Court of Queen's Bench of Alberta

Citation: Sweiss v. Alberta Health Services, 2009 ABQB 691

Date: 20091124
Docket: 0903 15198
Registry: Edmonton

Between:

Ahmed Sweiss & Samir Sweiss by his Next Friend (Ahmed Sweiss)
Applicants (Plaintiffs)

- and -

Alberta Health Services & Royal Alexandra Hospital & Dr. Randall G. Williams
Respondents (Defendants)

Reasons for Judgment
of the
Honourable Mr. Justice Vital O. Ouellette

I. Introduction

[1] The Sweiss family, on behalf of their father, Samir Sweiss, seek an injunction to (i) discontinue the "do not resuscitate" [DNR] order of the Respondent doctor; and (ii) prevent any doctor from removing the mechanical ventilation machine.

II. Issues

Issue 1: **What is the most appropriate procedure to be followed in making an application for an injunction in the context of an urgent life-threatening situation?**

Issue 2: **What, if any, consideration should be given to a patient's wishes, beliefs, and values when they are contrary to the course of treatment recommended by the health care providers?**

Issue 3: **What is the appropriate test to be applied in determining whether an injunction should be granted in the context of an urgent life-threatening situation?**

III. Facts

[2] The patient, Samir Sweiss, was born on March 20, 1945. He had significant health problems including ischemic cardiomyopathy, hypertension, Type II diabetes, chronic obstructive pulmonary disease, obesity, and congenitive heart failure. These health issues, coupled with an extensive cardiac history, resulted in 98 previous hospital admissions.

[3] Mr. Sweiss knew that he was sick. As a result, he signed a declaration on August 15, 2009 stating that he practiced the Islamic faith and followed all Islamic rules including Sharia law. The declaration further provided that in the event something happens to him, Mr. Sweiss wished that all Islamic law be followed. The declaration is attached as Appendix 1.

[4] On September 16, 2009, Mr. Sweiss went into cardiac arrest which necessitated over 40 minutes of cardio-pulmonary resuscitation [CPR], and as a result, he suffered significant brain damage. This brain injury, in addition to his prior cardio-pulmonary problems, left him in a far worse condition than he had ever been. His prognosis was grave.

[5] Mr. Sweiss was placed on mechanical ventilator support and remained on the mechanical ventilator support from September 16, 2009 to September 30, 2009. Although there was evidence of some basic reflex brain stem function, such as breathing or the heart beating, there was no useful cortical function and his brain activity was primarily reflexic. In the treating physician's opinion, Mr. Sweiss had incurred severe irreversible brain damage and had no hope of making a meaningful recovery.

[6] Mr. Sweiss also underwent an independent assessment by a neurologist. The neurologist diagnosed him with severe irreversible hypoxic ischemic encephalopathy, with severe cortical damage. In the neurologist's opinion, Mr. Sweiss had a zero percent chance of recovery and keeping him on the mechanical ventilator would only cause him further suffering.

[7] Dr. Randall Williams, internal medicine specialist and cardiologist, was Mr. Sweiss' treating physician. Dr. Williams opined that it was in Mr. Sweiss' best interest that the mechanical ventilation support be discontinued and that the Respondents not be compelled to perform CPR.

[8] Mr. Sweiss' family members were told that a DNR order had been put in place and informed that the Respondents intended to discontinue the mechanical ventilation support of

their father. On September 25, 2009, further to receiving this information, the Sweiss family came before this Court seeking an injunction.

[9] The Sweiss family brought this application on an emergency basis seeking an injunction to discontinue the DNR order and to prevent the removal of the mechanical ventilation machine. The application was brought on the grounds that the proposed treatment was contrary to Mr. Sweiss' religious beliefs. The family relied on the declaration signed by Mr. Sweiss on August 15, 2009 (See Appendix 1).

[10] In support of its position, the Sweiss family presented evidence concerning the meaning of the right to live and die by the Sharia law and when it is permissible to turn off the life support system of a person who is thought to be dead. The evidence before the Court was that Sharia law only allows for the termination of life support in the following situations: (i) when the heartbeat and breathing stop completely and the doctors decide that they cannot be restarted; or (ii) when all the functions of the brain stop completely and experienced doctors and specialists state that this is irreversible, and that the brain has started to disintegrate. A copy of the interpretation of Sharia law by the Canadian Islamic Centre is attached as Appendix 2.

[11] The evidence before the Court, which was not in dispute, was that Mr. Sweiss' heartbeat, brain function, and breathing had not stopped completely and the doctors had not decided that they could not be restarted.

