

COURT OF APPEAL

CANADA
PROVINCE OF QUEBEC
MONTREAL SEAT

No.: 500-09-031214-240
(500-64-000125-240)

DATE: December 19, 2024

**CORAM: THE HONOURABLE ROBERT M. MAINVILLE, J.A.
GUY COURNOYER, J.A.
JUDITH HARVIE, J.A.**

N. G.
APPELLANT – Impleaded Party
v.

McGILL UNIVERSITY HEALTH CENTRE
RESPONDENT – Plaintiff
and
NA. G.
IMPLEADED PARTY – Defendant

JUDGMENT

WARNING: Disclosure and circulation prohibited: The *Code of Civil Procedure* (“C.C.P.”) provides that, except as authorized by the court, no person shall disclose or circulate any information that would allow a party or a child whose interests are at stake in a proceeding in a matter regarding authorization for care to be identified (art. 16 C.C.P.).

[1] The appeal pertains to an application for authorization with respect to care. The care plan proposed by the respondent, the McGill University Health Centre (the “**Institution**”) consists in discontinuing life-sustaining treatment and replacing it with palliative care until the death of the patient in question, Na. G. (the “Patient”), who is the impleaded party in this appeal and is unable to express his wishes due to his state of

health. Despite the refusal of the appellant, the Patient's sister (the "**Sister**" or the **Appellant**"), the Superior Court, which was of the view that this refusal is unjustified, authorized the proposed care plan on the basis that it is in the Patient's interests.¹ The following is a brief background to this case.

I. Background

[2] The Patient, who is currently 77 years old,² is originally from Egypt and has lived in Montreal since the early 1980s. He was married, then separated in the mid-2000s, and subsequently moved in with his Sister. He has an adult son, with whom he has had little contact for the past fifteen years or so.

[3] In 2007, the Patient signed a notarial protection mandate in favour of his Sister, in which he authorized her, in the event of his incapacity, to consent to any care required by his state of health "to the extent that such care is beneficial, despite its effects, or that it is advisable under the circumstances and that the risks involved are not disproportionate to the anticipated benefit",³ but he did not provide more specific directives. Based on the evidence presented, this mandate was not homologated by the Superior Court.

[4] The expert medical reports prepared in 2024 point out that the Patient has an extensive medical history, with the most serious problems dating back to 2016. At that time, he was operated on for a perforated stomach ulcer and was left with a large abdominal hernia, for which he declined surgical treatment. He has had a left femur injury for many years and, in 2023, he fractured his right hip, which left him wheelchair dependent.

[5] Over time, his hernia resulted in a kidney obstruction leading to an accumulation of fluid in his lungs, which necessitated hospitalization in October 2023. He refused to have a tube inserted to clear the kidneys, resulting in the need to undergo dialysis. In the months that followed, he left the various institutions treating him on five occasions, against medical advice. Each time, he had to be re-hospitalized shortly afterwards.

[6] In 2024, he was admitted to intensive care for aspiration pneumonia and atrial fibrillation that made his cardiac condition unstable. He was intubated and put on a mechanical ventilator, but on the advice of his Sister, he refused the proposed medications to treat his cardiac issues because he believed them to be harmful. Through his Sister, he insisted on continued intubation and artificial respiration, notwithstanding that the doctors hoped to extubate him as soon as possible given the risks associated with such treatment, particularly the risk of infection. In mid-April 2024, the Institution

¹ *McGill University Health Centre v. N.G.*, Montreal Sup. Ct., No. 500-64-000125-240, October 3, 2024, Charrette, J.S.C. [judgment under appeal].

² He will turn 78 in early January 2025.

³ Protection Mandate, April 24, 2007, Article II (c).

obtained an order for provisional confinement so as to carry out a psychiatric assessment.⁴

[7] Two psychiatric assessments were performed in the days that followed: (1) the first, by Dr. Lawrence Hoffman, concluded that the Patient was incapable of caring for himself and recommended confinement in an institution for 30 days on the ground that he was a danger to himself; and (2) the second, by Dr. Rahel Wolde-Giorghis, found that the Patient's capacity to care for himself was yet to be determined and recommended confinement in an institution for 30 days for the same reason. On April 22, 2024, the Court of Québec issued an interim order of confinement in an institution, effective until May 8, 2024, the hearing on the confinement in an institution having been postponed until that date.⁵ The Institution ultimately discontinued that application, the Superior Court having made an order with respect to care.⁶

[8] Indeed, in late April 2024, Dr. Jason Shahin, Associate Chief of the Institution's Critical Care Program, prepared a report recommending numerous treatments, including the administration of medication for the Patient's heart, dialysis, drainage of the lungs and occasional use of the ventilator, all this despite the Patient's refusal and that of his Sister, who was acting as his representative, at a time when the Patient's capacity was disputed. In this report, the doctor stated:

[...] The patient and the surrogate decision maker of course have the right to refuse care that they do not want, but the objection to basic standard care while insisting on all other life sustaining measures is illogical and harmful in the long run to the patient. It is clear that basic medications are safer and less invasive than mechanical ventilators.

