Federal Court  Cour fédérale

Date: 20120127

Docket: T-236-11

Citation: 2012 FC 106

Ottawa, Ontario, January 27, 2012

PRESENT: The Honourable Madam Justice Bédard

BETWEEN:

OLGA PLESZKEWYCZ

Applicant

and

THE ATTORNEY GENERAL OF CANADA

Respondent

REASONS FOR JUDGMENT AND JUDGMENT

[1] This is an application for judicial review of a decision by Marc Gervais, Manager of the Allan Memorial Institute Depatterned Persons Assistance Plan (the Assistance Plan), dated January 11, 1994, in which he confirmed his initial decision of April 18, 1993, whereby he denied Ms. Pleszkewycz's (the applicant) application for compensation under the *Order Respecting Ex Gratia Payments to Persons Depatterned at the Allan Memorial Institute Between 1950 and 1965*, P.C. 1992-2302 (the Order). For the following reasons, this application will be dismissed.

I. Background of the Order

[2] It will be useful, for a good understanding of the decision at issue, to outline the historical context into which the Order was adopted.

[3] In the early 1980s, the Government of Canada became concerned about medical research and controversial medical treatments that had been administered to psychiatric patients who had been treated at the Allan Memorial Institute of the Royal Victoria Hospital in Montreal (the AMI) during the 1950s and the 1960s, and more specifically, to patients under the care of the psychiatrist Dr. Ewen Cameron. These concerns arose in the context of a lawsuit initiated by former patients of the AMI against the Government of the United States, claiming damages for injuries resulting from psychiatric treatments received from Dr. Cameron. The claimants were alleging that the Central Intelligence Agency funded Dr. Cameron to perform psychiatric experiments on them without their consent. The treatments at issue involved massive electroshocks, psychic driving, drug-induced sleep and the use of chemicals such as lysergic acid diethylamide, or LSD, that caused severe and long-lasting damages to the patients.

[4] Since the research that led to the psychiatric treatments dispensed by Dr. Cameron was funded, in part, by the Federal Government of Canada, it was concerned about its potential liability. The Minister of Justice mandated an attorney, George T.H. Cooper, to investigate into the matter and prepare a legal opinion as to the Crown's potential liability. Mr. Cooper carried out a thorough inquiry into Dr. Cameron's research and the treatments that were administered to patients of the AMI at the time. He prepared a report that he submitted to the Minister of Justice in February 1986,

which comprised a comprehensive description of Dr. Cameron's research and treatments, along with his opinion about the Government's liability.

[5] Mr. Cooper focussed his work on a specific technique called "depatterning" because it was similar to some of the treatments at issue before the courts in the United States, but at the outset of his opinion, he listed and classified different psychiatric techniques that were used at the AMI in the 1940s, 1950s and 1960s as follows:

> The psychiatric treatments administered at the Allan at various times during the 1940's, 1950's and 1960's may for present purposes be divided into two categories:
>
> (1) those in use elsewhere in Canada and the world; these included ECT (electro convulsive therapy, sometimes called electroshock therapy), insulin coma shock therapy, sleep therapy and drugs (including lysergic acid diethylamide, or LSD); and
>
> (2) those in use at the Allan and at a few centres in some other countries (but not elsewhere in Canada); these included depatterning, psychic driving and sensory isolation.
>
> (p. 13 of the report)

[6] Mr. Cooper provided a good summary of Dr. Cameron's beliefs which inspired his research and the administration of depatterning treatments to patients. At pages 14 and 15 of his report, he expressed the following:

> Dr. Cameron held the view that mental illness was the consequence of the patient's having learned over the years "incorrect" ways of responding to the world around him or her.

> The "brain pathways" had thus developed through repetition a set of "learned responses" that were not socially acceptable and resulted in the patient's being classified as mentally ill.
>
> It had been observed over many years by psychiatrists that persons who were subject to convulsions of the brain did not become mentally ill. Examples are those who suffer from epileptic convulsions, and those who suffer from insulin coma. It was speculated that these naturally occurring convulsions somehow cleared the "brain pathways" and thus eliminated these "incorrect" thought processes. From these observations it was deduced that if convulsions could be applied artificially to mentally ill patients, the "brain pathways" would be broken up and the patient's illness would be relieved. This was the fundamental idea behind ECT, insulin coma shock therapy and other therapies designed to induce convulsions.
>
> Dr. Cameron took hold of this idea and developed it much further than psychiatrists in the mainstream of European and North American practice. His idea was to break up the brain pathways through the highly disruptive application of massive electroshocks, many times the number of shocks in a normal ECT treatment – two times a day, as opposed to three times a week, for example – until the patient's brain had been "depatterned"; i.e. (in the case of psychotic patients) until all schizophrenic symptoms were lost, as well as other aspects of memory. After this had occurred, the idea was then to "re-pattern" the brain by trying to instill new and "correct" patterns of thinking in the patient's mind.