[12] Dr. Williams stated that he understood that Mr. Sweiss was a strong believer in Sharia law and, further, that he was aware of the interpretation of Sharia law as it related to the permissibility of turning off the life support system of a person who is thought to be dead. Dr. Williams stated that Mr. Sweiss was not brain dead but had suffered severe higher brain function damage as a result of his recent cardiac arrest. With respect to the mechanical ventilation process, it was Dr. Williams' opinion that this was uncomfortable for Mr. Sweiss and that he may be in distress as a result of being on the mechanical ventilation support. Dr. Williams further stated that Mr. Sweiss was breathing on his own, but should be extubated (provided breathing support by oxygen administered by prongs or a mask) for his comfort and dignity. It was Dr. Williams' firm belief that forcing anything but palliative care and comfort measures upon Mr. Sweiss would be medically futile and ethically inappropriate.

[13] With respect to the DNR order, it was Dr. Williams' view that if Mr. Sweiss suffered another cardiac pulmonary arrest, it would be devastating to attempt any form of CPR. It was Dr. Williams' opinion that CPR attempts would likely be harmful to Mr. Sweiss and make his death less dignified. According to Dr. Williams, these measures would have no appreciable benefit, and moreover, were not medically indicated. Dr. Williams' primary medical guiding principle is to do no harm. Allowing the mechanical ventilation support to continue and requiring that CPR be performed was contrary to this principle and bordering on inhumane.

[14] The Respondents, Alberta Health Services and Royal Alexandra Hospital, supported the treatment plan proposed by Dr. Williams. In order to assist the care providers and the family, a

consultation was held with clinical ethicist, Gary Goldsand, on September 22, 2009. In Gary Goldsand's view, if the family's request to have a few final tests conducted confirming their father's condition was complied with, they would likely agree to the recommended extubation and know that they fought for their father's wishes. With respect to any attempts at resuscitation, including CPR, Gary Goldsand supported Dr. Williams' position that another cardio-pulmonary arrest at this time would be utterly devastating and resuscitation would likely harm Mr. Sweiss and make his death less dignified.

[15] Due to the urgency of the situation, the Court rendered an oral decision on the two requests late on Friday night, September 25, 2009. The Court, however, reserved the right to provide written reasons at a later date which could be expanded and clarified. This was to allow a more detailed consideration of the associated procedural issues, how a statement of the patient's personal wishes is to be used, and the appropriate test to be applied in making these types of decisions.

[16] The Court granted an interim injunction preventing the removal of the mechanical ventilator until Wednesday, September 30, 2009, at 4:00 p.m. The purpose of the interim injunction was to allow the Sweiss family to obtain an independent assessment regarding their father's condition.

[17] Further, the Court refused to remove or lift the DNR order because it was in Mr. Sweiss' best interests that there be no attempts at resuscitation in the event of a cardiac failure.

[18] An agreement was reached allowing for the removal of the mechanical ventilator. The parties returned to Court on September 30, 2009, requesting that the previous order of September 25, 2009 be terminated as of 2:00 p.m on Wednesday September 30, 2009. This Order was granted. This Court was subsequently informed by counsel for the Applicants that Mr. Sweiss passed away on October 8, 2009.

IV. Positions of the Parties

A. Position of the Applicants

[19] The Applicants contend that the actions proposed by Dr. Williams will ultimately end Mr. Sweiss' life and constitute an assault and battery. Further, it is argued that the actions proposed are not consistent with the patient's religious beliefs and wishes as he expressed them in the direction he signed on August 15, 2009 (See Appendix 1). The Applicants' position is that the Respondents (Defendants) must accede to the wish of the patient. The Applicants further submit that the Court must apply the three-part test set out in ***RJR-MacDonald v. Canada (Attorney General)*** [1994] 1 S.C.R. 311 in order to properly determine whether an injunction is appropriate in these circumstances.

[20] The first part of the ***RJR -MacDonald*** test requires that the Court consider whether there is a serious issue to be tried. In this respect, the Applicants submit that the issue of who makes

the ultimate decision on the termination of life support and the imposition of a DNR order are serious legal issues which must be adjudicated. It is further argued that there is no established law in Canada which is clear on who has the right to make such decisions where the physician and the family disagree. In addition, due to the religious undertone of this particular case, the *Charter of Rights and Freedoms* is engaged.

[21] The second prong of the ***RJR-MacDonald*** test requires that the Court consider whether irreparable harm will result. The Applicants submit that the actions being proposed by the Respondents will ultimately lead to the death of Mr. Sweiss and this result cannot be compensated by damages. Thus, the harm would be irreparable.

[22] The third part of the ***RJR-MacDonald*** test requires that the Court consider whether the balance of convenience favours granting the remedy. In this respect, the Applicants submit that the balance of convenience favours the granting of the injunction as the real risk of death should the injunction not be granted outweighs the need to respect the opinion of the treating physicians. The Applicants further submit that the injunction order would be for a brief period, particularly, until there is a consensus between the parties or a legal determination of the matter on a full trial.

