Unofficial English Translation of the Judgment of the Court

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| A.P. c. Centre hospitalier universitaire Sainte-Justine | | | | | 2023 QCCA 58 |
| COURT OF APPEAL | | | | | |
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| CANADA | | | | | |
| PROVINCE OF QUEBEC | | | | | |
| REGISTRY OF | | MONTRÉAL | | | |
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| (500-17-122162-228) | | | | | |
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| DATE: | January 17, 2023 | | | | |
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| CORAM: | | | THE HONOURABLE | GENEVIÈVE MARCOTTE, J.A.  BENOÎT MOORE, J.A.  CHRISTINE BAUDOUIN, J.A. | |
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| A. P. | | | | | |
| P. A. | | | | | |
| APPELLANTS – respondents | | | | | |
| c. | | | | | |
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| CENTRE HOSPITALIER UNIVERSITAIRE SAINTE-JUSTINE | | | | | |
| RESPONDENT – applicant | | | | | |
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| JUDGMENT | | | | | |
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1. On June 12, 2022, the appellants’ five-year-old child drowned in the family swimming pool. This is undoubtedly one of the worst tragedies a family can experience. When the child was rescued, he had been under water for approximately 20 minutes and was in cardiopulmonary arrest. Resuscitation attempts were made for more than an hour, first by the paramedics and then by the staff at the hospital centre to which he had been brought, until finally a heartbeat was restored. In the evening, the child was transferred to the respondent’s pediatric intensive care unit, where he remains to this day.
2. The accident caused the child massive and irreversible damage. He suffers from diffuse ischemic cerebral injury affecting every area of his brain, as a result of which he is in an irreversible vegetative state. His prognosis is very bleak.[[1]](#footnote-1) He will require a feeding tube for the rest of his life. He will be unable to speak or see, will be totally unconscious, and will depend on external help for all activities of daily living. His body is subject to dystonic and non-dystonic spastic quadriparesis, which causes him considerable discomfort and quite possibly pain. He can expect to live five more years at the very most.
3. Although the child can breathe independently, he remains connected to a ventilator by means of a tube inserted in his trachea, called an endotracheal tube. The institution that first admitted the child intubated him in the first few hours after the accident.
4. As part its care plan for the child, the respondent wishes to remove his endotracheal tube. This extubation risks causing death, not because the child depends on the apparatus to breathe but because of the chance he will be unable to manage his secretions as a result of his neurological condition. The parents object to such an extubation. Their foremost wish is for the child to remain alive. More specifically, they understand that the extubation is required and would be beneficial for their child, but they refuse to allow it to be fatal and demand the child be reintubated if the extubation is unsuccessful.
5. Despite many discussions between the parents and the treatment team over the course of the summer,[[2]](#footnote-2) the parties are at an impasse, unable to agree on how to proceed. Meanwhile, the status quo has prevailed, and the child remains mechanically ventilated despite the suffering and discomfort this causes for him and the significant risks associated with the ventilation.
6. On September 2, 2022, the respondent applied to the Superior Court, seeking permission to withdraw the tube without otherwise providing for the child’s reintubation in the event of failure because, in the respondent’s opinion, the indicated care in such a case is comfort care. The respondent argues that the parents’ refusal to consent to the treatment plan, which provides for several steps[[3]](#footnote-3) intended to maximize the chances of success for the extubation, is inconsistent with the child’s interests. The parents say they will agree to an attempted extubation, subject to an assurance that their child will be reintubated in the event of failure so the procedure does not cause death. In other words, they refuse the proposed treatment plan if it does not include reintubation of their child in the event that extubation fails.
7. On November 1, 2022, the Honourable Justice Bernard Jolin of the Superior Court (“the judge”), in a carefully and sensitively worded judgment, found that the parents’ refusal is neither reasonable nor justified under the circumstances[[4]](#footnote-4) because the parents’ view of the best interests of the child demands that he be kept alive regardless of his condition.[[5]](#footnote-5) In the judge’s opinion, the parents’ decision to refuse the treatment plan proposed by the respondent is influenced by their mistrust of the treatment team and their religious beliefs, and cannot be justified having regard to the child’s best interests.[[6]](#footnote-6)
8. The judge rigorously analyzed the proposed treatment plan and determined, in light of the considerable medical evidence adduced, that it is indicated by the child’s condition, subject to three changes that he ordered.[[7]](#footnote-7) The plan contemplates the extubation of the child under optimal conditions but without the possibility of reintubation in the event of failure.[[8]](#footnote-8) The judge accepted the unanimous opinion of the experts that [translation] “the plan is appropriate, consistent with best practices and in the best interests”[[9]](#footnote-9) of the child, given not only that assisted ventilation in no way improves the child’s neurological prognosis or his future ability to manage his secretions, but also that it poses numerous disadvantages that need to be considered. One of those uncontradicted disadvantages is that the child is suffering, notably during episodes of dysautonomia caused by the presence of the endotracheal tube.[[10]](#footnote-10) Moreover, maintaining the child’s connection to mechanical ventilation equipment when he can breathe independently is not indicated and results in several other adverse consequences, which the judge describes as follows:

[translation]

(a) [I]t increases the risks of contracting pneumonia, which causes pain, can be fatal, reduces lung efficiency and increases the possibility of heart damage.

(b) There is a risk of septic shock caused by microorganisms in the blood.

(c) There is also a risk of tracheal inflammation.

(d) He is at risk of developing bedsores.

(e) The presence of the endotracheal tube renders him immobile and therefore makes it impossible to offer physiotherapy exercises despite his being in a state of permanent muscle contraction.

(f) Because he is intubated, [the child] must remain in the pediatric ICU—an active environment propitious to stimuli that trigger dysautonomia.[[11]](#footnote-11)

1. Accordingly, the judge, among other things, allowed the treatment team to commence implementing the plan suggested by the respondent, and in particular, to extubate the child under favourable clinical conditions and not to reintubate him if the plan fails, except in the event of planned surgery requiring transient and temporary reintubation. He also authorized the medical personnel to adjust or change the treatment plan based on the child’s clinical response.
2. The parents appeal this decision before this Court, stating the following five grounds of appeal:

[translation]

Did the judge at first instance err in law by using his intervention power without explaining why the parents’ refusal of a unilateral extubation accompanied by a permanent limitation of the level of care was unjustified?

Did the judge at first instance commit a palpable and overriding error in finding that the appellants’ position was to keep X intubated as long as possible while awaiting a miracle?

Did the judge at first instance err in law by failing to specify a precise duration for his order?

Did the judge at first instance clearly err in fact and in law by failing to take into account the probability that X would die following the implementation of the respondent’s proposed care plan?

Did the judge at first instance commit a palpable and overriding error in finding that the experts were unanimous that the care plan proposed by the respondent is in the child’s best interests?

1. In essence, these five grounds of appeal converge into the following central question: Was the parents’ refusal to consent to the proposed treatment plan justified in view of the child’s interests?

**Analysis**

**The legal principles**

1. Article 10 of the *Civil Code of Québec* (C.C.Q.) provides that “[e]very person is inviolable and is entitled to the integrity of his person. Except in cases provided for by law, no one may interfere with his person without his free and enlightened consent.” These fundamental principles seek to protect people’s autonomy and dignity over their bodies and destiny,[[12]](#footnote-12) and are enshrined not only in that provision of the C.C.Q. but also in the Quebec *Charter of human rights and freedoms* and the *Canadian Charter of Rights and Freedoms*, further confirming their fundamental nature. The judge explained these principles well in his decision.
2. The judge began by noting the importance of respecting everyone’s right to the integrity and inviolability of their person, and of the principle that nobody can be made to undergo care of any nature without their consent.[[13]](#footnote-13) Where, as here, a minor under the age of 14 is involved, the judge noted that consent is given by the person having parental authority or by the minor’s tutor.[[14]](#footnote-14) As a result, in the present case, it is the parents who have the power to give consent.
3. The judge then reiterated the principles established by art. 12 C.C.Q., which serve as a guide in determining whether or not proposed care is in the interests of the person concerned.[[15]](#footnote-15) This provision, which is at the heart of this case, is worded as follows:

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| **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 circumstances and that the risks incurred are not disproportionate to the anticipated benefit. | **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 circonstances et que les risques présentés ne sont pas hors de proportion avec le bienfait qu’on en espère. |