[7] Dr. Cameron used depatterning procedures with psychotic patients and psycho-neurotic patients. The technique involved the destructuring of the patient's brain followed by its restructuring. Mr. Cooper described as follows the procedures involved in depatterning and prolonged sleep treatment:

> In depatterning, the patient would be subjected to massive electroshock treatments – sometimes up to twenty or thirty times as intense as the "normal" course of electro convulsive therapy (ECT) treatments. At the end of up to 30 days of treatment – up to 60 treatments at the rate of two per day – **the patient's mind would be more or less in a childlike and unconcerned state**.

> **In preparation for the treatment, the patient would be put into a state of prolonged sleep for a period of about ten days, using various drugs. At that point, the massive electroshock therapy would begin, the patient being maintained on continuous sleep throughout.** Somewhere between the thirtieth and sixtieth day of sleep, and after 30 to 60 electroshock treatments, depatterning would be complete. Depatterning was then maintained for about another week, with electroshocks being reduced to three per week.
>
> Gradually the treatments were reduced to one a week. **Then followed a period of reorganization, when the patient came back from the "third stage", through the "second stage", up to the "first stage" of depatterning.** . . . (pp. 17-18 of Mr. Copper's report).
>
> [Emphasis added]

[8] Mr. Cooper indicated that it was in 1955 that Dr. Cameron perfected the full depatterning procedure.

[9] Mr. Cooper concluded that it is now clear that Dr. Cameron's depatterning procedures were not "based on sound principles of science or medicine" (p. 26 of the report). Mr. Cooper concluded, however, that Dr. Cameron's research and treatments, including the depatterning procedure, were still acceptable in light of the medical practice standards applicable at the time. With respect to the Crown's liability, Mr. Cooper concluded as follows:

> In my opinion, given the climate of the times, and the prevailing practices as to medical research and experimentation, ethics and consent, the Government of Canada cannot be expected to bear responsibility for what happened at the AMI, even assuming (contrary to my own conclusion on the point) that Dr. Cameron crossed over the line of the acceptable in medical research. . . . (p. 126 of the report).

[10] Despite his opinion that the Federal Government had neither a legal nor a moral liability towards patients treated by Dr. Cameron, Mr. Cooper discussed the possibility of *ex gratia*

payments to Dr. Cameron's patients and examined at length the relevant issues; yet, he did not make a positive recommendation that such payments be made. The Government of Canada nevertheless decided to make an Order authorizing the Minister of Justice to make, under certain conditions, an *ex gratia* payment of $100,000 to any depatterned person.

[11] The Government adopted the Assistance Plan to administer the compensation process provided for in the Order. The Assistance Plan's information guide stated as follows the purpose of the plan:

> BACKGROUND INFORMATION
>
> The Allan Memorial Institute Depatterned Persons Assistance Plan (A.M.I.D.P. Assistance Plan) of the Government of Canada is providing $100,000 to assist persons living in Canada, as a compassionate response, to a group of victims of medical misfortune. These people are the former patients of Dr. Ewen Cameron who, between the years 1950 and 1965, were treated with psychiatric depatterning techniques funded by the Government of Canada.

[12] The Order provided definitions of the phrases "depatterned person" and "depatterning treatment" which correspond essentially, although in an abridged form, to the definitions and explanations contained in Mr. Cooper's report. These definitions read as follows:

> "depatterned person" means a person who received full or substantial depatterning treatment at the Allan Memorial Institute in Montreal between 1950 and 1965 as a patient of Dr. Ewen Cameron;
>
> "depatterning treatment" means prolonged sleep followed by massive electroshock treatments, reducing the patient's mind to a childlike state;

[13] The Assistance Plan's information guide provided information about the application procedure and about the administrative decision-making process. It indicated that applications

would be reviewed by a medical examiner whose recommendation would then be reviewed by a Department of Justice Committee (the Judicial Committee), which would make the final decision.

II. The applicant's history and the decision under review

[14] The applicant was admitted at the AMI on July 3, 1958 and was discharged on August 26, 1958. She was treated by Dr. Cameron and his team for a "post partum psychosis, schizophrenic in type" (Dr. Cameron's report at page 79 of the applicant's record). During her stay at the AMI, the applicant received intensive electro-convulsive therapy; she received 25 electroshocks (ECTs), 13 of them being of the Page Russell type (six times more intense than a regular ECT). She was also given Sodium Amytal and Lagactil. After her discharge, the applicant was followed by Dr. Cameron as an out-patient until 1960.

[15] On December 6, 1992, the applicant filed an application for compensation under the Order. The application, along with the applicant's hospital record from the AMI, was reviewed by a medical examiner from the Blue Cross. The medical examiner recommended that the applicant's application be denied on the ground that there was no indication that she had received sleep therapy or depatterning treatment. The recommendation read as follows:

> The applicant was treated on one occasion at the Allan Memorial Institute. The applicant received 24 ECT's during this admission, however there is no indication of sleep therapy or depatterning.
>
> In view of the medical records provided, I cannot recommend acceptance of this application for assistance.

[16] There is a note in the record from the Judicial Committee members who received the medical examiner's recommendation. The notes states as a final evaluation: "Good example of difference between intensive electro-convulsive therapy and depatterning."