Other basic medical care has been refused such as suctioning of secretions, antibiotics for a pneumonia, a drainage catheter for water around the lungs, a permanent dialysis catheter, and anticoagulants and angiograms for a heart attack. Most importantly, when the patient was intubated the past few months in the ICU the sister would refuse for the patient to be weaned from the ventilator. I explained on many occasions that leaving the patient intubated unnecessarily would lead him to have more complications such as pneumonias which could lead to death. I explained that to not wean him from the ventilator when in fact he seemed ready to be weaned was unethical as it would lead to unnecessary harm to the patient. In fact, the patient was weaned and eventually liberated from the ventilator and

⁴ *McGill University Health Centre et al. v. N.G.*, Montreal C.Q., No. 500-04-075194-246, April 16, 2024, Bergeron, J.C.Q.

⁵ *Centre universitaire de santé McGill c. N.G.*, Montreal C.Q., No. 500-04-075194-246, April 22, 2024, Philippe, J.C.Q.

⁶ *McGill University Health Centre et al. v. N.G.*, Montreal Sup. Ct., No. 500-17-129660-240, May 7, 2024, Legendre, J.S.C.

discharged to the medical floor the following week. The patient then left the hospital against medical advice (one of 5 times and only to return the following week).⁷

[9] Social worker Antoinette Lemieux, in a report dated that same day, concluded that the Patient was incapable of making decisions regarding the care required by his medical condition, and she pointed out the worrisome lack of compatibility between his expressed desire to remain alive and his refusal to receive several therapies essential for treating his condition. She appended a document in which she indicated the possible existence of unintentional mistreatment of the Patient by his Sister because, among other things, the latter did not understand her obligations and encouraged her brother to refuse essential care while insisting he receive non-indicated care, such as intubation and mechanical ventilation.

[10] In early May 2024, the Superior Court found that the Patient was incapable of consenting to the Institution's proposed care plan and that his behaviour amounted to a categorical refusal to receive the required care. In light of the evidence presented, it ordered a 12-month care plan providing as follows:

- a) Medical (i.e. routine physical monitoring and investigations, full physical evaluations, including blood tests, urine tests, drug screenings, vital signs assessments, radiological assessments (e.g. imaging tests like CXR, ultrasounds and or CT scans), electroencephalograms, and electrocardiograms required to evaluate the Defendant's state of health), psychiatric, psychosocial, and healthcare professional examinations;
- b) Antiarrhythmics, such as digoxin, beta blockers and amiodarone to treat heart arrhythmia as deemed fit by the treating physician;
- c) Positioning and mobilization to avoid bed sores;
- d) Dialysis catheter placement (permanent, or replacement if suspected of being infected);
- e) Drainage of lung water, if needed;
- f) Placement of intravenous catheters, including central lines as per standard of care;
- g) Tracheostomy inserted to progress the Defendant's ventilatory care for the shortest duration required to wean Defendant from the ventilator and/or to provide pulmonary toilet as needed;
- h) Enteral feeding or insertion of a feeding tube (PEG) undertaken for the shortest duration required to adequately provide nutrition to the Defendant;
- i) Use of pain medications in the sole goal of ensuring comfort of the Defendant during the application of the Care Plan;
- j) Carrying out basic ventilatory care while the Defendant is on any mode of ventilatory therapy. This generally involves suctioning the Defendant, changing of ventilatory circuits, and weaning the ventilator as is needed and as directed by the physician;
- k) Treatment of the Defendant's current conditions (i.e. cardiac issues, pulmonary issues, kidney issues, and infections) and complications that may arise from the Care Plan, ensuring that any such modifications or additions to the authorized Care

⁷ Medical Report for an Authorization of Care, dated April 22, 2024.

Plan are made only when necessary and justifiable, without undue alteration or expansion of said Care Plan.⁸

[11] Treatment was begun in accordance with the order, and the Patient's health condition improved, such that the intensive care team was able to extubate him on May 12, 2024. Five days later, he was transferred to a regular medical ward. Unfortunately, in late May 2024, he suffered a seven-minute cardiac arrest due to hypercarbia and, despite being resuscitated, sustained anoxic brain damage as a result. He was readmitted to the intensive care unit, where he was once again intubated and placed on a mechanical ventilator. For nearly three months, in keeping with the court order with respect to care, he received numerous treatments to improve his condition, but to no avail. He never regained consciousness, and his condition worsened. The Institution then suggested to the Patient's Sister that the care plan be modified so as to discontinue life-sustaining treatment and, instead, provide the Patient with palliative care for comfort. On numerous occasions, physicians and other consultants at the Institution spoke to the Sister, who refused to agree to any change in care.