1. Therefore, apart from the wishes expressed by the person who is to receive the care—a factor that cannot apply in the present case—the people who can consent to the child’s care must ensure (i) that the care will be beneficial notwithstanding the gravity and permanence of certain of its effects; (ii) that the care is advisable in the circumstances; and (iii) that the risks incurred are not disproportionate to the anticipated benefit. Furthermore, the person giving consent must act solely in the interests of the child, not in their own interests, whether they be a parent, another relative, or even a third party.[[16]](#footnote-16)
2. It is from this perspective that the judge noted the principle, reiterated numerous times by the courts, including the Supreme Court, that the interests of the person who is to receive the care, and especially the interests of a child, are fundamental and constitute the “cornerstone” of any decisions to be made concerning them.[[17]](#footnote-17) In fact, this cardinal rule is strengthened by art. 33 C.C.Q., which provides that decisions concerning a child shall be taken in light of the child’s interest and in the respect of his rights.
3. The judge adds that, to the extent that a person having parental authority is prevented from consenting or, without justification, refuses to consent to care in a way that is unreasonable given the totality of the circumstances, art. 16 C.C.Q. enables the court to override the refusal and authorize the requisite care.[[18]](#footnote-18) As our Court has noted, it is not up to the court [translation] “to substitute itself for the person having parental authority and to decide in his or her place. The court's role is to correct a decision which is clearly wrong. This power of intervention must be exercised with caution.[[19]](#footnote-19)
4. The court’s role, then, is to be guardian of the process ensuring the consideration and protection of the fundamental rights of persons who cannot consent or refuse for themselves.[[20]](#footnote-20) Any medical decision regarding such a person is to be guided solely by the person’s best interests.
5. For the following reasons, the Court finds that the evidence unequivocally supports the lower court judge’s conclusions that the parents’ refusal to consent to the respondent’s proposed treatment plan was not justified under the circumstances because the treatment plan, as amended by the judge at the hearing, is in the child’s interests and is consistent with best medical practices, even if it indirectly risks leading to the child’s death. Although this finding is very understandably difficult on a human level for the parents, it is in keeping with the law because, according to the medical evidence submitted, it is, above all, in the interests of the child.

**The judge at first instance and the evidence considered**

1. The judge had the benefit of hearing the opinions of several experts, as well as the positions of the parents,[[21]](#footnote-21) before deciding the respondent’s application to authorize care. He found that the experts who gave evidence were unanimous: the proposed treatment plan is in the child’s interests and is consistent with best medical practices.[[22]](#footnote-22) This determination is supported by the evidence that was heard and is in keeping with that evidence. Consequently, not only does the decision contain no error that would allow this Court to substitute its opinion for the judge’s, but it also appears correct in every respect.
2. Several experts in pediatric medicine were heard. The first is Dr. Baruch Toledano, a pediatric intensive care specialist since 1996 and part of a group of 14 intensivists who has spent time at the child’s bedside since his arrival at the pediatric ICU in June 2022. Dr. Toledano has been involved in the child’s care since then and has had several conversations with the parents about the evolution of their child’s state of health and the best care to provide for him. In his opinion, maintaining intubation is not indicated here, because the child can breathe on his own and because the presence of the tube not only places him at risk of major complications such as muscular deconditioning, pressure sores, vocal cord inflammation, and susceptibility to developing pneumonia[[23]](#footnote-23) and tracheitis, but also causes him pain and discomfort. He also believes there are several benefits to extubation, including the fact that the child could then be mobilized, which might make it possible for him to return home as the parents wish.[[24]](#footnote-24)
3. Dr. Inge Meijer is a physician specializing in pediatric neurology. She confirmed that the child has suffered extensive neurological injury and said the child’s prognosis is [translation] “very bleak”, specifying that his current chronic state will not change. She favours extubation because the presence of the endotracheal tube can have no impact on the child’s neurological condition and offers no prospects of improving his brain stem reflexes or his state of consciousness. In her opinion, extubation would make it easier to assess the child’s condition and to ascertain whether or not he is capable of managing his secretions with the aid of aspiration, and would make it more likely that he could be mobilized and positioned more comfortably, especially given that the tube is causing him pain and suffering and puts him at risk of developing respiratory infections. She writes:

[translation]

To summarize, the breathing tube is more harmful than beneficial at this point because it has no impact on the neurological prognosis, puts the child at risk of medical complications, and slows rehabilitation. It is not the withdrawal of the tube that threatens [the child]’s life but the brain damage he sustained with the cardiac arrest. So we are not making a pronouncement regarding [the child]’s vital prognosis, but we can assert that the neurological prognosis is very bleak and permanent.[[25]](#footnote-25)