[17] Marc Gervais, member of the Judicial Committee and Manager of the Assistance Plan denied the applicant's application in a decision dated June 25, 1993, which reads as follows:

> Your application under the Allan Memorial Institute Depatterned Persons Assistance Plan has been received and your eligibility for assistance cannot be approved.
>
> The Order in Council which established authority to compensate persons under the provisions of the Assistance Plan defined depatterning as follows:
>
> > "prolonged sleep followed by massive electroshock treatments, reducing the patient's mind to a childlike state".
>
> Accordingly, to be successful for an ex-gratia payment of $100,000 a person must have undergone depatterning treatment as defined above.
>
> The medical evidence you provided does not indicate that you were subjected to depatterning as defined in the Order in Council or that any treatments your [*sic*] received while at the Allan Memorial Institute reduced your mind to a child like state.
>
> Based on the medical records submitted with your application, Blue Cross recommended the application not be accepted and the Examination Committee of the Department of Justice reviewed and accepted that recommendation.

[18] The applicant asked for a reconsideration of that decision, but, on January 11, 1994, Marc Gervais sent a letter to the applicant informing her that the decision remained unchanged.

[19] This application for judicial review was filed in September 2010, well beyond the 30-day time limit provided for in section 18.1 of the *Federal Courts Act*, RSC, 1985, c. F-7 and Rule 359 of the *Federal Courts Rules*, SOR/98-106. The applicant instituted these proceedings after having been informed of two judgments rendered by this Court with respect to decisions from the Judicial

Committee denying compensation under the Order to former patients of Dr. Cameron. In June 2004, Justice Beaudry, in *Kastner v Canada (Attorney General)*, 2004 FC 773, 254 FTR 97 [*Kastner*], overturned the decision of the Judicial Committee to deny compensation to Gail Kastner under the Order; Ms. Kastner had been treated by Dr. Cameron at the AMI in 1953. In February 2007, Justice Martineau granted an extension of time to serve and file an application for judicial review of a decision rendered by the Judicial Committee in a case involving Janine Huard, another former patient of Dr. Cameron who was denied compensation under the Order (*Huard v Canada (Attorney General)*, 2007 FC 195, 328 FTR 1).

[20] When informed about those two cases, the applicant initiated these proceedings. On August 26, 2010, she served and filed a Motion for an extension of time to serve and file a Notice of Application. The Motion was granted on consent on December 16, 2010.

Issue

[21] The issue herein is whether the decision to deny the applicant compensation under the Order was reasonable.

III. Standard of review

[22] It is not clear from the applicant's submissions whether this Court is invited to review the Judicial Committee's decision on a standard of correctness or reasonableness. She argues that no deference is owed to it since the Order does not contain a privative clause, important human rights are at stake, and the Judicial Committee does not have special expertise in psychiatry. She concedes, however, that her case raised a question of mixed fact and law and that the Judicial Committee

enjoyed a measure of discretion. Those two elements militate in favour of deference. The applicant argues that, in any event, the Judicial Committee's decision cannot stand on either standard of review since it erred by having addressed the wrong issue.

[23] The respondent contends that the decision should be reviewed on the reasonableness standard of review and cites *Kastner*, where Justice Beaudry held that the applicable standard was reasonableness *simpliciter*.

[24] I agree with the respondent. In *Canada (Canadian Human Rights Commission) v Canada (Attorney General)*, 2011 SCC 53 at paras 16-17, 337 DLR (4th) 385, the Supreme Court reiterated the applicable process in the standard of review analysis:

> **16** *Dunsmuir* kept in place an analytical approach to determine the appropriate standard of review, the standard of review analysis. The two-step process in the standard of review analysis is first to "ascertain whether the jurisprudence has already determined in a satisfactory manner the degree of deference to be accorded with regard to a particular category of question. Second, where the first inquiry proves unfruitful, courts must proceed to an analysis of the factors making it possible to identify the proper standard of review" (para. 62). The focus of the analysis remains on the nature of the issue that was before the tribunal under review (*Khosa*, at para. 4, *per* Binnie J.). The factors that a reviewing court has to consider in order to determine whether an administrative decision maker is entitled to deference are: the existence of a privative clause; a discrete and special administrative regime in which the decision maker has special expertise; and the nature of the question of law (*Dunsmuir*, at para. 55). *Dunsmuir* recognized that deference is generally appropriate where a tribunal is interpreting its own home statute or statutes that are closely connected to its function and with which the tribunal has particular familiarity. Deference may also be warranted where a tribunal has developed particular expertise in the application of a general common law or civil law rule in relation to a specific statutory context (*Dunsmuir*, at para. 54; *Khosa*, at para. 25).

> **17** *Dunsmuir* nuanced the earlier jurisprudence in respect of privative clauses by recognizing that privative clauses, which had for a long time served to immunize administrative decisions from judicial review, may point to a standard of deference. But, their presence or absence is no longer determinative about whether deference is owed to the tribunal or not (*Dunsmuir*, at para. 52). In *Khosa*, the majority of this Court confirmed that with or without a privative clause, administrative decision makers are entitled to a measure of deference in matters that relate to their special role, function and expertise (paras. 25-26).