[12] The Sister believed her brother had a chance of recovering. In her view, although his neurological condition was serious, it was not irreversible, since he had allegedly responded to verbal commands given by her in Arabic by squeezing her hand and opening his eyes. She acknowledged that he would have aftereffects, but considered that he nevertheless had the right to live.

[13] In September 2024, Dr. Gordan Samoukovic, a cardiac surgeon and intensive care specialist, prepared a report in which he recommended a re-orientation of the care plan, because the care then being provided was futile and, moreover, was causing unnecessary pain and suffering by prolonging the Patient's agony:

[...] Most recently, 11 weeks ago, the patient suffered a cardiac arrest secondary to hypercarbia. He was reanimated but unfortunately suffered irreversible anoxic brain injury leaving him in a minimally conscious state with no meaningful interaction with the surroundings. He occasionally opens eyes but does not react to stimuli. He has been intubated since; tracheostomy has proven to be technically challenging due to anatomic barriers and has not been performed deviating from standard practices and inflicting pain and discomfort to the patient. Due to intermittent bacteremic state, the patient has not been able to tolerate dialysis without hemodynamic support thus proving that the dialysis itself is causing more harm than benefit overall. The coccygeal wounds have worsened, and osteomyelitis is inevitable, making the medical team to believe that he is constantly in an extreme degree of pain and discomfort. The nasal septum has started to necrose from continuous instrumentation.

[...]

⁸ *McGill University Health Centre et al. v. N.G.*, Montreal Sup. Ct., No. 500-17-129660-240, May 7, 2024, Legendre, J.S.C.

As much, as the medical team had made all efforts to provide adequate care to the patient with the goal of recovery, unfortunately, mortality in this case is now inevitable and the therapeutic options have become futile and are resulting in harm and prolongation of pain and suffering.⁹

[Underlining added]

[14] Dr. Samoukovic recommended the application of the following care plan (“**Care Plan**”), until the Patient’s death, notwithstanding that this plan will inevitably lead to the Patient’s death in the near future:

1. Cessation of resuscitative efforts, including vasoactive medications, pacing and cardioversion;
2. Cessation of ventilatory support;
3. Cessation of all transfusion, including blood products and albumin;
4. Cessation of renal replacement therapy (dialysis);
5. Administration of analgesia and narcotics/sedatives to alleviate pain and respiratory distress;
6. Management of secretions with scopolamine;
7. Cessation of antimicrobial therapy;
8. Continuation of feeding.¹⁰

[15] It is his view that the Patient’s Sister does not understand the gravity of the situation and the futility of the care currently being provided.

[16] Another report, prepared by Dr. Liam Durcan, a neurologist, indicated the Patient’s grim neurological prognosis:

As outlined above, this man has suffered an anoxic injury and, despite aggressive and appropriate medical care, has not had improvements in his condition, now three months post arrest. His exam today does not meet criteria for ‘Minimally Conscious State’, nor has he had changes verified by any staff of MCS (despite being under constant surveillance). His course in the last three months—the absence of any signs of improvement beyond persistent vegetative state (or post-coma unresponsiveness) in the context of his inciting event, is perhaps the strongest indicator of a poor outcome.¹¹

[17] On September 12, 2024, the Institution filed a new application for authorization with respect to care asking the Court to authorize the recommended Care Plan notwithstanding the refusal of the Patient’s Sister, who was an impleaded party in first instance. On September 17, 2024, with the Patient’s Sister being absent in Court despite having been duly summoned, the Court appointed a lawyer to represent the Patient’s interests, in virtue of art. 90 C.C.P., and scheduled the application to be heard on September 19, 2024. That day, the Sister, in the presence of counsel for the Institution

⁹ Medical Report for an Authorization of Care, dated September 10, 2024.

¹⁰ Medical Report for an Authorization of Care, dated September 10, 2024.

¹¹ Medical Expert Report of Dr. Liam Durcan, dated September 11, 2024.

and for the Patient, asked that the hearing be postponed so she could retain the services of a lawyer, file a second opinion and summon witnesses. The Institution objected to the postponement request, arguing the urgency of the matter given the Patient's state of health, which was causing him undue pain and suffering. The Court agreed to postpone the hearing until October 2, 2024, emphasizing the following:

DECLARES that given the experts' opinions filed by McGill University Health Centre which remain at this time uncontradicted and conclude that Mr. G. remains in a vegetative state and suffers from what the experts qualify as inhumane pain, the hearing must proceed as scheduled on October 2, 2024 unless this Court decides otherwise;

[18] On October 2, 2023, the Sister attended the hearing without counsel and asked for another postponement, claiming that the lawyer who could represent her was not available and that she had not managed to obtain a second opinion, but she filed no documents demonstrating that any steps had been taken. The judge refused the postponement and proceeded.