1. Then, Dr. Sam Shemie, a pediatric intensive care physician who specializes in devastating brain injury,[[26]](#footnote-26) was heard at the respondent’s request, though it was the parents who had initially sought his opinion. Dr. Shemie examined the child and met with the parents to explain his conclusions, which leave no room for interpretation:

1) Severity of anoxic brain injury 2) that he will never recover to any degree compatible with quality of life; [*sic*] 4) he will remain unconsciousness meaning no thinking, no hearing, no vision, no purposeful movements, dependency for all aspects of daily, never walk/talk/feed himself 5) complication will include aspiration pneumonia, seizures, spasticity, susceptibility to viruses.

At this stage, he is clearly ready for trial of extubation + parents understanding that reintubation may be required but the HSJ team + family should agree on next step.

My recommendation from a medical perspective is a one-way extubation + end-of-life comfort care should he not succeed. However, as clearly expressed by parents, it is god, not doctors who decides. My role as above, was to provide a second external opinion.[[27]](#footnote-27)

[Verbatim transcript]

1. Dr. Shemie’s testimony at trial is particularly eloquent regarding the need to extubate the child without planning to reintubate him.

[translation]

Q. And with respect to [the child], you’re recommending unilateral extubation?

A. That’s right.

Q. Would reintubation be in [the child]’s interest?

A. In his interest, no, but if it’s… it’s going to be… helping the family to accept the reality, yes, but once, because it’s not fair to [the child], in my opinion. [original english] It’s not fair to him. He’s suffering. . . .[[28]](#footnote-28)

1. With respect to his recommendations about post-extubation care, Dr. Shemie continued:

[translation]

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| A. | . . . For my part, our recommendation with the families we have in this situation is to extubate; we don’t reintubate, provide cardiac resuscitation or CPAP or BiPAP, we do provide oxygen, suction, medication for comfort, and medication to try to get rid of and dry secretions, and then we see what occurs.  If the child shows signs of respiratory distress, the level of treatment to be provided is clear. If we see he’s lacking air, he’s suffering, we provide medication for comfort, not interventions to resume mechanical ventilation. There are two things—two kinds of mechanical ventilation: intubation with the machine or with a mask and the same machine.[[29]](#footnote-29) |

1. He, too, concludes that there is no benefit to keeping the child mechanically ventilated even though he might not survive the procedure, given, notably, that he is suffering because the tube causes injuries to his trachea that lead to inflammation, and poses significant risks of complications and infections. He confirms that the institution where he practises, the Montreal Children’s Hospital, would offer the same treatment plan as the respondent in such circumstances.[[30]](#footnote-30)
2. Lastly, Dr. Claude Cyr, a pediatrician at the CHU de Sherbrooke intensive care unit, was heard at the court’s request. Although he did not examine the child, he confirmed that the neurological assessments made by the experts who were heard were proper and in line with the standards for assessing children with devastating neurological injury.[[31]](#footnote-31) The child is in a chronic vegetative state, and attempted extubation has been indicated for several weeks. It is Dr. Cyr’s opinion that the proposed extubation plan is appropriate and consistent with the usual practices for such a situation. He adds that in light of the child’s life expectancy and clinical condition, the child’s care should be transferred to pediatric palliative care.[[32]](#footnote-32)
3. However, Dr. Cyr’s report contains a passage, quoted below, on which the parents seek to rely to establish that the trial judge was not entitled to consider their refusal unjustified. In their view, the passage amounts to a physician expressing the opinion that more than one attempt at extubation might be indicated. They argue that, by refusing to contemplate more than one reintubation attempt as part of the authorized treatment plan, the judge erred in law. Here is the wording of the expert’s pronouncements that form the basis for the parents’ argument in this regard:

[translation]

Given [the child]’s prolonged intubation, an airway obstruction caused by the tube is a possibility. For this type of problem, before finding that extubation has failed, more than one extubation attempt is indicated. Some authors suggest three or four attempts. The delays associated with the disagreements have probably reduced the chances of a successful extubation for [the child]. If there are several failed extubations, it would be medically acceptable not to reintubate [the child] because the grave and irreversible damage would then be considered incompatible with life.[[33]](#footnote-33)