[25] I am, for the most part, in agreement with the principles enunciated in *Kastner*. I am also of the view that a standard of review analysis would lead to adopting the reasonableness standard of review. The decision of the Judicial Committee involved a question of mixed fact and law: it was asked to interpret the Order and apply it in light of the evidence submitted in each case. The Judicial Committee was created specifically to examine applications made under the Order; that was its sole mandate. Although not composed of physicians or psychiatry experts, the Judicial Committee was composed of jurists who were familiar with the Order and who had the advantage of being apprised of the recommendations of a medical examiner who had reviewed the file prior to undertaking their own examination. Considering the context and the purpose of the Order, the absence of a privative clause is not determinative. The Judicial Committee's decision will, therefore, be reviewed on a standard of reasonableness.

[26] That standard was described as follows in *Dunsmuir v New Brunswick*, 2008 SCC 9 at para 47, [2008] 1 SCR 190:

> **47** Reasonableness is a deferential standard animated by the principle that underlies the development of the two previous standards of reasonableness: certain questions that come before administrative tribunals do not lend themselves to one specific, particular result. Instead, they may give rise to a number of possible, reasonable conclusions. Tribunals have a margin of

> appreciation within the range of acceptable and rational solutions. A court conducting a review for reasonableness inquires into the qualities that make a decision reasonable, referring both to the process of articulating the reasons and to outcomes. In judicial review, reasonableness is concerned mostly with the existence of justification, transparency and intelligibility within the decision-making process. But it is also concerned with whether the decision falls within a range of possible, acceptable outcomes which are defensible in respect of the facts and law.

[27] Recently, in *Newfoundland and Labrador Nurses' Union v Newfoundland and Labrador (Treasury Board)*, 2011 SCC 62 at paras 14-16 (available on CanLII) [*Newfoundland and Labrador Nurses' Union*], the Supreme Court made comments on the deference owed to decision-makers when the reasonableness standard of review applies and stressed the necessity to assess the reasonableness of the outcome and the possibility for the reviewing court to examine the record for that purpose:

> **14** . . . the reasons must be read together with the outcome and serve the purpose of showing whether the result falls within a range of possible outcomes. This, it seems to me, is what the Court was saying in *Dunsmuir* when it told reviewing courts to look at "the qualities that make a decision reasonable, referring both to the process of articulating the reasons and to outcomes" (para. 47).
>
> **15** In assessing whether the decision is reasonable in light of the outcome and the reasons, courts must show "respect for the decision-making process of adjudicative bodies with regard to both the facts and the law" (*Dunsmuir*, at para. 48). This means that courts should not substitute their own reasons, but they may, if they find it necessary, look to the record for the purpose of assessing the reasonableness of the outcome.
>
> **16** Reasons may not include all the arguments, statutory provisions, jurisprudence or other details the reviewing judge would have preferred, but that does not impugn the validity of either the reasons or the result under a reasonableness analysis. A decision-maker is not required to make an explicit finding on each constituent element, however subordinate, leading to its final conclusion (*Service Employees' International Union, Local No.*

> *333 v. Nipawin District Staff Nurses Assn.*, [1975] 1 S.C.R. 382, at p. 391). In other words, if the reasons allow the reviewing court to understand why the tribunal made its decision and permit it to determine whether the conclusion is within the range of acceptable outcomes, the *Dunsmuir* criteria are met.

IV. Discussion

[28] The applicant bases her submission that the Judicial Committee erred in its decision on the following factual assertions: while treated by Dr. Cameron at the AMI in 1958, she received experimental treatments that included ECTs and was given experimental drugs that induced sleep; after the treatments, she experienced significant memory loss and was unable to care for herself and her child; the treatments that she received brought her mind to a childlike state. In sum, the applicant contends that the evidence shows that she was submitted to the rudiments of depatterning, and hence that she qualified for compensation under the Order. In paragraph 24 of her Memorandum of fact and law, the applicant stated as follows in support her contention:

> 24. Applicant applied for compensation since she was treated by Dr. Cameron between 1950 and 1965, and she, like Gail Kastner, Janine Huard and Morris Gutherz, was subjected to the rudiments of depatterning treatments and was at least substantially if not totally depatterned by these treatments thereby reverting her into a childlike state, as appears from her Medical Record at the Royal Victoria Hospital;

[29] The applicant argues that the Judicial Committee misinterpreted and misapplied the Order in that it inquired as to whether she received the full depatterning treatment; it should have examined whether she received full, or substantial, depatterning treatment. It thus failed to comply with the purpose of the Order, and, hence, overlooked relevant considerations. Furthermore, by addressing the wrong issue, the Judicial Committee fettered its discretion.

[30] The applicant contends that the Judicial Committee's misinterpretation of the Order was evidenced in what she called the "lead case" involving Ms. Kastner. In *Kastner,* Justice Beaudry held that the Judicial Committee had limited its analysis to assessing whether Ms. Kastner, who had received treatments from Dr. Cameron in 1953, had received the full depatterning treatment available after 1955 instead of inquiring whether she was "substantially" depatterned as provided in the Order. Justice Beaudry held that by "[a]sking the wrong question and therefore failing to consider a very relevant consideration, the word "substantially", render[ed] the decision unreasonable" (*Kastner*, above at para 37).