II. Judgment under appeal

[19] After reviewing the applicable principles, the judge determined that the Patient is incapable of giving consent and cannot participate in decision-making regarding his care. He accepted the testimony of Dr. Samoukovic, as supported by the report of Dr. Durcan, in which Dr. Samoukovic explained that the Patient has been in a vegetative state since his cardiac arrest and that the signs perceived by his Sister are but a reflexive response that do not indicate consciousness.

[20] He examined the matter and concluded that the Sister's refusal of the Care Plan is unreasonable and unjustified. He recognized the fact that she loves her brother and wants him to recover, but he was of the view that she is unable to objectively assess his state of health when she asserts that the care will allow him to recover with some limitations.

[21] After a thorough review, he was of the opinion that the Care Plan proposed by the physician, in consultation with several members of the Institution's team, is in the Patient's interests because it offers more advantages than disadvantages in that it allows the Patient to live out the remainder of his life with dignity and minimizes his suffering. The evidence convinced him that the current treatments are futile since they have no chance of improving the Patient's state of health, but, instead, are prolonging his agony. Even taking into account the Patient's desire to live as expressed in the past, the judge concluded, in light of the complete clinical picture, that death is now inevitable and that continued life-sustaining treatment contravenes applicable medical and ethical principles.

[22] The judge questioned the reliability of the notes allegedly written by the Patient in April 2024, in which he asked to be moved to Ontario to receive treatment there, and

added that they predate his cardiac arrest, an event that changed the situation by creating severe neurological problems. Additionally, he found that the Sister had not shown that after the Patient allegedly expressed this desire to move, she had taken serious steps to implement that wish.

[23] Consequently, he authorized the implementation of the Care Plan until the Patient passes away.

[24] On October 4, 2024, the Sister filed a notice of appeal, to which the Institution responded in the days that followed by an application to dismiss on the ground that the appeal has no reasonable chance of success. The Appellant obtained a number of postponements so she could find counsel to represent her, but once again to no avail. On October 25, 2024, the Court dismissed the application to dismiss.¹²

III. Grounds of appeal

[25] The Appellant asks that the judgment under appeal be reversed because it allegedly infringes the Patient's right to life and discriminates against him by reason of his state of health and handicap. She emphasizes that her brother always wanted to stay alive, and she remains convinced that he can recover if treatment is continued. According to her, he responds to some of her commands, which indicates that he is not in a vegetative state. Additionally, she argues that the treatment the Patient received aggravated his condition, and she claims she contacted an ambulance to have him transferred to Ontario, as he had wished prior to his cardiac arrest. She asks that life-sustaining care continue until the transfer to Ontario.

[26] The Institution argues that the trial judge did not commit a reviewable error in his judgment. It submits that the Appellant is making an unjustified decision given that the uncontradicted medical evidence shows that there is no possibility of recovery. In its view, continuing the current treatment violates medical principles and ethics. It considers that the Patient should not be subjected to futile therapies that are maintaining him alive artificially, constitute therapeutic obstinacy and violate his dignity. It argues that several physicians, including the Institution's ethics committee, participated in the Patient's assessment and came to the same conclusions.

IV. Analysis

Principles

[27] The *Canadian Charter of Rights and Freedoms* protects the right to life, liberty and security of the person, in accordance with the principles of fundamental justice.¹³ In

¹² *N.G. v. McGill University Health Center*, 2024 QCCA 1473.

¹³ *Canadian Charter of Rights and Freedoms*, Part 1 of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, s. 7 [*Canadian Charter*].

Quebec, the *Charter of Human Rights and Freedoms*, which is founded on the equality and dignity of human beings, provides that they have “a right to life, and to personal security, inviolability and freedom”, that “[e]very person has a right to the safeguard of his dignity” and that “[n]o one may be deprived [...] of his rights except on grounds provided by law and in accordance with prescribed procedure”.¹⁴ The *Civil Code of Québec*, in harmony with the *Quebec Charter*, provides that “[e]very person is the holder of personality rights, such as the right to life, the right to the inviolability and integrity of his person”, and that no one may interfere with those rights without the person’s free and enlightened consent, except in cases provided for by law.¹⁵ These fundamental principles therefore protect the life, physical integrity, autonomy and dignity of human beings.¹⁶