1. For essentially two reasons, the argument does not withstand analysis.
2. First, this Court finds that the parents are reading more into Dr. Cyr’s words than what was meant. Dr. Cyr submits it might be indicated to attempt extubation more than once if the airways are obstructed for a reason related to the tube’s presence, such as inflammation of the tracheal wall. This possibility is raised to cover situations where extubation fails due to an external, reversible cause that arises in the moment[[34]](#footnote-34) and is not related to the child’s brain damage.
3. The judge at first instance addressed this possibility raised by Dr. Cyr, who essentially identifies five causes of such a nature: pneumonia, lung collapse, convulsions, tracheal wall lesion, or surgery requiring intubation. The judge eliminated the first three possibilities because they are neither reversible nor something that can arise in the moment but rather, are related to the child’s inherent neurological condition.[[35]](#footnote-35) In other words, reintubation would not be indicated in those situations, because they are related to the neurological damage that followed the accident—for example, the child’s inability to cough. As for the latter two possibilities, namely surgery and tracheal lesion, the judge took them into account, considered them, and amended the treatment plan accordingly. Specifically, in the event that, after extubation, the child were to require surgery—for example to insert a gastric tube—the judge contemplated a potential reintubation during the procedure on a transient and temporary basis. However, this would also mean that it would no longer be possible for the child to be mechanically ventilated on a permanent or chronic basis. As for a possible tracheal wall injury, the judge, at the suggestion of Dr. Toledano, added the possibility of a bronchoscopy prior to attempting extubation in order to ensure that the trachea is in good condition.[[36]](#footnote-36)
4. Therefore, it is inaccurate to assert that Dr. Cyr is saying that it is indicated in the present case, and under the specific circumstances that concern us, to make three or four attempts before providing alternative care in the event that extubation fails. Dr. Cyr testified as follows:

[translation]

Q. So… And what you’re saying, and I’m trying to summarize, is that unless there is a reversible condition or cause that prompts the failure of intubation, reintubation is not advisable. But if the cause can be corrected, it might be advisable—reintubation might be advisable. But I imagine this does not mean going down a path of extubation, reintubation, extubation, and reintubation?

A. No. That, that… I think that making several extubation attempts for [the child] in this situation would not be reasonable. So… Well, it seems simple when I lay it out, but bear in mind that things will get complicated and complex pretty quickly, because the causes of extubation failure are often multi-factorial, hence the planning with the family and consultations with them to see what actions or solution they consider reasonable for the child.[[37]](#footnote-37)

1. In fact, then, the proper understanding of Dr. Cyr’s testimony is that reintubation and chronic ventilation of the child are not indicated here, but can be envisaged, only in the specific cases discussed above, to seek to secure the parents’ approval. Here is what Dr. Cyr said on this subject:

[translation]

So, from a medical standpoint, we believe chronic reintubation or chronic ventilation of the child in question is inappropriate because, in our opinion, a life dependent on a breathing tube is incompatible even with a minimal quality of life. In my opinion, this is why the medical team is not suggesting reintubation.

For the family, time and making room for a miracle to happen appear to be the priorities.[[38]](#footnote-38)

1. Dr. Cyr made no reference or assertion to the effect that it would be in the child’s interest, given his present circumstances, to make several attempts at extubation and reintubation. His remarks were limited to the possibility of reintubation in the event of a failure attributable to a reversible cause—an eventuality which, it should be noted, the other experts rule out.
2. Secondly, the judge was clearly not bound by Dr. Cyr’s opinion, especially in light of the clear evidence about the adverse effects of such a practice on the child. Thus, he was entitled not to accept it.
3. Lastly, the judge also had the benefit of the expert report of Ms. Levasseur, a clinical ethicist, which concludes, among other things, that in the event extubation fails, it would be ethically acceptable not to reintubate the child because of the grave and irreversible damage from which he is suffering, the episodes of discomfort he is experiencing, and the impacts on the various spheres of his quality of life.[[39]](#footnote-39)
4. As for the parents, they testified very openly about their beliefs and their hopes of seeing their child live and perhaps emerge from this terrible situation. But despite all the empathy that one can have for them, their hopes are not based on any scientific data, whereas it is clear from the entirety of the medical evidence that mechanical ventilation is causing their child suffering, that it is not required by his state of health or beneficial for him, and that, inevitably, the child will die soon, even if he remains intubated, or is reintubated.

