File No. 34362

IN THE SUPREME COURT OF CANADA
(ON APPEAL FROM THE COURT OF APPEAL FOR ONTARIO)

BETWEEN:

DR. BRIAN CUTHBERTSON and DR. GORDON RUBENFELD

Appellants

-and-

HASSAN RASOULI, by his litigation guardian and substitute decision maker, PARICHEHR SALASEL

Respondent

-and-

THE CONSENT AND CAPACITY BOARD, CANADIAN ASSOCIATION OF CRITICAL CARE NURSES, EUTHANASIA PREVENTION COALITION, CANADIAN CRITICAL CARE SOCIETY, ADVOCACY CENTRE FOR THE ELDERLY AND ARCH DISABILITY LAW CENTRE, MENTAL HEALTH LEGAL COMMITTEE AND HIV & AIDS LEGAL CLINIC ONTARIO, EVANGELICAL FELLOWSHIP OF CANADA

Interveners

FACTUM
CANADIAN ASSOCIATION OF CRITICAL CARE NURSES

NORTON ROSE CANADA
TD Waterhouse Tower
Toronto-Dominion Centre
79 Wellington Street West
Suite 2300, P.O. Box 128
Toronto, Ontario M5J 2Z4

Rahool P. Agarwal
Nahla Khouri
Nicholas Saint-Martin
Tel: (416) 216-3943
Fax: (416) 216-3930
E-mail: rahool.agarwal@nortonrose.com

Counsel for the Intervener
Canadian Association of Critical Care Nurses

NORTON ROSE CANADA LLP
45 O'Connor St., Suite 1600
Ottawa, Ontario K1P 1A4

Sally A. Gomery
Tel: (613) 780-8604
Fax: (613) 230-5459
E-mail: sally.gomery@nortonrose.com

Agent for the Intervener
Canadian Association of Critical Care Nurses

MCARTHY TÉTRAULT LLP
Box 48, 5300-66 Wellington St. W.
Toronto Dominion Bank Tower
Toronto, Ontario M5K 1E6

Harry C. G. Underwood
Erica J. Baron
Andrew McCutcheon
Tel: (416) 601-7911
Fax: (416) 868-0673
E-mail: hunderwo@mccarthy.ca

Counsel for the Appellants
Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld

GOWLING LAFLEUR HENDERSON LLP
2600 - 160 Elgin St
P.O. Box 466, Stn "D"
Ottawa, Ontario K1P 1C3

Henry S. Brown, Q.C.
Tel: (613) 233-1781
Fax: (613) 788-3433
E-mail: henry.brown@gowlings.com

Agent for the Appellants
Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld

HODDER BARRISTERS
Adelaide Place, ING Tower
181 University Avenue, Suite 2200
Toronto, Ontario M5H 3M7

J. Gardner Hodder
Guillermo Schible
Stefan De Smit
Tel: (416) 601-6809
Fax: (416) 947-0909
E-mail: ghodder@poltenhodder.com

Counsel for the Respondent
Hassan Rasouli, by his Litigation Guardian and substitute decision maker, Parichehr Salasel

BLAKE, CASSELS & GRAYDON LLP
World Exchange Plaza
20th Floor, 45 O'Connor
Ottawa, Ontario K1P 1A4

Gordon K. Cameron
Tel: (613) 788-2222
Fax: (613) 788-2247
E-mail: gord.cameron@blakes.com

Agent for the Respondent
Hassan Rasouli, by his Litigation Guardian and substitute decision maker, Parichehr Salasel

SCHER LAW PROFESSIONAL CORPORATION
69 Bloor Street East
Suite 210
Toronto, Ontario M4W 1A9

Hugh R. Scher
Tel: (416) 515-9686
Fax: (416) 969-1815
E-mail: hugh@sdlaw.ca

Counsel for the Intervener
Euthanasia Prevention Coalition

BURKE-ROBERTSON
70 Gloucester Street
Ottawa, Ontario K2P 0A2

Robert E. Houston, Q.C.
Tel: (613) 566-2058
Fax: (613) 235-4430
E-mail: rhouston@burkerobertson.com

Agent for the Intervener
Euthanasia Prevention Coalition

POLLEY FAITH LLP
357 Bay Street, Suite 900
Toronto, Ontario M5H 2T7

Andrew S. Faith
Alexi N. Wood
Tel: (416) 365-1602
Fax: (416) 365-1601
E-mail: afaith@polleyfaith.com