[28] Based on the application of these principles, a person’s free and informed consent is required before the person is made to undergo care of any nature.¹⁷ Consequently, when dealing with a person of full age who is able to give consent, health-care personnel must respect the person’s refusal of treatment or request to interrupt treatment, even if this decision may result in death or seems unreasonable.¹⁸

[29] If the person concerned is incapable of consenting to care, “a person authorized by law or by a protection mandate may do so in his place”.¹⁹ If the incapable person has no mandatary or tutor, consent may be given by the person’s spouse or, if the person has no spouse or the spouse is prevented from giving consent, it may be given by a close relative or a person who shows a special interest in the incapable person.²⁰ The criteria that must guide the person giving substitute consent are set out in art. 12 C.C.Q.:

12. A person who gives his consent to or refuses care for another person is bound to act in the sole interest of that person, complying, as far as possible, with any wishes the latter may have expressed.

If he gives his consent, he shall ensure that the care is beneficial notwithstanding the gravity and permanence of certain of its effects, that it is advisable in the

12. Celui qui consent à des soins pour autrui ou qui les refuse est tenu d’agir dans le seul intérêt de cette personne en respectant, dans la mesure du possible, les volontés que cette dernière a pu manifester.

S’il exprime un consentement, il doit s’assurer que les soins seront bénéfiques, malgré la gravité et la permanence de certains de leurs effets, qu’ils sont opportuns dans les

¹⁴ *Charter of Human Rights and Freedoms*, CQLR, c. C-12, ss. 1, 4 and 24 [*Quebec Charter*].

¹⁵ Arts. 3 and 10 C.C.Q.

¹⁶ *A.P. c. Centre hospitalier universitaire Sainte-Justine*, 2023 QCCA 58, para. 12; *X.Y. c. Hôpital général du Lakeshore*, 2017 QCCA 1465, para. 4.

¹⁷ Arts. 10 and 11 C.C.Q.; s. 9 of the *Act respecting health services and social services*, CQLR, c. S-4.2.

¹⁸ *Carter v. Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331, para. 67; *J.M.W. c. S.C.W.*, [1996] R.J.Q. 229, 1996 CanLII 6132 (QC CA), pp. 234-235; *Nancy B. c. Hôtel-Dieu de Québec*, [1992] R.J.Q. 361 (Sup. Ct.).

¹⁹ Art. 11 para. 2 C.C.Q.

²⁰ Art. 15 C.C.Q.

circumstances and that the risks incurred are not disproportionate to the anticipated benefit.

circonstances et que les risques présentés ne sont pas hors de proportion avec le bienfait qu'on en espère.

[30] Consequently, the interests of the person concerned constitute the “cornerstone” when making decisions regarding proposed care,²¹ which decisions must comply, “as far as possible, with any wishes the latter may have expressed”.²²

[31] The legislature provides that “where the person who may give consent to care required by the state of health of [...] a person of full age who is incapable of giving his consent is prevented from doing so or, without justification, refuses to do so”, a court may intervene to authorize the care required in the interests of the person concerned.²³

[32] Consequently, where the person who may give consent to care required by the state of health of the person of full age who is incapable of giving his consent is prevented from doing so, the court must act in the former’s place so as to decide on the care required. In such a case, the court must examine the matter in light of the criteria set out in art. 12 C.C.Q.²⁴

[33] Where, however, the situation involves an unjustified refusal by the person who may give consent to care required by the state of health of a person of full age who is incapable of giving his consent, the court’s role is not the same. In such a case, the court must decide whether the refusal by the representative of the incapable person of full age is clearly wrong in light of the criteria in art. 12 C.C.Q.²⁵ This is not a question of the court acting in place of the patient’s representative, but rather of the court reviewing the latter’s decision so as to determine whether it is clearly unjustified in light of the incapable patient’s interests.

[34] In *Couture-Jacquet c. Montreal Children’s Hospital*, a case involving a young girl suffering from cancer, the Court had to decide whether to intervene in the decision of the persons having parental authority to refuse chemotherapy treatments that had significant side effects, in a context in which the expectation of the child being cured was very low.

²¹ *A.P. c. Centre hospitalier universitaire Sainte-Justine*, 2023 QCCA 58, para. 16.

²² Art. 12 C.C.Q.

²³ Art. 16 C.C.Q. [underlining added].

²⁴ *F.D. c. Centre universitaire de santé McGill, (Hôpital Royal-Victoria)*, 2015 QCCA 1139, para. 54; *X.Y. c. Hôpital général du Lakeshore*, 2017 QCCA 1465, paras. 5-6.