**The interests of the child in light of art. 12 C.C.Q.**

1. In the parents’ opinion, a treatment plan that does not seek to keep the child alive must be rejected because it is part of a trajectory that conflicts with his interests.[[40]](#footnote-40) But 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.[[41]](#footnote-41)
2. 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,[[42]](#footnote-42) 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.
3. Thus, preservation of life at all costs is not an absolute when the conditions under which life would be maintained are unacceptable.[[43]](#footnote-43)
4. It is true that this case is different from *Couture-Jacquet v. Montreal Children’s Hospital*,a decision our Court rendered more than 35 years ago.[[44]](#footnote-44) There, the child’s mother, who had parental authority, asked that the chemotherapy treatments her child was undergoing be stopped because of the significant side effects and the slim chance of expected success, while the health care institution sought to be able to provide another course of chemotherapy despite the mother’s refusal. Owen, Chevalier and Monet, JJ.A. found in favour of the mother even though the decision reduced the child’s chances of survival. They determined that the mother’s refusal was not unjustified having regard to the child’s interests.
5. In this case, the situation is reversed because the respondent is seeking to disregard the parents’ refusal and be authorized not to reintubate the child even though the child’s neurological condition could lead to death should he be unable to manage his secretions. Nonetheless, the principles are the same and the teachings in *Couture‑Jacquet* are fully transferable to this case. While there is a principle that decisions made by the people who have parental authority must be respected, there is also a principle stating that where such decisions are unreasonable or “clearly wrong”[[45]](#footnote-45) having regard to all the evidence adduced, the court may intervene and correct them, because the child’s interest, sacred in nature, is paramount and must therefore prevail.
6. As Monet, J.A. notes:

[35] The wording used by the Legislature clearly indicated 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. He must act in the child’s best interest but it is only if, in light of all the factors in the case, his decision turns out to be unreasonable and contrary to the interests of the child that a court of justice may intervene. Therefore, it is not up to the court to substitute itself for the person having parental authority and to decide in his place. The court’s role is to correct a decision which is clearly wrong.

1. The Court finds that the judge properly assessed the evidence adduced and did not err when he concluded that the requirements of art. 12 C.C.Q. were met in that an extubation followed by a reintubation in the event of failure is neither beneficial nor opportune for the child and that the risks of such a procedure are too great compared to the potential benefits for the child.

**The proposed treatment plan**

1. However, this finding does not settle the entire matter because the parents also question some of the judge’s determinations regarding the treatment plan that the respondent is permitted to implement as part of the extubation procedure.
2. The determinations that they attack are as follows:

[translation]

[144] **AUTHORIZES** the attending physicians of the Centre hospitalier universitaire Sainte-Justine, or any person or health care institution responsible for treating [the child], not to reintubate him if the treatment plan fails, except in the event of a planned surgery that requires a transient and temporary reintubation.

[145] **AUTHORIZES** the attending physicians of the Centre hospitalier universitaire Sainte-Justine, or any person or health care institution responsible for treating [the child], to adjust or change the treatment plan based on [the child]’s clinical response to it.[[46]](#footnote-46)

1. At the hearing, the parents argued that these determinations are without basis and should be struck, essentially for two reasons: first, they are unduly broad and leave too much discretion to the medical team, thereby excluding the parents from the decision‑making concerning their child, perhaps even to the point of depriving them of parental authority; and secondly, they are not given a precise duration, and therefore run afoul of the Court’s jurisprudence on medical care and violate the child’s fundamental rights.
2. It is true that paragraph [144] of the judge’s disposition might at first seem broad because it contemplates the child’s reintubation only in the event of a planned surgery. However, it would be inaccurate to read the paragraph as though it applied to the child in the event of any future medical situation. Paragraph [144] of the disposition is limited to situations that arise specifically as part of the respondent’s treatment plan, in connection with procedures that seek to take the child off the artificial breathing apparatus to which he is connected. If the child survives and the steps of the treatment plan are followed, paragraph [144] is spent and therefore no longer applies to any situations experienced by the child in the future, including the possibility that he will be reintubated again if his medical situation requires it outside the confines of a planned surgery.
3. Thus, however broad the disposition put in place by the judge might seem, it applies only within a specific framework: the implementation of the treatment plan. Adding a duration would therefore have been superfluous because the treatment plan in question is circumscribed, will happen just once, and is not permanent in nature. Indeed, it will necessarily end after the extubation. Any future health care needs the child might have do not come within this Court’s order and will depend on how his health evolves.
4. Likewise, the disposition does not deprive the parents of their parental authority. If the extubation is successful and the child survives, the parents will retain all their prerogatives concerning the future care to be administered to their child, with the help of the medical team, in keeping with the requirements of the Civil Code.
5. As for paragraph [145], if adjustments need to be made while the post-extubation treatment plan is implemented so as to ensure that the best care is provided and that the child can be made more comfortable, the attending physicians will obviously be able to make those adjustments, provided this is done within the framework established by the authorized treatment plan.
6. Therefore, in light of the foregoing and the entirety of the evidence submitted, the judge did not err in determining that the parents’ refusal to consent to their child’s extubation without provision for reintubation in the event of failure was unjustified and was not in the child’s best interests. The judge’s decision, while difficult and heartbreaking, is nonetheless just, respectful of the law, and in the best interests of the child in question.