Counsel for the Intervener
Canadian Critical Care Society

CAVANAGH WILLIAMS CONWAY BAXTER LLP
1111 Prince of Wales Drive
Suite 401
Ottawa, Ontario K2C 3T2

Colin S. Baxter
Telephone: (613) 569-8558
FAX: (613) 569-8668
E-mail: cbaxter@cwcb-law.com

Agent for the Intervener
Canadian Critical Care Society

ADVOCACY CENTRE FOR THE ELDERLY
2 Carlton Street, Suite 701
Toronto, Ontario M5B 1J3

Graham Webb
Clara Ho
Tel: (416) 598-2656
Fax: (416) 598-7924

Counsel for the Intervener
Advocacy Centre for the Elderly and ARCH Disability Law Centre

SUPREME ADVOCACY LLP
397 Gladstone Avenue
Suite 100
Ottawa, Ontario K2P 0Y9

Eugene Meehan, Q.C.
Tel: (613) 695-8855 Ext: 101
Fax: (613) 695-8580

Agent for the Intervener
Advocacy Centre for the Elderly and ARCH Disability Law Centre

SWADRON ASSOCIATES
115 Berkeley Street
Toronto, Ontario
M5A 2W8

Marshall A. Swadron
Mercedes Perez
Telephone: (416) 362-1234
FAX: (416) 362-1232

Counsel for the Intervener
Mental Health Legal Committee and HIV & AIDS Legal Clinic Ontario

SUPREME ADVOCACY LLP
397 Gladstone Avenue
Suite 100
Ottawa, Ontario K2P 0Y9

Marie-France Major
Tel: (613) 695-8855 Ext: 101
Fax: (613) 695-8580

Agent for the Intervener
Mental Health Legal Committee and HIV & AIDS Legal Clinic Ontario

VINCENT DAGENAIS GIBSON LLP
325 Dalhousie Street
Suite 600
Ottawa, Ontario K1N 7G2

Albertos Polizogopoulos
Tel: (613) 241-2701
Fax: (613) 241-2599
E-mail: albertos@vdg.ca

Counsel for the Intervener
Evangelical Fellowship of Canada

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PART I - OVERVIEW AND STATEMENT OF FACTS

A. Overview

1. This appeal engages a seemingly irreconcilable tension: the rare disagreement between a physician and family over how to treat a patient at the end of his life. The Appellants' proposal to withdraw care is based on their medical expertise, but the patient's family's desire to continue care is grounded in their understanding of the patient's non-medical interests – his wishes, his values and his beliefs.

2. The Canadian Association of Critical Care Nurses (**CACCN**) intervenes in this appeal to provide a perspective at the middle of that tension. Critical care nurses provide continuous care for patients in end of life situations, and are the primary point of contact for patients' families. They also play an important role in developing treatment options as part of the health care team. This role requires them to fully appreciate the wishes of families as well as the expertise of physicians.

3. The patient's best interests must be paramount. Critical care nurses know and acknowledge that "best interests" does not simply mean the best medical decision for the patient. Non-medical factors also play a significant role, particularly at the end of life.

4. CACCN proposes a modification to the common law standard of care that ensures full consideration of the patient's best interests: a physician must be required to obtain consent from a patient's substitute decision-maker (**SDM**) to withdraw life-sustaining treatment.[1] The physician alone is not equipped to consider the patient's non-medical interests, and so the SDM must represent those interests. If the parties disagree, the court may be called upon to determine the most appropriate course of action.

5. The common law concerning the withdrawal of life-sustaining treatment remains unsettled and inconsistent. This uncertainty leaves physicians, nurses and families unsure of their legal obligations and rights. The incremental change proposed by CACCN will provide valuable clarity, and will help the parties arrive at a decision that is in the best interests of the patient.

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[1] CACCN emphasizes that the requirement should be for oral consent only. The experience of CACCN's membership is that burdensome consent requirements disrupt the relationship between patients' families and health care practitioners, particularly in end of life scenarios.

B. Statement of relevant facts

6. CACCN adopts the facts as set out in facta of the parties.

PART II - STATEMENT OF POSITION

7. CACCN's position is two-fold: (i) physicians should not have unilateral discretion to withdraw life-sustaining treatment, and (ii) in the event of a disagreement between the physician and the SDM about a proposed withdrawal, there should be a process available to adjudicate that disagreement.