B. Position of Alberta Health Services - Royal Alexandra Hospital

[23] Alberta Health Services submits that the application for an injunction should be dismissed because the consent of the patient, or anyone else, is not required for a physician to refrain from intervening. Further, it is argued that the decision to withhold life-sustaining care is ultimately that of the treating physician. The Respondents cite the text Picard, J.A. and Professor Robertson in support of the proposition that there is no legal duty to perform treatment which the doctor reasonably believes to be medically futile: E.I. Picard and G.B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed. (Toronto: Thomson Carswell, 2007).

[24] Alberta Health Services further submits that the principles governing interlocutory motions are not appropriate in the medical context and should not be considered. The fundamental issue to be considered is whether the Court should require a medical practitioner to adopt a course of treatment which, in the clinical judgment of the physician, is not in the best interest of the patient. They further suggest that judges should not replace the opinion of the medical community with their own.

[25] With respect to the procedural issue, Alberta Health Services was of the view that the Applicants may not be properly before the Court because proceedings had not yet been commenced by way of Statement of Claim.

C. Position of Dr. Randall Williams

[26] A preliminary submission was made on behalf of Dr. Williams that the application was not properly before the Court as it was brought by Originating Notice and not Statement of

Claim. While the arguments advanced on behalf of Dr. Williams coincide with those presented on behalf of Alberta Health Services, Dr. Williams submits that the proper approach is to consider what would best serve the interests of the patient. He further submits that it is in the patient's best interest that the application for an injunction be denied. Alternatively, Dr. Williams submits that if the Court applies the tripartite test outlined in ***RJR-MacDonald***, the facts and evidence in this case clearly support a dismissal of the application.

V. Analysis

A. Issue 1: What is the most appropriate procedure to be followed in making an application for an injunction in the context of an urgent life-threatening situation?

[27] There have been a number of reported decisions addressing injunctions in the context of a medical crisis: See ***Jin v. Calgary Health Region,*** 2007 ABQB 593 ***; Sawatsky v. Riverview Health Centre Inc.,*** [1996] 6 W.W.R. 298 (Man.Q.B.)***; Golubchuk v. Salvation Army Grace General Hospital,*** 2008 MBQB 49***; Re J. (A Minor) (A Wordship: Medical Treatment),*** [1992] 3 W.L.R. 507 (C.A.)***; Re I.H.V.,*** 2008 ABQB 250***; Rotary v. Vancouver General Hospital Intensive Care Unit,*** 2008 BCSC 318. However, there appears to be some confusion around the proper procedure to use when making applications for injunctive relief in the context of medical urgency.

[28] To date, the approach appears to be that proceedings are commenced by way of Statement of Claim pursuant to Rule 6 of the *Alberta Rules of Court*, Alta. Reg. 390/1968 [*Rules of Court*]. I am of the opinion that requiring that an action be commenced by Statement of Claim does not account for the sensitive nature of applications in the context of medical urgency. Furthermore, the time lines and formal processes prescribed in the *Rules of Court* for actions commenced by Statement of Claim are inappropriate in these circumstances. Namely, the requirement that parties file a Statement of Defence and/or Counterclaims and Affidavit of Records, and further that Examinations for Discovery and eventually a trial be conducted, are inconsistent with the objectives which underlie the need for injunctions in this context. There is no intention that a trial of the action will follow. Rather, the injunction is generally sought to preserve the *status quo* in the interim while a final decision is reached between families and physicians.

[29] In my view, Part 30 of the *Rules of Court* - Special Applications to the Court - provides the appropriate procedure to be followed in these circumstances. Rule 394 governs the applicability of Part 30 and reads as follows:

> **394** This Part applies
> (a) where by a statute or regulation the court or a judge is designated as having authority to issue any certificate or make any direction or order (otherwise than in any action), and
> (b) no procedure for an application to the court or a judge is provided.

[30] To fall within the scope of R. 394, the Court must (i) have the authority, by statute or regulation, to issue the order; and (ii) there must be no existing procedure for the application.

[31] In my opinion, the first requirement under R. 394 is satisfied by the authority given to the Court pursuant to the ***Judicature Act***, R.S.A. 2000, c. J-2. Specifically, s. 8 of the ***Judicature Act*** provides the following:

> The Court in the exercise of its jurisdiction in every proceeding pending before it **has power to grant and shall grant, either absolutely or on any reasonable terms and conditions that seem just to the Court, all remedies** whatsoever to which any of the parties to the proceeding may appear to be entitled in respect of any and every legal or equitable claim properly brought forward by them in the proceeding, so that as far as possible all matters in controversy between the parties can be completely determined and all multiplicity of legal proceedings concerning those matters avoided. [Emphasis added]

[32] Further, s. 13(2) of the *Judicature Act* states the following:

> An order in the nature of a mandamus or injunction may be granted or a receiver appointed by an interlocutory order of the Court in all cases in which it appears to the Court to be just or convenient that the order should be made, and the order may be made either unconditionally or on any terms and conditions the Court thinks just.