[31] The applicant places considerable reliance on *Kastner* and, in view of the definition of "depatterned person" found in the Order, argues that, in her case, the Judicial Committee committed the same error: it simply inquired as to whether she had received full depatterning treatment, and did not attempt to ascertain whether she had received substantial depatterning treatment. By failing to base its decision on this relevant consideration, the Judicial Committee erred in the exercise of its discretion and rendered a decision that was unreasonable. The applicant further submits that the treatments she received and the effect of those treatments on her condition are similar to those of Ms. Kastner. Therefore, if the Judicial Committee had addressed the correct issue, it would have concluded that she qualified for compensation. In the alternative, the applicant submits that, in view of her medical record, her application should be resubmitted to the Judicial Committee for a re-examination under the appropriate approach.

[32] The respondent, on the other hand, argues that the Judicial Committee's decision was reasonable and that the applicant's medical record clearly shows that she was not a "depatterned

person" as defined in the Order, as she was not fully or partially subjected to depatterning treatments.

[33] For the following reasons, I am of the view that the decision of the Judicial Committee was reasonable and I agree with the respondent that the evidence cannot support a conclusion that the applicant is a "depatterned person" as defined in the Order.

[34] As stated above, the applicant relies extensively on *Kastner*. With respect, there are significant differences between the facts and evidence submitted in the Kastner case and those prevailing in this case, and Justice Beaudry's judgment must be understood in the context of the particular circumstances of Ms. Kastner.

[35] First, it is important to keep in mind that Ms. Kastner had undergone treatment at the AMI in 1953 – before 1955 when Dr. Cameron perfected the depatterning treatment – and the expert evidence that she submitted clearly indicated that she had undergone treatments that constituted the rudiments of depatterning. Such is the context that brought Justice Beaudry to emphasize that, although the depatterning procedure became fully developed in 1955, the Order provided for compensation for those who received treatments as of 1950 and those who had received substantial depatterning treatments. Justice Beaudry held that the decision-makers erred because they simply determined whether the applicant had received full depatterning treatment, as opposed to full or substantial depatterning treatment.

[36] The following excerpts explain Justice Beaudry’s reasoning:

> **4** It was in 1955 that his full destructuring procedure was perfected and subsequently published. However, the procedures practiced before 1955 involved most of the depatterning features, in particular induced sleep and ECTs.
>
> . . .
>
> **37** I agree with the Applicant that the decision-makers do seem to have asked themselves "whether Ms. Kastner received the full treatment available after 1955" rather than the right question, which would have been "whether she was substantially depatterned in effect between 1950 and 1965". Asking the wrong question and therefore failing to consider a very relevant consideration, the word "substantially", renders the decision unreasonable.
>
> . . .
>
> **39** It is important to understand that the treatments received by Ms. Kastner in 1953 (massive ECTs with drug-induced sleep) were the rudiments of depatterning treatments. The actual "depatterning treatments" (prolonged drug-induced sleeps and massive ECTs) did not commence until 1955, as confirmed on page 25 of the Report where it is stated that "[i]t was in 1955 that Cameron himself decided, in his words to 'develop the potentialities of this procedure [depatterning].'" Yet, the Order expressly provides for compensation for full or substantial depatterning treatments administered between 1950 and 1965. Since the full method of depatterning was not developed until 1955, if the legislator had intented [*sic*] it to be the criterion, he would not have used 1950 as the starting date. The legislator also made it clear he wanted to leave some flexibility in the analysis of the treatments received by Dr. Cameron's patients by using the term "substantial depatterning treatment". This flexibility is not reflected in the decision made by Marc Gervais and confirmed by Ken Duford, especially not in the words "[t]he evidence does not indicate that you were subjected to sleep therapy and/or depatterning."
>
> 40 The question of whether the Applicant was substantially depatterned had to be considered and it was not. […]
>
> [Emphasis in original]

[37] It is also important to keep in mind that Justice Beaudry was satisfied that the evidence showed that Ms. Kastner was submitted to substantial depatterning treatment and that she therefore qualified for compensation under the Order. This finding, which was determinative, is evidenced in the conclusion of Justice Beaudry's judgment where he states that the applicant was entitled to receive the $100 000 *ex gratia* payment.

[38] This finding was supported by compelling evidence. In support of her application for compensation, Ms. Kastner provided the medical opinion of two expert psychiatrists, along with her medical record and the opinion of the psychiatrist who was following her at the time and who had referred her to Dr. Cameron. In her request for revision, she also provided affidavits of her sister and her sister's husband that attested to her condition during and after the treatments.

[39] Justice Beaudry assessed the medical evidence by dividing it in relation with the three conditions set forth in the definition of depatterning. With respect to the first two conditions - prolonged sleep and massive ECTs - Justice Beaudry summarized as follows the medical evidence:

> **42** During her two and one-half months at the AMI, Ms. Kastner received, according to her medical record, 43 electroshock treatments, four of which were Page-Russells. A Page-Russell is six times more intense than a regular electroshock treatment, which means she received an actual total of 63 electroshock treatments. She was also subjected to insulin comas and to different drugs to induce sleep.
>
> **43** Dr. Hoffman, with whom Dr. Pierre-Louis concurred, is of the opinion that Ms. Kastner received massive, high-intensity ECTs, the whole in conjunction with the administration of barbiturates, in order to induce sleep (letters dated respectively September 29, 1993 and October 5, 1993). Dr. Hoffman also considered that there was a clear connection between the administration of the electroshocks and the barbiturates, which demonstrates that Ms. Kastner underwent the

rudiments of depatterning treatments. It is worth reproducing excerpts from his expert opinion:

> I wish to advise the Review Committee of my following opinions pertaining to her situational claim:
>
> […]
>
> 2) That she suffered an iatrogenic illness secondary to massive (and inappropriate) ECT use, drug use, and sleep induction. This resulted in an iatrogenic delirium and infantile regressive behaviour.
>
> 3) ECT use was massive and of an excessively high-level intensity.
>
> 4) That the ECT administration was coupled to previous night induced sleep. This was accomplished by use of barbiturates.
>
> 5) From the above points there is a clear linking of enforced sleep and massive ECT use which constitutes the rudiments of depatterning. […]

44 As for Dr. Stern, the only other expert whose evidence was before the decision-maker, he concludes that Ms. Kastner did indeed undergo depatterning treatment in a letter dated March 17, 1994:

> Upon her discharge she displayed the usual symptoms of depatterning, that is memory loss that was and is severe and persists to this very day. She was unable to recognize her own family, not even her twin sister upon whom she depended upon (sic) and lived with as she was regressed to the level of a child. [...]
>
> She was also drug addicted and dependant. For many years patient suffered from - convulsions, comas - (sic)...

45 To summarize, the evidence is clear that Ms. Kastner received large doses of insulin and barbiturates to induce sleep, followed by massive ECTs, including Page-Russells (one Page-Russell being the equivalent of six ECTs). As discussed in a point above, it was not necessary to prove prolonged sleep, which is a characteristic of the depatterning treatment that started in 1955, but simply induced sleep, as part of the rudiments of the depatterning technique. It is also important to remember that, according to the

> Order, undergoing substantial depatterning treatment was sufficient to qualify as depatterning treatment.
>
> [Emphasis in original]

[40] Justice Beaudry was also satisfied that Ms. Kastner met the third condition, *i.e.*, the treatment had the result of reducing her mind to a childlike state. The above-reproduced excerpt of a letter by Dr. Stern provides a good indication of her condition. The applicant's medical record, the opinion of the medical experts and the affidavits of the applicant's twin sister and her husband also substantiated that condition. Justice Beaudry summarized as follows the evidence on this matter:

> **47** Not only does the Order require the proof of a patient undergoing at least substantial depatterning treatment, but it also requires that the person's mind was reduced to a childlike state at a certain point in time as a result of undergoing the treatment. Both Ms. Kastner's medical record and affidavits filed by Zelda and Herbert Hoffman show her reversion to infantile conduct.
>
> **48** Ms. Kastner's medical Record contains medical notations indicating that she was in a child-like state: . . .
>
> **49** During visits to the hospital and thereafter, the Applicant's twin sister, Zelda Hoffman, and her husband, Herbert Hoffman, noticed her regression to a child-like state, in that she was talking like a baby, suffering from urinary incontinence, sucking her thumb and demanding to be fed from a bottle, as appears from the following extracts of Ms. Hoffman's affidavit:
>
> > 8. THAT when I would visit my sister at the Allan Memorial Institute, I found that she was in a child-like condition, by talking babytalk and sucking her thumb;
> >
> > 9. THAT after April 23, 1953, having completed her stay at the Allan Memorial Institute, I found her on many occasions urinating on the living room floor;
> >
> > 10. THAT the above child-like condition continued and persisted intermittently for many years, particularly the babytalk and thumb sucking;

> 11. THAT furthermore, my sister did not remember anything about her childhood or her past and to date, she has a very vague and unclear memory of same.

[41] The applicant herein is asking the Court to follow Justice Beaudry's conclusions since Justice Beaudry concluded that the Judicial Committee had applied the wrong factor in Ms. Kastner's case, it necessarily applied the same wrong factor in this case.

[42] I do not agree with such a proposition. The Judicial Committee assessed each application on a case-by-case basis, in light of the evidence of record; its decisions cannot be challenged indiscriminately.

[43] As aptly suggested by the Supreme Court in *Newfoundland and Labrador Nurses' Union* at para 15, it is proper to "look at the record for the purpose of assessing the reasonableness of the outcome."

[44] The circumstances of this case are totally different from those in *Kastner*. First, the applicant received treatments from Dr. Cameron in 1958 after the depatterning treatment was perfected by Dr. Cameron. Therefore, the context did not call for an assessment of whether the applicant was subjected to the rudiments of what later became depatterning as in *Kastner*. This is not to say however that the applicant could not have qualified for compensation if she had shown that she had been subjected to substantial depatterning treatments.

[45] The Judicial Committee's decision reads as follows:

> The medical evidence you provided does not indicate that you were subjected to depatterning as defined in the Order in Council or that any treatments your [*sic*] received while at the Allan Memorial Institute reduced your mind to a child like state.

[46] This decision was supported by the medical examiner who had noted in his recommendation that "there is no indication of sleep therapy or depatterning."