8. With respect to the *Health Care Consent Act*[2] (**HCCA** or the **Act**), CACCN agrees that the withdrawal of life-support is included within the definition of "treatment" and thus requires consent from the SDM. Should the SDM not consent, the physician may apply, pursuant to section 37(1) of the Act, to the Consent and Capacity Board (**CCB**) for a determination as to whether the SDM is acting in the patient's best interests.

9. CACCN's argument, however, focuses on the common law. CACCN argues that, if the HCCA does not apply to the withdrawal of life-support, the physicians' common law standard of care requires them to obtain consent from the patient's SDM. If consent is not given, the physician may apply to the court for permission to withdraw care. The court will decide the issue on the basis of the patient's best interests.[3]

PART III - STATEMENT OF ARGUMENT

A. The application of the common law

10. If the withdrawal of life-support is not addressed by the HCCA, the common law governs. It is "trite but true" that absent express legislative intention to oust the common law, the common law will apply.[4] It is also settled law that the common law may be employed to fill legislative gaps.[5]

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[2] SO 1996 c 2 [**HCCA**].

[3] This remedy is also available to the SDM. If a physician were to proceed with the withdrawal of life-support without consent, the SDM could apply to the courts to determine which course of action best advances the patient's best interests.

[4] *Rawluk v Rawluk,* [1990] 1 SCR 70 at 90, CACCN's Book of Authorities **[CACCN's Authorities]**, Tab 1.

[5] *R v Lavigne,* [2006] 1 SCR 392 at para 45, CACCN's Authorities, Tab 2.

11. The application of the common law is contemplated by the HCCA itself. Section 8(2) provides that the Act "does not affect the law relating to giving or refusing consent to anything not included in the definition of 'treatment'...".[6]

B. The need for a consistent common law rule

12. As Justice Himel observed in the application decision, the common law in Canada relating to the withdrawal of life-support is "unclear", "not firmly decided" and "not well-settled".[7] The common law landscape can be summarized as follows:

(a) *Child and Family Services of Central Manitoba v L(R)*,[8] *Rotaru v Vancouver General Hospital Intensive Care Unit*[9] and *Children's Aid Society of Ottawa-Carleton v MC*[10] support the view that health practitioners do not need consent to withhold or withdraw life-sustaining treatment;

(b) *Sawatzky v Riverview Health Centre Inc*,[11] *Golubchuk v Salvation Army Grace General Hospital*,[12] *Sweiss v Alberta Health Services*[13] and *May v Alberta Health Services*[14] conclude that a physician does not necessarily have unilateral authority to withdraw life-support, and that the court has a role to play in adjudicating end of life decisions;

(c) in *Sawatzky* and *Golubchuk*, Manitoba courts addressed requests for injunctive relief to stop the withdrawal of life-sustaining treatment. In both cases, there was no consideration of the merits because the courts applied the traditional *RJR-MacDonald* test, which considers only whether there is a serious issue to be tried;

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[6] HCCA, s 8(2). In the Application decision, Justice Himel held that "the common law continues to apply to any matters that fall outside the purview of the HCCA and the [Substitute Decisions Act]": Reasons for decision of Justice Himel of the Superior Court of Justice dated March 9, 2011 [Reasons of Justice Himel], para 53, Record of the Appellants, Vol 1 of 4, Tab 2 (citing Dr. Hy Bloom and Michael Bay, "A Practical Guide to Mental Health, Capacity, and Consent Law of Ontario" (Scarborough: Thomson Canada Ltd., 1996) at 17).

[7] Reasons of Justice Himel, para 83, Record of the Appellants, Vol 1 of 4, Tab 2.

[8] [1997] MJ No 568 (CA), CACCN's Authorities, Tab 3.

[9] [2008] BCJ No 456 (SC), Appellants' Book of Authorities [**Appellants' Authorities**], Volume 2, Tab 21.

[10] [2008] OJ No 3795 (Sup Ct), CACCN's Authorities, Tab 4.

[11] (1998), 26 CPC (4th) (Man QB), Respondent's Book of Authorities [**Respondent's Authorities**], Volume 3, Tab 14.

[12] (2008), 55 CPC (6th) 78 (Man QB), Respondent's Authorities, Volume 1, Tab 1.

[13] (2009), 314 DLR (4th) 474 (Alta QB) [***Sweiss***], Respondent's Authorities, Volume 3, Tab 12.

[14] [2010] AJ No 843 (QB) [***May***], CACCN's Authorities, Tab 5.