²⁵ *A.D. c. Centre intégré universitaire de santé et de services sociaux du Centre-Sud-de-l’Île-de-Montréal*, 2023 QCCA 1240, para. 46; *A.P. c. Centre hospitalier universitaire Sainte-Justine*, 2023 QCCA 58, paras. 42-43; *Couture-Jacquet c. Montreal Children’s Hospital*, [1986] R.J.Q. 1221 (C.A.), pp. 1227-1228; *Centre intégré universitaire de santé et de services sociaux du Centre-Sud-de-l’Île-de-Montréal c. M.M.*, 2022 QCCS 879, paras. 39-41; *Institut universitaire en santé mentale Douglas c. S.M.*, 2018 QCCS 3968, paras. 36 and 43-44; *CHU de Québec c. M.G.*, 2014 QCCS 1404, paras. 23-25.

The trial judge had authorized the chemotherapy treatments notwithstanding the refusal of the holders of parental authority, but the Court intervened in order to reinstate the latter's decision to refuse such care. In his reasons, Justice Chevalier explained that the fundamental issue on appeal was the power of the courts to intervene in such a situation. He concluded that courts must intervene only when it has been shown that the decision of the holders of parental authority to refuse treatment is clearly wrong – in other words, unreasonable – because it is the holders of parental authority to whom the legislature has primarily entrusted such decisions:²⁶

[TRANSLATION]

The wording used by the legislature clearly indicates that in the case of a child under 14 years of age, the person having parental authority is, primarily and to the exclusion of all others, the person who has the power to make the decision in that child's stead. That person must act in the child's best interest, but it is only if, in light of all the factors at play, the person's decision turns out to be unreasonable and contrary to the interests of the child that a court may intervene. Therefore, it is not up to the court to substitute itself for the person having parental authority and make a decision in that person's place, but, rather, to correct a decision that is clearly wrong.

This power of intervention must be exercised with caution.

[35] As the Superior Court concluded in *Centre hospitalier universitaire Sainte-Justine c. A.P.*, a decision upheld by the Court, [TRANSLATION] “[a]lthough this approach was developed more than 35 years ago, it is still relevant when analyzing and characterizing a refusal”.²⁷ That approach applies just as much when the patient in question is an incapable person of full age.

[36] A care plan that provides for the withdrawal of active life-sustaining treatment in order to replace it with palliative care providing comfort until the person's death may seem contrary to the usual notion of “care”, which generally seeks “to maintain and improve the physical, mental and social capacity of persons”.²⁸ Case law, however, recognizes that the purpose of a care plan may be to support a patient so they can die with dignity.

²⁶ *Couture-Jacquet c. Montreal Children's Hospital*, [1986] R.J.Q. 1221 (C.A.), pp. 1227-1228. These comments were cited with approval in *A.P. c. Centre hospitalier universitaire Sainte-Justine*, 2023 QCCA 58, paras. 42-43. See also: *Institut universitaire en santé mentale Douglas c. S.M.*, 2018 QCCS 3968, paras. 36 and 43-44.

²⁷ *Centre hospitalier universitaire Sainte-Justine c. A.P.*, 2022 QCCS 4033, para. 42 (appeal dismissed by *A.P. c. Centre hospitalier universitaire Sainte-Justine*, 2023 QCCA 58), referring to *Institut universitaire en santé mentale Douglas c. S.M.*, 2018 QCCS 3968, paras. 36-40, and *CHU de Québec c. M.G.*, 2014 QCCS 1404, paras. 23-25.

²⁸ Section 1 of the *Act respecting health services and social services*, CQLR, c. S-4.2.

[37] In *A.P. c. Centre hospitalier universitaire Sainte-Justine*,²⁹ the proposed care consisted in the removal of the mechanical ventilation of a child who was in an irreversible vegetative state, which removal was intended to alleviate the child's suffering. The parents refused on the basis that extubation could lead to the child's death. They wanted assurances that, should that situation arise, their child would be reintubated, something that was not provided for in the care plan. The parents were of the view that care that did not ensure their child's survival was contrary to his interests and should be rejected. The Court, which concluded that the parents' refusal was unjustified, did not agree with this argument, stating:

[TRANSLATION]

[38] [...] the considerations should focus here not on keeping the child alive no matter what, but on the child's interest in living, or perhaps more like surviving, under conditions determined to be unacceptable because they involve suffering and offer no way out. In this regard, art. 12 C.C.Q. is quite clear when it specifies that the care to be given must be beneficial notwithstanding the gravity and permanence of some of its effects – effects which, under some circumstances, include death.

[39] If the child's overall medical condition is inconsistent with the maintenance of life under reasonable conditions, and the care received or proposed is not required by his state of health or is even futile, the judge at first instance was allowed, as he did, to assess the interests of the child from that standpoint, even if there are risks that might result in the child's death after the extubation. In this regard – indeed, as the respondent submitted – the chance that the child will die is not directly related to the extubation. Rather, when death occurs, it will unfortunately be the inevitable consequence not of the removal of the mechanical ventilation equipment, but of the child's severe and irreversible neurological injury, the extubation merely being the procedure that will confirm whether or not the child's condition is compatible with life.