[47] I acknowledge that the Judicial Committee did not specify in its decision whether it had inquired as to whether the applicant had been submitted to full and/or substantial depatterning treatment. In its note, however, it stated that the applicant's case was a good example of the difference between intensive electro-convulsive therapy and depatterning and the medical examiner noted that there was no indication of depatterning. In light of the applicant's medical record, and considering those notes, there was no need, in my view, for the Judicial Committee to provide more elaborate reasons. If there was no indication of depatterning at all, it was not necessary to specify that the applicant had not been submitted to either full or substantial depatterning treatment.

[48] Moreover, even assuming that it is unclear from the Judicial Committee's decision whether it just inquired as to whether the applicant had received full depatterning treatment or whether it also examined if she had received substantial depatterning treatment, I am of the view that that is of no consequence for two reasons.

[49] First, the evidence submitted by the applicant could not, with respect, support a conclusion that she had received either full or even substantial depatterning treatments. The evidence does not show that the applicant was a "depatterned person" as defined in the Order. Second, the Judicial

Committee's decision was very clear that the evidence did not show that the treatments that the applicant had received had reduced her mind to a childlike state. To be recognized as a "depatterned person", an applicant must show that he or she has been fully or, at least, substantially submitted to the three components of depatterning as defined in the Order. The third condition requires that the treatment (be it full or substantial) has reduced the patient's mind to a childlike state. This mandatory condition was also recognized by Justice Beaudry in *Kastner*, at para 47. The Judicial Committee's finding on that regard was unequivocal and, as will be seen, was entirely reasonable in light of the evidence. This finding was fatal to the eligibility of the applicant. Therefore, the outcome reached by the Judicial Committee was reasonable in light of the evidence.

[50] I will now address the evidence adduced by the applicant to substantiate my conclusions above. Unlike Ms. Kastner, the applicant has not offered any expert evidence in support of her allegation that she had been submitted to full or substantial depatterning treatments. The medical evidence she submitted consisted solely of her medical record. While that record shows that she received massive electro-convulsive therapy while treated at the AMI, this was not unique to depatterning, whether full or substantial, as evidenced by Mr. Cooper's report. Indeed, the note made by the Committee evoked a "Good example of difference between intensive electro-convulsive therapy and depatterning." It cannot be conclusively inferred from massive ECTs that the patient received full or substantial depatterning treatment. The definition of depatterning treatment in the Order provides for three cumulative conditions: (1) Prolonged sleep (2) that is followed by massive electroshock treatments (3) which reduced the patient's mind to a childlike state. Two of these conditions remain unfulfilled in this case: there is no evidence of prolonged

sleep, or even induced sleep that preceded the ECTs, and there is no evidence, contrary to Ms. Kastner's file, that the ECTs that the applicant received reduced her mind to a childlike state.

[51] With respect to the first condition, there is evidence that the applicant received Sodium Amytal and Lagactil but there is no indication that the dosage that she received induced sleep, that the drugs were administered just prior to the ECTs, nor that there is a connection between the administration of the drug, induced sleep and the ECTs.

[52] But the most compelling element is the absence of evidence that the ECTs resulted in bringing the applicant's mind to a childlike state. There is some evidence that the applicant exhibited, to a certain extent, childish manners. However, the evidence shows that this behaviour was present when she was admitted to the AMI and related to her condition, not to the treatment that she received at the AMI. The admission note states as follows:

> . . . She has a distracted air and is continually picking at her clothes and picking up objects for no apparent reason. She finds it hard to sit still and contorts herself into peculiar and undignified positions. Her speech is coherent but she does not answer questions straightforwardly but replies by irrelevancies. When asked what was her main complaint she said she was perspiring a lot under the arms and had done so every since she could remember. Her manner was vague her mood unremarkable, affect was very flat and quite incongruous and schizophrenic thought disorder was apparent. She was disoriented to a certain extent as to time and place but not person. Insight was completely lacking. She giggled and behaved foolishly throughout the interview.

[53] There is a note from Dr. Peterfy on July 21, 1958, where he outlined some improvement on that account:

> MENTAL EXAMINATION: The pt. is much quieter than at the first examination. She speaks coherently and gives correct answers. At

> the time of examination she was not disorientated for time place or person but her memory is somewhat impaired. This is more apparent in the pathologic memory field. She worries about her baby and she wants to go home and take care of it. Her behaviour is somewhat childish and foolish and she laughs and giggles sometimes, **but markedly less than the first examination**. At the moment she has no delusions or hallucinations.
>
> [Emphasis added]

[54] On August 15, 1958, Dr. Ruper noted that the applicant's "behaviour on occasion is rather childish and we are unsure whether this was the case before her **illness**." [Emphasis added]

[55] The bedside notes state that, on a few occasions, namely on July 22 and July 23, she laughed inappropriately at times.

[56] With respect to memory loss, the medical record shows that the applicant experienced important memory loss on her arrival at the AMI but that her condition improved over time.

[57] On August 22, 1958, the day before her discharge, Dr. Ruper noted the following:

> We have a report from the husband which was asked for last week and Dr. Peterfy states that according to the husband, the pt's condition is exactly as it was before her illness. She is well and happy at home and he sees no signs of any unusual thought or behaviour. On the ward we noticed that she is still rather quiet and seclusive, but takes part in ward activities such as groups etc. We are going to discharge her tomorrow for the Schizophrenic Follow-up. She will continue on the present medication and the present rate of ECT.