(d) in *Sweiss* and *May*, Alberta courts similarly addressed requests for injunctive relief. However, the courts expressly rejected the traditional legal test, and instead applied a test focused on the "best interests of the patient"; and

(e) no case has determined whether a physician's common law standard of care permits the unilateral withdrawal of life-support. [15]

13. The inconsistency in the jurisprudence should be resolved by this appeal. This Court has made clear that the "resolution of conflicting lines of authority lies well within the powers of a court at common law."[16] Resolving the inconsistency will have a significant practical benefit: there will be a uniform standard applicable in all Canadian jurisdictions, which will give clarity and certainty to health practitioners and patients' families.

C. The physician's duty to obtain consent for the withdrawal of life-sustaining treatment

14. At common law, a physician's duty is to act in the best interests of the patient. In end of life situations, this duty requires the physician to obtain consent from the patient's SDM to withdraw life-support. If the SDM does not consent, the physician may apply to court to determine the course of action that best advances the patient's best interests.

(i) The standard of care: acting in the best interests of the patient

15. The physician's standard of care requires that he or she act in the best interests of the patient.

16. In *Ter Neuzen v Korn*, this Court relied upon the patient's best interests when defining the applicable standard of care for physicians:

> It is well settled that physicians have a duty to conduct their practice in accordance with the conduct of a prudent and diligent doctor in the same circumstances.
>
> ...

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[15] Other cases have approached the issue of withdrawal of life-support within the confines of a statute: see *Re LIC*, 2006 ABQB 130, Appellants' Authorities, Volume 2, Tab 22; *Scardoni et al v Hawryluck*, 2004 CanLII 34326 (Ont Sup Ct), Appellants' Authorities, Volume 3, Tab 36; and *Grover (Re)*, 2009 CanLII 16577 (Ont Sup Ct) Appellants' Authorities, Volume 3, Tab 40.

[16] *Retail, Wholesale and Department Store Union v Pepsi-Cola,* [2002] 1 SCR 156 at para 16, CACCN's Authorities, Tab 6.

> It is generally accepted that when a doctor acts in accordance with a recognized and respectable practice of the profession, he or she will not be found to be negligent. This is because courts do not ordinarily have the expertise to tell professionals that they are not behaving appropriately in their field. In a sense, the medical profession as a whole is assumed to have adopted procedures which are in the best interests of patients and are not inherently negligent.[17] (emphasis added)

17. Ellen Picard, in her textbook *Legal Liabilities of Doctors and Hospitals in Canada*, explicitly characterizes the standard of care as acting in the patient's best interests:

> A doctor is not liable for an honest error of judgment provided he acts after a careful evaluation in what he believes to be the patient's best interests.[18]

(ii) The meaning of "best interests"

18. Almost every Canadian jurisdiction has legislation that addresses a patient's "best interests".[19] Best interests have also been defined at common law.[20]

19. The notion of best interests certainly includes medical interests, but also extends to non-medical considerations. The legislation and common law establish that a patient's best interests include the patient's "well-being" and "quality of life" (as distinct from his or her medical "condition"), the patient's known wishes and the patient's values and beliefs.

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[17] *Ter Neuzen v Korn,* [1995] 3 SCR 674 at paras 33, 38, Appellants' Authorities, Volume 2, Tab 19.

[18] Ellen Picard, *Legal Liabilities of Doctors and Hospitals in Canada*, cited in *Coughlin v Kuntz*, [1989] BCJ No 2365 (CA) at 6-7, CACCN's Authorities, Tab 7.