**FOR THESE REASONS, THE COURT:**

1. **DISMISSES** the appeal, without legal costs.

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|  | | GENEVIÈVE MARCOTTE, J.A. |
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|  | | BENOÎT MOORE, J.A. |
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|  | | CHRISTINE BAUDOUIN, J.A. |
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| Mtre Patrick Martin-Ménard | | |
| Mtre Maude Lépine | | |
| Mtre Myriam Sahi | | |
| MÉNARD, MARTIN AVOCATS | | |
| For the appellants | | |
|  | | |
| Mtre Mona Daoud-Kayal | | |
| MONETTE, BARAKETT | | |
| For the respondents | | |
|  | | |
| Date of hearing: | December 19, 2022 | |

1. His Glasgow Outcome Score varies from 0 to 2. This is the lowest score and reflects his vegetative state. [↑](#footnote-ref-1)
2. By June 16, 2022, the respondent was already advocating extubation for the child, notably because he was able to breathe independently. [↑](#footnote-ref-2)
3. Specifically, the treatment plan provides for the following: administration of corticosteroids and an anti‑inflammatory at least 12 hours before extubation; glycopyrrolate as needed; fasting; a calm environment where the parents, nurses, respiratory therapists and physicians are present; administration of oxygen as appropriate and under continuous supervision; aspiration of secretions; and use of positive and negative pressure to help loosen and aspirate secretions. Further maneuvers in the plan include administration of epinephrine and dexamethasone if the child develops stridor, which is an inflammation of the trachea. Also, in the event of respiratory distress, opioids or benzodiazepines can be administered to provide comfort. (Testimony of Dr. Toledano in connection with the application for the court’s authorization to provide care required by the child’s state of health, September 2, 2022.) [↑](#footnote-ref-3)
4. *Centre hospitalier universitaire Sainte-Justine c. A.P. et P.A.*, 2022 QCCS 4033 [judgment under appeal] at para. 81. [↑](#footnote-ref-4)
5. Judgment under appeal at para. 82. [↑](#footnote-ref-5)
6. Judgment under appeal at paras. 83–93. [↑](#footnote-ref-6)
7. Specifically, the judge (1) added an initial bronchoscopy to be certain of the condition of the airways, (2) deleted the statement to the effect that medical team will determine the appropriate place to transfer the patient when his medical condition permits; and (3) provided for transient and temporary reintubation if a planned surgery requires it. [↑](#footnote-ref-7)
8. Judgment under appeal at paras. 101–102. [↑](#footnote-ref-8)
9. Judgment under appeal at para. 103. [↑](#footnote-ref-9)
10. Judgment under appeal at para. 104. [↑](#footnote-ref-10)
11. Judgment under appeal at para. 112. [↑](#footnote-ref-11)
12. *X.Y. c. Hôpital général du Lakeshore*, 2017 QCCA 1465 at para. 4. [↑](#footnote-ref-12)
13. Section 7 of the *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), c. 11; section 1 of the *Charter of Human Rights and Freedoms*, CQLR, c. C-12; art. 11 C.C.Q.; judgment under appeal at paras. 30–32. [↑](#footnote-ref-13)
14. Art. 14, para. 1 C.C.Q. [↑](#footnote-ref-14)