[33] Sections 8 and 13(2) of the *Judicature Act* set out the Court's authority to grant injunctions, and as such, I find that the first requirement under R. 394 is satisfied.

[34] The second requirement under R. 394 is that no procedure exist for bringing the application in question. It is clear that a definitive procedure has not been established for bringing applications for injunctive relief in the context of medical emergencies where end of life measures are contemplated.

[35] Given the Court's authority pursuant to the *Judicature Act* and the fact that no procedure currently exists for applications of this nature, I am of the opinion that both requirements under R. 394 are satisfied. As such, I find that applications for injunctions in the context of medical emergencies fall within the scope of Part 30 of the *Rules of Court*.

[36] Upon finding that Part 30 of the *Rules of Court* applies, R. 395 is triggered and sets out the procedure the Court is to follow when entertaining applications under Part 30. The Rule provides following:

> **395(1)** In any such case it is not necessary to file any document commencing proceedings, but the applicant shall, on an affidavit of the facts, apply ex parte to a judge, who may
> (a) proceed to determine the matter, ex parte, or

(b) direct that the matter be set over for hearing on notice, in which case the judge shall designate what persons are to be served with notice, and may prescribe the nature of the notice, and the time for and mode of service.

(2) The directions given shall either be endorsed upon the affidavit of facts or set forth in an order.

(3) Subject to any such directions, the form and content of the notice and the procedure applicable shall be as provided in Part 33, mutatis mutandis.

(4) Upon the return of the application the court has all the powers that the court has on return of an originating notice under Part 33.

(5) All original affidavits, orders, or directions and copies of notices, shall be filed in the office of the clerk for the district in which the application is made.

(6) Affidavits for use in the proceedings under this Part may be sworn at any time.

(7) The costs of and incidental to any application under this Part are in the discretion of the court and subject thereto, Part 47 relating to costs applies.

[37] In short, R. 395 provides that the applicant shall apply *ex parte* on an Affidavit of facts rather than requiring that commencing documents, such as a Statement of Claim, be filed. The Court is then permitted to proceed to determine the matter *ex parte* or direct that the matter be set over for a hearing on notice to those persons the Court deems appropriate. Further, the Court may prescribe the nature of the notice, the time for, and the mode of service.

[38] Rule 395(3) goes on to state that, subject to any directions of the Court resulting from an order under Rule 395(1)(b), the form and content of the notice and the procedure applicable shall be in accordance with Part 33 of the *Rules of Court*. That is, R. 404 - 410 which deal with Originating Notices. In addition to the Affidavit requirements contained in Part 33, the Court may give such direction as is necessary and permit evidence to be given orally: *Rules of Court*, R. 407.

[39] Finally, under R. 409 the Court has the power to summarily dispose of the questions arising on the Originating Notice application. Moreover, the Court may make such orders as the nature of the case requires or may give such directions as seem proper for the trial of any questions arising on the application.

[40] Rules 394 -395 and the *Judicature Act* were considered and applied by this Court in ***Switzer v. Gruenewald*** (1997), 207 A.R. 391 (Q.B.). In ***Switzer,*** an application was made to set aside an *ex parte* Restraining Order on the grounds that no action had been commenced at the time the Restraining Order was granted. The Court held that it had the authority to issue a Restraining Order even though commencement documents had not been filed. The Court found that it was authorized to issue a Restraining Order or interlocutory injunction pursuant to s. 13(2) of the *Judicature Act*. Seeing as no procedure was provided for in a statute, the Court held that R. 395 was applicable.

[41] In summary, it is my view that the current practice of bringing these types of applications by Statement of Claim is not the proper procedure. Rather, when an injunction is sought in the context of medical urgency, or in other similar situations, the proper and appropriate process is found in Parts 30 and 33 of the *Rules of Court*. Applications of this nature necessitate timely decisions and cannot be left to linger for months, as may be the case in other non-urgent civil proceedings.

[42] The rules contained in Parts 30 and 33 of the *Rules of Court* permit the Court to meet the special needs associated with applications in this context. Where an injunction is sought in this context, it is not with a view to preserve the *status quo* pending further litigation. Rather, the injunction is akin to a final determination of the matter because the Court's decision is often linked to life or death. The procedure set out in Parts 30 and 33 is more consistent with the objectives associated with injunctions of this nature and allows the Court more flexibility and discretion when making determinations in these sensitive situations. Accordingly, it is my view that it is the proper process to be followed in such situations.