[19] Legislation from several provinces and territories specifies that determining the "best interests" of the patient requires consideration of non medical factors: see HCCA s 21; the *Adult Guardianship and Trusteeship Act,* SA 2008, c A-4.2, s 92 (Alberta); the *Health Care (Consent) and Care Facility (Admission) Act,* RSBC 1996, c 181, s 19 (British Columbia); and the *Consent to Treatment and Health Care Directives Act,* RSPEI 1996, c 17.2, s 13 (Prince Edward Island) all of which require consideration of the values and beliefs of the patient. In other provinces, the "best interests" of the patient are only considered if the SDM does not know the values and beliefs of the patient, which take precedence: see the *Advance Health Care Directives Act,* SNL 1995, c A-4.1, s 12 (Newfoundland and Labrador); the *Hospitals Act,* RSNS 1989, c 208, s 54 (Nova Scotia); the *Health Care Directives Act,* CCSM 1992, c H27, s 13 (Manitoba); the *Alberta Personal Directives Act,* RSA 2000, c P-6, s 14 (Alberta); and the *Health Care Directives and Substitute Health Care Decision Makers Act,* SS 1997, c H-0.001, s 12 (Saskatchewan). Some provinces simply leave the determination of the "best interests" up to the SDM: see the *Personal Directives Act,* SNS 2008, c 8, s 15 (Nova Scotia); the *Personal Directives Act*, SNWT 2005, c 16, s 3 (Northwest Territories); the *Care Consent Act* being Schedule B of the *Decision Making Support and Protection to Adults Act,* SY 2003, c 21, s 20 (Yukon); and the *Adult Guardianship and Co-decision Making Act,* SS 2000, c A-5.3, s 25 (Saskatchewan). Some legislation pertaining to psychiatric treatment does not include values or beliefs in the best interest analysis: see *Involuntary Psychiatric Treatment Act* SNS 2005, c 42, ss 39-40 (Nova Scotia); *Mental Health Act,* RSNB 1973, c M-10, s 8.6 (New Brunswick).

[20] *Sweiss* at para 63, Respondent's Authorities, Volume 3, Tab 12.

20. No single factor is paramount. Medical and non-medical factors should be balanced against each other and receive due consideration in the decision-making process.[21] Indeed, the importance of non-medical factors is highlighted by their relationship to fundamental values enshrined in the *Charter of Rights and Freedoms*:[22]

(a) the patient's wishes speak to personal autonomy, protected by s. 7 of the *Charter*;

(b) the patient's values and beliefs are protected under s. 2(a);

(c) the patient's well-being and quality of life reflect the patient's right to human dignity, which underlies all of the rights and freedoms enshrined in the *Charter*.[23]

(iii) Best interests at the end of life

21. In the normal course, decisions to provide treatment are made on the basis of medical benefit to the patient. This satisfies the standard of care: providing a medical benefit will advance the patient's best interests because the patient's medical condition is usually the primary concern.

22. But at the end of life, the analysis changes. The prospect of imminent death elevates the significance of certain non-medical interests, such as religious beliefs and cultural values.

23. For example, a person's religious beliefs and values become more pronounced as he or she moves closer to death. In an article on the relationship between religion and end of life care, Dr. Christina Puchalski and Edward O'Donnell state that:

> ...Religions provide concepts, rituals, and values that help us: find meaning and purpose, experience the power of community, and cope with serious aspects of our life, <u>in particular illness, loss, and death and dying.</u>[24]

24. In *Malette v Shuman*, a leading Ontario case on consent, the court recognized the increased importance of religious beliefs at the end of life:

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[21] *Sweiss* at para 65, Respondent's Authorities, Volume 3, Tab 12.

[22] *Canadian Charter of Rights and Freedoms,* Part I of the *Constitution Act, 1982,* being schedule B to the *Canada Act 1982* (UK), 1982, c 11.

[23] *Blencoe v British Columbia (Human Rights Commission),* [2000] 2 SCR 307 at para 76, CACCN's Authorities, Tab 8.

[24] Christina M Puchalski and Edward O'Donnell, "Religious and spiritual beliefs in end of life care: how major religions view death and dying," (2005), 9 Techniques in Regional Anesthesia and Pain Management 114-121 at page 115, CACCN's Authorities, Tab 9.

> If objection to treatment is on a religious basis, this does not permit the scrutiny of "reasonableness" which is a transitory standard dependent on the norms of the day. If the objection has its basis in religion, it is more apt to crystallize in life threatening situations.[25]

25. Recognizing the significance of non-medical considerations is essential for determining the best course of action at the end of life. Focusing strictly on medical considerations may dictate one course of action, but after considering all relevant factors, it may be in the patient's best interests to pursue a different course of action.

(iv) Withdrawal of life-support requires consent from the SDM

26. The common law standard of care for physicians ought to recognize the significance of non-medical considerations in end of life situations. This is achieved by modifying the standard of care to require physicians to obtain consent from a patient's SDM to withdraw life-sustaining treatment.

1. Expertise related to non-medical interests

27. Consent from the SDM is necessary to ensure that a patient's non-medical interests are properly considered. Physicians alone are not, and cannot be expected to be, equipped to fully weigh and evaluate the many factors that comprise a patient's best interests. A physician's medical opinion is a critical component of the best interests analysis, but it alone should not govern the outcome.