15. *F.D. c. Centre Universitaire de santé McGill (Hôpital Royal-Victoria)*, 2015 QCCA 1139 at para. 28. [↑](#footnote-ref-15)
16. Art. 10 C.C.Q. [↑](#footnote-ref-16)
17. *C.(G.) v. V.-F.(T.)*, [1987] 2 S.C.R. 244 at para. 42; *CHU de Québec c. M.G*., 2014 QCCS 1404; *Couture-Jacquet v. Montreal Children’s Hospital*, [1986] R.J.Q. 1221 (C.A.) at para. 35; *CHU de Québec–Université Laval c. R.C*., 2022 QCCS 3116; *McGill University Health Centre (MUHC) c. M.S*., 2019 QCCS 3851. See also art. 33 C.C.Q. [↑](#footnote-ref-17)
18. *X.Y. c. Hôpital général du Lakeshore*, 2017 QCCA 1465. [↑](#footnote-ref-18)
19. *Couture-Jacquet v. Montreal Children’s Hospital*, [1986] R.J.Q. 1221 (C.A.) at 3 (reasons of Chevalier, J.A.). [↑](#footnote-ref-19)
20. *A.F. c. Centre intégré de santé et de services sociaux des Laurentides*, 2021 QCCA 928 at para. 29. [↑](#footnote-ref-20)
21. As required by art. 23 C.C.Q. [↑](#footnote-ref-21)
22. Judgment under appeal at para.103. [↑](#footnote-ref-22)
23. In fact, according to the record, the child has already contracted pneumonia twice. [↑](#footnote-ref-23)
24. Exhibit P-1, Medical report of Dr. Baruch Toledano dated September 1, 2022. [↑](#footnote-ref-24)
25. Exhibit P-6, Medical report of Dr. Inge Meijer dated September 1, 2022. [↑](#footnote-ref-25)
26. Testimony of Dr. Sam Shemie. [↑](#footnote-ref-26)
27. Exhibit P-4, Report of Dr. Sam Shemie dated August 1, 2022. [↑](#footnote-ref-27)
28. Testimony of Dr. Sam Shemie. [↑](#footnote-ref-28)
29. Testimony of Dr. Sam Shemie. [↑](#footnote-ref-29)
30. Testimony of Dr. Sam Shemie. [↑](#footnote-ref-30)
31. Exhibit T-1, Medical report of Dr. Claude Cyr. [↑](#footnote-ref-31)
32. Exhibit T-1, Medical report of Dr. Claude Cyr. [↑](#footnote-ref-32)
33. Exhibit T-1, Medical report of Dr. Claude Cyr. [↑](#footnote-ref-33)
34. Testimony of Dr. Claude Cyr. [↑](#footnote-ref-34)
35. Judgment under appeal at para. 115. [↑](#footnote-ref-35)
36. Judgment under appeal at para. 115. [↑](#footnote-ref-36)
37. Testimony of Dr. Claude Cyr. [↑](#footnote-ref-37)
38. Testimony of Dr. Claude Cyr. [↑](#footnote-ref-38)
39. Exhibit P-5, *Rapport de l’unité d’éthique et organisationnelle* [Report of the ethics and organizational unit] prepared by Marie-Claude Levasseur and dated August 25, 2022. [↑](#footnote-ref-39)
40. Testimony of A.P, the child’s mother. [↑](#footnote-ref-40)
41. *Couture-Jacquet v. Montreal Children’s Hospital*, [1986] R.J.Q. 1221 (C.A.). [↑](#footnote-ref-41)
42. Robert P. Kouri, “Le traitement futile et le devoir de soigner en droit québécois : l’impact normatif du désespoir”, in Benoit Moore, ed., *Mélanges Jean-Louis Baudouin* (Cowansville: Yvon Blais, 2012) at 86. [↑](#footnote-ref-42)
43. *Carter v. Canada (Attorney General)*, 2015 SCC 5; *Centre hospitalier affilié universitaire de Québec c. L.B*., 2006 QCCS 1966 at para. 32. In addition, see *Couture-Jacquet v. Montreal Children's Hospital*, [1986] R.J.Q. 1221 (C.A.). [↑](#footnote-ref-43)
44. *Couture-Jacquet v. Montreal Children's Hospital*, [1986] R.J.Q. 1221 (C.A.). [↑](#footnote-ref-44)
45. *Ibid*. at para. 35. [↑](#footnote-ref-45)
46. Judgment under appeal. [↑](#footnote-ref-46)