[58] This extract from a letter addressed by Dr. Cameron to the applicant's physician on August 30, 1958 is also instructive as to the treatment that the applicant received while at the AMI.

> The applicant was admitted to the AMI on July 3, 1958. Dr. Cameron notes the following:
>
> We decided to put her on to intensive electro-convulsive therapy, and by July 10th, she had had 9 ECT, and was going on a 3 a week Offner. She was also on Sodium Amytal mgm. 200 q.h.s. By that date her condition was much better. She had no memory of her recent illness. She was oriented, quite coherent, and her mood was appropriate. She was seen by her husband who found her quite well.
>
> By August 5th she had had 20 ECT, and she had been home the previous weekend, and she had gotten along quite satisfactorily, although she had been somewhat astonished at the size of her child. She showed no delusional thinking.
>
> In reviewing her case, we saw this [illegible] the patient's first attack, but that there was a good deal of [blank] of the family. By August 7th she had had another weekend at home. She had done extremely well, and had shown no delusional thinking whatsoever.
>
> On August 13th she was transferred to the Day Hospital. She was quiet and passive on the ward, spoke quite infrequently, but seemed to get along well with the other patients. Her husband reported to Dr. Peterfy that he found her quite well. She was happy and contented at home. Her behaviour was rather childish, but it was not altogether clear whether this might not have been the case prior to her breakdown. By August 22, the patient had had 24 ECT. She was continuing to do well, was quiet, rather seclusive on the ward, but this we found was as a result of her husband's advice not to mix too much with the other patients.
>
> . . .

[59] It will be noted that while the depatterning treatment had been perfected by Dr. Cameron at the time the applicant was treated in 1958, the letter that he sent to the applicant's physician in which he summarized the treatment that the applicant received refers to "intensive electro-convulsive therapy", not to depatterning.

[60] The medical evidence can be summarized as follows: the applicant was quite disoriented when she was admitted at the AMI and already presented a behaviour that involved some childish

manners and memory loss. The applicant's childish manners were noted on a few occasions during her stay but improved over time. The same can be said about the memory loss.

[61] There is a significant difference between exhibiting a childish behaviour at times and being reduced to a childlike state as a result of a treatment. The evidence in the *Kastner* case about the childlike state of Ms. Kastner was compelling. In this case, we are far from the description of a childlike or infantile state of mind, typical of depatterning. Moreover, the evidence clearly shows that the applicant's condition improved as the treatment was being administered and there is absolutely no evidence that the applicant's childish manners resulted from the ECTs that she received.

[62] In sum, the evidence does not show that the applicant's mind was reduced to a childlike state and there is no evidence of a causal connection between the childish manners of the applicant that were noted and the treatments that she received. Moreover, the evidence appears to reveal a nexus between her behaviour and her illness. It is therefore impossible to support a conclusion that the ECTs and the drug that the applicant received corresponded to full or substantial depatterning treatment and that the treatment that she received reduced her mind to a childlike state. These were essential conditions to qualify for compensation under the Order. Therefore, in light of the evidence, the outcome reached by the Judicial Committee was reasonable and ought not to be disturbed.

[63] In her Memorandum of fact and law, the applicant also raised an issue of discrimination under section 15 of the *Canadian Charter of Rights and Freedoms*. At the hearing, counsel for the

applicant did not expand on the discrimination issue and stated that it was not necessary to address that argument for resolution of this case. Nevertheless, I will make the following comments.

[64] In paragraphs 87 and 88 of her Memorandum, the applicant submits as follows :

> 87. In the present case an irrational distinction between those treated before and after 1965 is created without statutory authorization;
>
> 88. Furthermore, Me Alan Stein had filed a number of applications for the Allan Memorial Depatterned Persons Assistance Plan for the former patients of Dr. Cameron between the years 1950 and 1965, and many of the patients who were compensated by the Department of Justice Committee had been subject to less drug use and ECT use than that of Gail Kastner, and notwithstanding same they were compensated by the Department of Justice, thereby creating discrimination on the basis of arbitrary decisions of the Review Committee of the Department of Justice;

[65] With respect, the allegation in paragraph 87 is not relevant to this case. The applicant was treated during the period covered by the Order and therefore could not have suffered discrimination on any grounds or reasons that could be related to the period subsequent to 1965.

[66] Paragraph 88, for its part, refers to Ms. Kastner and not to the applicant, but this is a typo. I have two comments to make. First, the allegation is not supported by any evidence. Second, it is clear that each applicant was to be assessed on a case-by-case basis and it is impossible to make generic comparisons. Furthermore, the number of ECTs and the dosage of the drugs received by patients were not the only relevant factors in assessing whether persons qualified for compensation under the Order.

[67] In my view, the applicant’s allegations of discrimination cannot succeed.

[68] For all the above reasons, this application will be dismissed.

JUDGMENT

THIS COURT'S JUDGMENT is that this application for judicial review is dismissed.

Costs are awarded to the respondent.

"Marie-Josée Bédard"

Judge

FEDERAL COURT

SOLICITORS OF RECORD

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