28. In a recent article, Jocelyn Downie and Karen McEwan comment on the limits of a physician's expertise:

> Although physicians have privileged access to medical information, knowledge, and analytical skills and are well-situated to make medical judgments, assessing someone's best interests is not a medical matter.[26]

29. This is not a criticism of physicians; it is a recognition that end of life care cannot be restricted to an analysis of medical benefits. A physician's role should be limited to his or her area of expertise.

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[25] *Malette v Shuman*, [1990] OJ No 450 (CA) at para 14, CACCN's Authorities, Tab 10.

[26] Jocelyn Downie and Karen McEwan, "The Manitoba College of Physicians and Surgeons Position Statement on Withholding and Withdrawal of Life-Sustaining Treatment (2008): Three Problems and a Solution" (2009), 17 Health LJ 115-137, Respondent's Authorities, Volume 2, Tab 10.

30. Acting in a patient's best interests at the end of life thus requires consultation with the SDM. The SDM is obligated by law to act in the patient's best interests, and is in a better position to have knowledge of the patient's non-medical interests. This approach is consistent with the jurisprudence, which recognizes that when a physician is confronted with a problem that falls outside of his or her own expertise, he or she is obligated to consult an expert in that field.[27]

2. Requiring consent is consistent with current policy and practice

31. Professional guidelines that govern physicians and the current practice of physicians support modifying the standard of care to require that physicians obtain consent to withdraw life-support.

32. Professional guidelines and policies are strong evidence of the applicable standard of care.[28] The College of Physicians and Surgeons of Ontario Policy Statement #1-06, "Decision-making for the End of Life" endorses consultation with SDMs when recommending treatment options in end of life situations:

> The patient or substitute decision-maker, and [the family], should have the opportunity to participate in informed discussions about the care options that may optimize the quality of the patient's life while he or she is living with a life-threatening illness, and when dying. These individuals should participate in choosing the best available options, based on those informed discussions and the patient's goals, values and beliefs.
>
> ...
>
> Physicians should ask about and seek to incorporate patient, and where appropriate, family choices, values, beliefs and goals in decisions for the end of life. In so doing, physicians should strive to understand the impact of culture and religion on the patient's personal choices.[29]

33. The policy also acknowledges that where the physician and SDM cannot agree on a course of action, the matter should be determined by a third party decision-maker:

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[27] *Kersey v Wellesley Hospital,* [1988] OJ No 1625 (Sup Ct) pages 16-17, aff'd [1992] OJ No 4188 (CA), CACCN's Authorities, Tab 11; *MacDonald v York County Hospital et al,* [1973] OJ No 2207 (CA) at paras 74-75, CACCN's Authorities, Tab 12.

[28] *Kern v Forest,* [2010] BCJ No 1364 (SC) at para 163, CACCN's Authorities, Tab 13; *Spillane (Litigation guardian of) v Wasserman,* [1992] OJ No 2607 (Ct J) at page 9, CACCN's Authorities, Tab 14.

[29] College of Physicians and Surgeons of Ontario (CPSO) Policy Statement #1-06, "Decision Making for the End of Life" July 2006 at pages 2-3 [CPSO Policy], Appellants' Authorities, Volume 2, Tab 26.

> Any recommendation not to initiate life support, or to withdraw life support, should be discussed with the patient or substitute decision-maker, and [the family]. If the patient or substitute decision-maker, and [the family], specifically requests the physician to provide or continue the treatment notwithstanding the recommendations of the health care team, the physician should turn to the conflict resolution measures discussed in Part 4.1 of this policy in an effort to achieve consensus.
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> ...
>
> The *Health Care Consent Act* provides a structure for managing conflicts about treatment decisions for incapable patients that cannot be resolved in other ways. Physicians should be aware of the relevant legislative processes.[30]

34. In addition, physicians regularly seek consent to withdraw life-sustaining treatment as a matter of established practice. Justice Himel commented on this practice in the application decision:

> It is noteworthy that the current practice of many doctors is to seek consent for end of life decisions, and if they disagree with the decision of a substitute decision-maker refer the decision to the CCB. *Maraachli and Nader v. Dr. Fraser*, *P. (D.), Re*, *Grover v. Grover*, *E.J.G. (Re)*, *G (Re)* and *N., (Re)* are all examples of cases where health practitioners requested consent from substitute decision-makers to stop life support treatments. In all of the cases, the substitute decision-makers refused, and the health practitioners applied to the Board to challenge the refusal pursuant to s. 37(1) of the *HCCA*. These decisions demonstrate that many health practitioners in Ontario regard the process under the *HCCA* as the appropriate recourse when consent to the withdrawal of life support is refused.[31] [emphasis added]

(v) The value of adjudication by the court

35. Where the physician is unable to obtain consent from the SDM for a proposed withdrawal of life-support, the physician can apply to the court to request a determination of the course of action that is in the best interests of the patient.