[Underlining added, references omitted]

Refusal of the Care Plan

[38] The judge did not commit a reviewable error in concluding that the Appellant's decision to refuse the Care Plan is unjustified, unreasonable and contrary to the Patient's interests.

[39] The Appellant argues that the Patient is entitled to the continuation of the current treatment because she believes he will recover, although she acknowledges that he will certainly have limitations. She bases her hopes on the fact that he responds to her commands by squeezing her hand or opening his eyes. There is no doubt that she loves

²⁹ 2023 QCCA 58. See also: *McGill University Health Centre (MUHC) c. M.S.*, 2019 QCCS 3851.

her brother and fervently wants him to get better. The medical evidence in the record, however, indicates that his state of health is irreversible and death is inevitable.

[40] The cardiac arrest that lasted several minutes caused a brain injury that, despite several months of treatment aimed at his recovery, has left him in a state that the neurologist characterized as a “persistent vegetative state”.³⁰ The chronicity of this state led the neurologist to conclude that it is “unlikely [there will] be any meaningful neurologic improvement which would lead to life without intensive interventions - intubation and mechanical ventilation (inability to clear secretions, recurrent aspiration pneumoniae while being colonized by multidrug resistance organisms)”. Dr. Samoukovic also testified that the brain damage is severe and irreversible. In his view, the prognosis is grim, and there is no prospect of improvement.

[41] The Patient’s responses described by the Sister could never be objectified by medical personnel, despite an attempt to do so by an Arabic-speaking person. Moreover, Dr. Samoukovic explained that the opening of the eyes is a reflex that does not indicate consciousness or an improvement in the Patient’s condition.

[42] In addition, the Patient’s clinical picture includes numerous comorbidities that have worsened since his cardiac arrest, supporting the conclusion that there is no benefit to be gained from maintaining current care.

[43] He has multiple organ failure. His large abdominal hernia is causing the protrusion of numerous organs, including his intestines, outside his abdominal cavity. He suffers from coronary heart disease, including atrial fibrillation and weakened heart muscle, which affects his vitals, particularly blood flow. The muscles surrounding his respiratory system have also been weakened and he suffers from pulmonary edema. He has irreversible kidney failure requiring dialysis, but the frequency of the dialysis has had to be reduced. Indeed, Dr. Samoukovic explained that the Patient’s fragile health means he cannot receive dialysis on a more regular basis without this treatment causing additional harm, as well as increasing the risk of a heart attack. In his report, the neurologist noted, instead, that dialysis treatments must be limited because of the futility of this care.

[44] Due to the Patient’s condition, ventilation through his neck via a tracheostomy is not possible, which requires that the ventilation tube pass through his mouth and throat, contrary to preferred practices for prolonged care. This limits access required for effective suctioning of mucus and secretions, leading to infections. Intubation also makes it difficult to move the Patient on a regular basis, leading to pressure ulcers that are worsening. Indeed, he has a large football-sized wound on his back that has reached all the way to the bones, which are infected, and has exposed his sacrum and a portion of his spine,

³⁰ Medical Expert Report of Dr. Liam Durcan. When testifying, Dr. Samoukovic, whose report had described the Patient’s condition as a “minimally conscious state”, agreed with the neurologist’s opinion and concluded that the Patient is in a near vegetative state. See: Medical Report for an Authorization of Care, dated September 10, 2024.

both of which are degrading. His nasogastric tube is eroding the tissue, leading to necrosis of the nasal cavity. He has recurrent infections requiring high doses of antibiotics, and his system is now colonized with drug-resistant organisms.

[45] Based on the overall clinical picture, the experts consulted have concluded that the care currently being provided is futile, contrary to the Patient's best interests, and violates current medical and ethical standards. Dr. Samoukovic testified that this case was discussed in team meetings of the intensive care unit,³¹ whose members unanimously supported his conclusions. Before drawing those conclusions, he also consulted physicians from various departments, including nephrology, infectiology and neurology.

[46] Prior to submitting its application, the Institution did not consider it necessary to obtain the opinion of an expert not involved in the Patient's care. When there is disagreement between the medical team and the person who can consent to care, and where this care will inexorably lead to the death of the patient who is incapable of giving consent, it will be preferable in most cases for the institution proposing the care plan to obtain a second medical opinion provided by a neutral expert who is independent of the treating team.