B. Issue 2: What, if any, consideration should be given to a patient's wishes, beliefs, and values when they are contrary to the course of treatment recommended by the health care providers?

[43] The issue raised relates to the level of importance which should be placed on the wishes and beliefs of the patient when those wishes and beliefs are contrary to a course of treatment recommended by the physician. On September 25, 2009, I found that the declaration signed by Mr. Sweiss on August 15, 2009 was not a personal directive which met the requirements of the *Personal Directives Act*, R.S.A. 2000, c. P-6. However, I did find that it provided a clear indication of his wishes to have Islamic Sharia law apply to these issues concerning his health.

[44] I am satisfied that the patient's direction regarding treatment is a factor which must be considered by the Court. Whether the wishes and direction of the patient are grounded in religious belief or otherwise makes little difference. However, I am of the view that religious beliefs can never be allowed to trump all other opinions or principles in determining what is in the best interest of the patient. Where possible, the wishes or religious beliefs of the patient should be given considerable weight, subject, however, to the patient's best interest.

[45] Although it was not argued before the Court, it is important to review the law relating to personal directives which meet the requirements of the *Personal Directives Act*. What implications would such a directive have on the medical personnel or service providers as defined under the *Personal Directives Act*? Section 19(1) of the Act provides that service providers, which includes doctors, "must" follow any clear instructions that may be contained in a personal directive. If the personal directive does not designate an agent, the service provider must follow any clear instructions in the personal directive that are relevant to the decision being made: *Personal Directive Act*, s. 19(1)(b).

[46] Section 14(3) of the Act provides assistance in determining the intent of the maker of the personal directive where the directive does not contain clear instructions. The primary consideration relates to what is believed to be the decision of the maker in the circumstances, taking into account the knowledge of the wishes, beliefs and values of the maker of the personal directive: *Personal Directives Act*, s. 14(1)(3)(a). Section 14(1)(3)(b) of the Act goes on to provide that if those wishes, beliefs and values are not known, then the instructions should be interpreted with reference to what is believed to be, in the circumstances, in the best interest of the maker.

[47] It should further be noted that any interested person may apply to the Court by way of Originating Notice for a hearing to determine different issues as provided for in s. 27(1): *Personal Directives Act*, s. 25. However, the Court cannot add or alter the intent of the instructions contained in a personal directive: *Personal Directives Act*, s. 27(3). Thus, in summary, it is clear from a reading of these provisions that a high level of importance is placed on the wishes of the individual making the personal directive.

[48] Given the mandatory wording of s. 19(1) of the *Personal Directives Act*, it appears that where a personal directive with clear instructions conflicts with recommended medical treatment, the wishes, directions and instructions of the patient will prevail. In my view, this drafting reflects the fact that the Legislature only contemplated that personal directives would state that no extraordinary measures be taken to keep a patient alive. The Legislature does not appear to have anticipated that some directives would provide for indefinite life support. Thus, as the law currently stands, it appears that if a personal directive directs that all possible measures be taken to keep the patient alive, whether or not he is brain dead or no longer breathing on his own, the direction must be followed despite the fact that life support may be required for an indefinite period of time.

C. Issue 3: What is the appropriate test to be applied in determining whether an injunction should be granted in the context of urgent life-threatening situations?

[49] The traditional test applied for the granting of an injunction in this context has been the three-part test outlined in ***RJR-MacDonald*** and other cases. The test requires that the following three things be demonstrated: (i) there is a serious issue to be tried; (ii) irreparable harm will result if the injunction is not granted; and (iii) the balance of convenience favours the granting of the inunction. Mr. Sweiss brought the following cases to the Court's attention to support the position that the ***RJR-MacDonald*** test ought to be used in these types of situations: ***Jin v. Calgary; Sawatsky v. Riverview; Golubchuk v. Salvation***.

[50] However, in more recent decisions the courts have moved away from the traditional approach and applied other tests. Alberta Health Services and Dr. Williams brought the following cases in support of their contention that different considerations ought to be applied when an injunction is sought in this context: ***Re J. (A Minor); Re I.H.V.; Rotary v. Vancouver General Hospital***.

[51] The differences in the cases put before me demonstrate that the law in this area is unsettled. However, I find that the traditional test for injunctive relief is inappropriate in the context of medical urgency or crisis and different factors ought to prevail. In my view, the three considerations that form the basis of the ***RJR-MacDonald*** test are somewhat nonsensical. Particularly, I find that the first two prongs of the test are improper considerations.

[52] First, in the majority of these cases there is no intention that the matter will proceed to trial. Moreover, the underlying dispute does not lend itself to adversarial litigation and forced resolution. Thus, considering whether there is a "serious issue to be tried" does not appear to be appropriate as (i) the matter before the Court is always serious; and (ii) the matter must be addressed but trial is likely not the method the parties intend.

