and that further analysis is required to identify whether a fiduciary duty applies in the circumstances of a given case. They submit that, first, the alleged fiduciary must have given an undertaking of responsibility to act in the best interests of a beneficiary. In relation to the required undertaking, the party asserting the duty must be able to point to a forsaking by the alleged fiduciary of the interests of all others in favour of those of the beneficiary, in relation to the specific legal interest at stake. Second, the duty must be owed to a defined person or class of persons who must be vulnerable to the fiduciary because the fiduciary has a discretionary power over them. Third, the claimant must show that the alleged fiduciary's power may affect the legal or substantial practical interests of the beneficiary: *Alberta* at paragraphs 30-35.

[408] With respect to the relationship between a physician and a substitute decision-maker, the physician cannot undertake to put the substitute decision-maker's interests above those of all others. Such an undertaking would, possibly, conflict with the duty of care owed by a physician to his or her patient. The plaintiff does not suggest that the defendants gave up their duty owed to Mr. DeGuerre in favour of a fiduciary duty to act only in the interests of the plaintiff. In this case, the plaintiff was insisting that CPR be administered to her father on a full code basis, and the defendants decided that it be medically inappropriate for them to do so. This is a conflict which makes the imposition on the defendants of a fiduciary duty to act in the best interests of the plaintiff untenable. I find that the plaintiff has failed to show that the defendants undertook to act in her best interests in favour of the interests of their patient, Mr. DeGuerre. This finding is sufficient for me to conclude that the defendants did not owe a fiduciary duty to the plaintiff.

[409] The defendants are not liable to the plaintiff for breach of a fiduciary duty owed to her.

PART IV - DISPOSITION

[410] For these reasons, the plaintiff's action is dismissed.

[411] I encourage the parties to try to reach agreement on costs. If agreement is not reached, the defendants may make written submissions within 30 days. The plaintiff may make responding

submissions within 20 days thereafter. The defendants may make brief reply submissions, if so advised, within 10 days thereafter.

Cavanagh J.

Released: August 20, 2019

CITATION: Wawrzyniak v. Livingstone, 2019 ONSC 4900
COURT FILE NO.: CV-10-409585
DATE: 20190820

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

Elizabeth Gwendolyn Joy Wawrzyniak

Plaintiff

– and –

Donald J. Livingstone Martin G. Chapman

Defendants

REASONS FOR JUDGMENT

Cavanagh J.

Released: August 20, 2019