[47] Indeed, an institution cannot rely on the fact that, in the event of disagreement, it will be up to the person required to give the substitute consent to obtain an expert assessment to verify the accuracy of the conclusions put forth by the treating physicians, considering the burden this would impose on that person, both personally and financially, and the short time limits such a situation often entails. In order to present a complete clinical picture and provide the court with the necessary tools to determine whether the refusal is unjustified and, if so, whether the proposed care plan is in the patient's interests, in accordance with arts. 12 and 16 C.C.Q., the whole in light of the permanent consequences of the judgment sought in the particular circumstances in question, in most cases it will be necessary for the institution to obtain a second, neutral and independent, opinion. Indeed, in cases involving fundamental rights, such as confinement in an institution, the legislature has set out a requirement for two independent examinations.³² This principle of prudence is all the more warranted when the institution's application with respect to care is likely to result in the patient's death in the short term. It is worth noting that in most of the similar cases identified by the Court, the conclusions of the treating medical team were supported by a second, independent, medical opinion.

[48] Thus, in such cases, an institution should preferably provide an independent expert opinion, failing which, a judge seized with a similar application could – except in urgent or

³¹ He mentioned that members from other hospitals, who have an interest in critical care, sometimes attend these meetings.

³² Art. 28 C.C.Q.

exceptional situations – order one *ex officio* before issuing an order with respect to care likely to result in the patient's death in the short term.

[49] The lack of such an expert assessment in the case at bar is of concern. Nonetheless, in light of the extreme seriousness of the Patient's overall clinical picture, the numerous steps taken by the health professionals, and the urgency of deciding the matter given the Patient's critical situation, it is possible to confirm the judgment under appeal based on the expert reports submitted.

[50] The Appellant argues that her brother's desire was to remain alive. Admittedly, the Patient wanted to live, but he demonstrated that he was not willing to accept just any care. Firstly, his mandate does not require that all possible care be given to prolong his life. Instead, it provides that his Sister, as mandatary, is authorized to consent to the care required by his state of health, if such care is beneficial, despite its effects, or is advisable under the circumstances and that the risks involved are not disproportionate to the anticipated benefit. The Sister's refusal does not fit within these parameters. In the past, the Patient refused treatment on numerous occasions, despite the advice of the physicians, and, in so doing, refused treatment he did not consider useful and beneficial.

[51] The Appellant is of the view that a Care Plan that leads to death cannot be in the Patient's best interests, and she demands the continuation of life-sustaining care. Yet the care being provided is neither beneficial nor advisable, as it is causing the worsening of comorbidities and the Patient's decline towards an inescapable outcome, without any real benefit being derived therefrom.

[52] The Patient's overall medical condition is incompatible with maintaining life under these conditions, which conditions cannot be described as reasonable. As this Court has noted, in a situation where a patient is not in a position to give informed consent to care, [TRANSLATION] "preservation of life at all costs is not an absolute when the conditions under which life would be maintained are unacceptable".³³

Care Plan

[53] Considering the matter as a whole, we find that the trial judge did not err in concluding that the Appellant's refusal to consent to the Care Plan proposed by the Institution was clearly unjustified in the circumstances. The judge performed a structured and thorough analysis [TRANSLATION] "in accordance with legal requirements and with utmost respect for human rights".³⁴ The proposed Care Plan makes it possible to put an end to futile treatments and preserve the Patient's human dignity up to the very last moment through care that is humane and provides comfort measures until his death, a

³³ A.P. c. Centre hospitalier universitaire Sainte-Justine, 2023 QCCA 58, para. 40.

³⁴ F.D. c. Centre universitaire de santé McGill, (Hôpital Royal-Victoria), 2015 QCCA 1139, para. 1.

death which appears inevitable in this case given his distressing medical condition and the absence of any reasonable expectation of improvement.

[54] Finally, a word about the Appellant's request for authorization to transfer the Patient to Ontario. She presented no concrete plan in this regard, having obtained only general information from an ambulance transport company. She did not provide evidence that the transport is possible in light of the Patient's condition, that a hospital is willing to receive him or that she is in a position to implement this plan.³⁵ Furthermore, she has not proved that such a proposal is in the best interests of her brother, who has lived in Montreal for many years and has received visits from members of the local church in which he was involved. The judge's refusal to modify the Care Plan to that effect was therefore justified.

FOR THESE REASONS, THE COURT:

[55] **DISMISSES** the appeal, without legal costs given the nature of the matter.

ROBERT M. MAINVILLE, J.A.

GUY COURNOYER, J.A.

JUDITH HARVIE, J.A.

N. G.
Unrepresented

Mtre Denisa Voiculescu
Mtre Stéphanie Rainville
MONETTE BARAKETT
For the respondent

Date of the hearing: December 13, 2024

³⁵ In this regard, the judgment cited by the appellant, *McGill University Health Centre c. O.S.*, 2024 QCCS 2559, can be distinguished.