[53] Second, in this context the determination of whether to grant an injunction often determines whether an individual lives or dies. There will never be an application made in this context where irreparable harm would not flow should the injunction be refused. Accordingly, the second prong of the ***RJR-MacDonald*** does not fit these circumstances either.

[54] In assessing what considerations should guide the court in these applications, it is important to note that the Supreme Court's decision in ***RJR-MacDonald*** was based on the principles set out by the House of Lords in ***American Cyanamid Co. v. Ethicon Ltd.***, [1975] A.C. 396 (H.L). The principles established in ***American Cyanamid*** formed the basis of the tripartite test now used in determining whether injunctions ought to be granted. Our courts appear to apply the ***RJR-MacDonald*** test strictly; however, in my view, it was never intended that the three-step approach be inflexible in its application.

[55] In ***Hubbard v. Vosper ,*** [1972] 2 Q.B. 84 at 96 (C.A.), Denning, L.J. stated that the remedy of injunction "must not be made the subject of strict rules." This position was adopted by McLachlin, J.A., as she then was, in ***British Columbia (A.G.) v. Wale*** (1986), 9 B.C.L.R. (2d) 333 at 346 (C.A.), aff'd [1991] 1 S.C.R. 62 .Writing for the majority, McLachlin J.A. noted the following:

> Having set out the usual procedure to be followed in determining whether to grant an interlocutory injunction, it is important to emphasize that the judge must not allow himself to become the prisoner of a formula. The fundamental question in each case is whether the granting of an injunction is just and equitable in all of the circumstances of the case...

[56] McLachlin J.A.'s comments are particularly instructive on how the ***RJR-MacDonald*** test is to be applied. In my view, the case stands for the proposition that there need not be strict adherence to a formula, and further, that the fundamental consideration is whether the granting of an injunction is just and equitable in all the circumstances of the case. As a result of the above, I am satisfied that strict compliance with the tripartite test set out in ***RJR-MacDonald*** is

not required in situations where an injunction is sought in the context of medical urgency or crisis.

[57] In ***I.H.V.***, Germain J. adopted the best interest approach. He stated that injunction applications in situations of medical crisis do not fit well into the traditional test set out in ***RJR - MacDonald*.** He did not grant the injunction request and set out his reasons as follows at para. 31:

> ... This type of case does not fit well and does not accord well with the normal injunction analysis that we embark on in Canada. It will always be in the patient's best interests if we look only at the issue of sustaining life v. quality- of-life, that herculean medical efforts take place. I am not satisfied that we as judges should be replacing our opinion with that of the medical community that has obtained extensive, unbiased third party analysis, including opinions from medical ethicists and an intensive care specialist, not associated with this health region as to the appropriateness of involving the care of their patient in palliative care.

[58] In ***I.H.V.***, Germain J. highlighted the English case of ***Re J.*** and found that it reflected the considerations which ought to inform the Court's decisions in this context. In ***Re J.***, a one-month-old child suffered from head trauma and was fighting for his life. When physicians suggested that life saving efforts be spared, the child's mother disagreed. The lower court issued an interim injunctive order preserving the *status quo*. However, in a unanimous judgment, the English Court of Appeal reversed the decision.

[59] In reasoning the judgment of the English Court of Appeal in ***Re J.,*** Donaldson L.J. stated the following at 516:

> Let me say at once that in a matter of this nature there is absolutely no room for the application of the principles governing the grant of interlocutory relief which were laid down by Lord Diplock in ***American Cyanamid Co. v. Ethicon Ltd.***, [1975] A.C. 396, 408. The proper approach is to consider what options are open to the Court in a proper exercise of its inherent powers and, within those limits, what orders would best serve the true interests of the infant pending the final decision. There can be no question of "balance of convenience." There can be no question of seeking, simply as such, to preserve the status quo, although on particular facts that may well be the Court's objective as being in the best interests of the infant. There can be no question of, "preserving the subject matter of the action." Manifestly, there can be no question of considering whether damages would be an adequate remedy.
>
> The fundamental issue in this appeal is whether the Court in the "exercise of its inherent power to protect the interests of minors should ever require a medical practitioner or a health authority acting by a medical practitioner to adopt a course of treatment which in the bona fide clinical judgment of the practitioner concerned is contra-indicated as not being in the best interests of the patient.

[60] The overriding theme which pervades the reasons of the English Court of Appeal in ***Re J.*** relates to its concern over the Court ordering a medical professional to treat his or her patient in a fashion which is contrary to clinical judgment. The Court in ***Re J.*** expressed its rationale as follows at 519:

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

[61] It appears that in both ***Re J.*** and ***I.H.V.*** the courts have rejected the three-part test traditionally used in determining whether to grant an injunction order. Further, these decisions reveal that the proper approach to be adopted in these circumstances is one which places the best interest of the patient at the forefront of the analysis. I agree and adopt the reasons outlined in ***Re J.*** when rejecting the use of the procedure set out in ***American Cyanamid*** and later ***R.J.R.-MacDonald***. I am also in agreement that, in exercising its inherent powers, the Court should consider whatever options are available in determining what orders would be in the best interest of the patient.

[62] However, the Courts in ***Re J.*** and ***I.H.V.*** appear to adopt the position that, although the recommended course of treatment is but one of the considerations or factors, it is in fact the consideration which trumps all others. That is to say that no court should order a physician or medical professional to prescribe a course of treatment which may be contrary to the views of health care providers. I respectfully disagree with this proposition.

[63] In my opinion, the proper test to be applied in this type of case in what is in the patient's best interest. This inquiry requires that several matters be considered and weighed. Some of the pertinent considerations include: (i) the medical condition of the patient; (ii) the recommended medical treatment, including doing something, nothing or very little; (iii) the wishes and beliefs of the patient, if they are known; and (iv) what is just and equitable in all of the circumstances of the case. This list does not exhaust the factors which may considered in such applications, but rather reflects some of the issues to be considered in determining what is in a patient's best interest. In addition, I wish to emphasize that no factor should be considered paramount and all considerations ought to receive equal weight.

[64] In light of the above, it is my opinion that simply because a medical procedure can be done does not mean that it should be done. I agree with the general premise that courts and patients should not require that doctors provide a course of treatment which is not in their best interest. I also believe that the patient's wishes and directions regarding his or her treatment are a factor which must be considered by the Court. It makes little difference whether these wishes

and directions are grounded in religion or otherwise. Rather, what is key is that the patient's wishes, values, and beliefs are considered by the Court in making a determination in this context. However, it is also my view that a patient's wishes and beliefs should never be said to trump all other factors, principles, or opinions where a determination as to what is in the patient's best interest is being made. There may be situations where the patients wishes or directions run contrary to his or her best interest or where they are inconsistent with what is just and equitable in the circumstances. For example, a direction not to provide a child or adult a necessary blood transfusion to avoid death.

[65] In summary, I am of the view that the proper test to be applied is what is in the best interest of the patient. In determining the best interest of the patient there are several factors and considerations which should be taken into account. Although not exhaustive, they include:

(i) the patient's actual condition;
(ii) the medical treatment that is recommended;
(iii) the wishes and directions of the patient; and
(iv) what is just and equitable in the circumstances.

All of these factors and considerations must be weighed and balanced and no one factor should be considered determinative.

[66] Having outlined what I believe to be the proper test in these types of applications, I move now to address the two requests before me. With respect to the removal of the mechanical ventilator, I am granting an interim injunction preventing the removal of the mechanical ventilator until Wednesday, September 30th at 4:00 p.m. I am satisfied that this is in Mr. Sweiss' best interest.

[67] Firstly, the Court relies on Dr. Williams evidence that there is still some brain function, although it is reflex brain function. Further, although the tube in Mr. Sweiss is more painful than a mask or prongs, it is Dr. Williams' opinion that Mr. Sweiss' pain indicators are markedly decreased, which means to me that he does not feel much pain. Therefore, leaving the tube in will not cause excessive, unwarranted pain for Mr. Sweiss.

[68] Additionally, granting the interim injunction which prevents the removal of the mechanical ventilator for this short period of time respects the wishes and beliefs of Mr. Sweiss and is consistent with the Sharia law. This is so because Mr. Sweiss' breathing has not stopped completely at this time. However, in addition to attempting to respect the wishes and beliefs of Mr. Sweiss, the purpose of this order is to allow the Sweiss family to obtain an independent assessment regarding their father's condition. I am satisfied that the interim injunction for this short period is appropriate for that purpose. It is also recommended by the clinical ethicist, Gary Goldsand, who stated that a few final tests to confirm Mr. Sweiss' condition could be beneficial.

[69] Second, the request that there be a removal or a lifting of the DNR order is not granted. I am satisfied that it is in Mr. Sweiss' best interest that there be no attempts at resuscitation in the

event of a cardiac failure. In that regard, I accept the evidence of Dr. Williams that active intervention would create substantial harm to Mr. Sweiss and that any such procedure would be of no benefit to him. Further, I accept that this Court should not, in the circumstances of this particular case, force the doctor to go against the primary medical principal of doing no harm. Whereas Dr. Williams has specifically said that he knows that there will be harm created if such an event is required to take place, I find that it would be inappropriate to grant the request.

[70] I further rely, but to a lesser extent, on the opinion of the clinical ethicist, Gary Goldsand, who spent substantial time with the family. His evidence was that attempting CPR would very likely be harmful to Mr. Sweiss and make his death less dignified. Lastly, I am of the opinion that allowing the DNR order to remain in place is consistent with Mr. Sweiss' wishes and religious beliefs. The Sharia law provided to me addressed the issue of at what stage a life support system can be turned off. The extraordinary measure, namely CPR, which would be required in the event of cardiac failure are clearly not in Mr. Sweiss' best interest nor are they a reflection of his wishes or beliefs as contained in Appendices 1 and 2.

VI. Conclusion

[71] In my view, Rules 394 and 395 provide the most appropriate procedure for making an injunction application in the context of an urgent medical situation. The use of these *Rules* clearly provides the Court with the tools necessary to summarily dispose of questions which require a prompt hearing and an immediate and timely decision.

[72] I am of the opinion that the proper test to be applied in determining whether an injunction should be granted in these types of applications is what is in the patient's best interest. In coming to this conclusion, I adopted the reasoning set out in ***Re J***. that the three-part test contained in ***R.J.R. MacDonald*** is not appropriate for this type of application. However, I wish to highlight that I do not agree with the idea that the overriding consideration ought to be what treatment is being recommended by physicians.

[73] In determining what is in the patient's best interest, consideration should be given to such matters as the patient's actual medical condition, the recommended treatment program, the patient's wishes and beliefs, and what is just and equitable. These factors should be weighed and balanced with a view to arriving at what is in the patient's best interest without any specific factor being determinative. Moreover, I do not purport to have created an exhaustive list of considerations, but rather a starting point for the analysis in these matters.

[74] Although I have held that no one factor should be treated as paramount, this conclusion may not apply where a valid personal directive exists which runs contrary to the proposed medical treatment program. In cases where a personal directive is found to exist, it would appear that, pursuant to the authority in the *Personal Directives Act*, the wishes, beliefs and values of the patient "must" be followed.

Heard on the 25th and 30th days of September, 2009.

Dated at the City of Edmonton, Alberta this 24th day of November, 2009.

Vital O. Ouellette
J.C.Q.B.A.

Appearances:

Mona F. Karout
for the Applicants (Plaintiffs) Ahmed Sweiss & Samir Sweiss by his Next Friend (Ahmed Sweiss)

Michael Waite
for the Respondents (Defendants) Alberta Health Services & Royal Alexandra Hospital

David Steele
for the Respondent (Defendant) Dr. Randall G. Williams

APPENDIX 1

In the name of Allah most gracious most merciful

I Samir Sweiss born March 20 1945 declare that there is only one god and Mohammed is the messenger of god. I practice and believe in the true religion of Islam and follow all Islamic rules including the sharia Law (Islamic Law).

I know that I have been sick and in and out of the hospital for a long time now, if something was to happen to me my wishes are to follow all Islamic law (the sharia law), in whatever comes my way.

Thank you *"Blessed be He in whose hands is the Dominion, and he has Power over all things. He who created death and life that He may test which of you are best in deed, and He is Exalted in Might, Oft-Forgiving." (Quran 67: 1-2)*

Samir Sweiss Samir Sweiss

Next of kin: Hait Sweiss Hait Sweiss

Witness: Bara'ah Sarhan

Date : Aug 15, 2009 @ 4:12 pm.

APPENDIX 2

بسم الله الرحمن الرحيم
IN THE NAME OF ALLAH, MOST GRACIOUS, MOST MERCIFUL
AU NOM DE DIEU LE CLEMENT LE MISERICORDIEUX
CANADIAN ISLAMIC CENTRE
(AL-RASHID MOSQUE)
"Let there be no compulsion in religion. Truth has been made clear from error." Quran: 256

When is it permissible to turn off the life support systems of a person who is thought to be dead?

Many doctors hesitate to decide the right time to turn off the life support systems of a person who is clinically dead. The doctor has two conflicting feelings: he may think that he is prolonging the agony of the dying person, and that if he turns of the life support system, he will be giving the person the relief of dying. On the other hand, however, he fears that by turning the life support systems off, he is depriving the person of the opportunity to continue living. When is it permissible to turn off the life support systems in the case of people who are clinically dead?

Praise be to Allah.

In sharee'ah, a person is considered to be dead and therefore subject to all the rulings concerning the deceased, when either of the two following signs are noted:

When his heartbeat and breathing stop completely, and the doctors decide that they cannot be restarted.

When all the functions of his brain stop completely, and experienced doctors and specialists state that this is irreversible, and his brain has started to disintegrate.

In these circumstances, it is permissible to turn off life support systems, even if some parts of his body – such as the heart, for example – are still functioning artificially with the help of these machines.

Majma' al-Fiqh al-Islami, p. 36.

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