36. The Alberta Court of Queen's Bench in *May* highlighted the need to have the court available to resolve disputes between the physician and the patient's family:

> Difficult decisions such as these likely are made everyday by physicians and the families with whom they interact. However, there are occasions, as in this case, when the family and medical professionals, for various reasons, do not agree on

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[30] CPSO Policy at pages 5, 7.

[31] Reasons of Justice Himel, para 50, Record of the Appellants, Vol 1 of 4, Tab 2.

> the continuation or withdrawal of medical treatment. In those circumstances, the parties must have recourse to another forum in which to efficiently resolve their conflict. [32]

37. The court has the expertise and procedural powers to balance relevant considerations and arrive at a fair result. *May* is an excellent example: the court ordered a time-limited injunction, allowing the parents to seek an independent medical assessment, but also providing a measure of certainty based on the physician's medical recommendation.

PART IV - COSTS SUBMISSIONS

38. CACCN does not seek costs, and requests that no order as to costs be made against it.

PART V - ORDER REQUESTED

39. CACCN takes no position on the outcome of the appeal.

40. CACCN requests that it be permitted to present oral argument at the hearing of the appeal, for 10 minutes or for a length of time that the Court determines to be just.

ALL OF WHICH IS RESPECTFULLY SUBMITTED this 26th day of July, 2012.

Norton Rose Canada LLP
Rahool P. Agarwal

Nahla Khouri

Nicholas Saint-Martin

[32] *May* at para 11, CACCN's Authorities, Tab 5.

PART VI - TABLE OF AUTHORITIES

Jurisprudence	**Paragraph(s)**
Rawluk v Rawluk, [1990] 1 SCR 70	10
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PART VII - STATUTORY PROVISIONS

Health Care Consent Act **SO 1996 c 2,S 8(2), 21**
Loi de 1996 sur le consentement aux soins de santé, **LO 1996, c 2, S 8(s), 21**

Law not affected 8 (2) Subject to section 3, this Part does not affect the law relating to giving or refusing consent to anything not included in the definition of "treatment" in subsection 2 (1).	**Maintien du droit** 8 (2) Sous réserve de l'article 3, la présente partie n'a pas d'incidence sur le droit se rapportant au fait de donner ou de refuser son consentement à tout ce qui n'est pas compris dans la définition du terme «traitement» qui figure au paragraphe 2 (1).
Principles for giving or refusing consent **21.** (1) A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles: 1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish. 2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests. 1996, c. 2, Sched. A, s. 21 (1). **Best interests** (2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration, (a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable; (b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and (c) the following factors: 1. Whether the treatment is likely to, i. improve the incapable person's condition or well-being, ii. prevent the incapable person's condition or well-being from deteriorating, or iii. reduce the extent to which, or the rate at which, the incapable	**Principes devant guider le consentement ou le refus de celui-ci** **21.** (1) La personne qui donne ou refuse son consentement à un traitement au nom d'un incapable le fait conformément aux principes suivants : 1. Si elle sait que l'incapable, lorsqu'il était capable et avait au moins 16 ans révolus, a exprimé un désir applicable aux circonstances, elle donne ou refuse son consentement conformément au désir exprimé. 2. Si elle ne sait pas si l'incapable, lorsqu'il était capable et avait au moins 16 ans révolus, a exprimé un désir applicable aux circonstances, ou s'il est impossible de se conformer au désir, elle agit dans l'intérêt véritable de l'incapable. 1996, chap. 2, annexe A, par. 21 (1). **Intérêt véritable** (2) Lorsqu'elle décide de ce qui est dans l'intérêt véritable de l'incapable, la personne qui donne ou refuse son consentement au nom de celui-ci tient compte de ce qui suit : a) les valeurs et les croyances qu'elle sait que l'incapable avait lorsqu'il était capable et conformément auxquelles elle croit qu'il agirait s'il était capable; b) les désirs qu'elle sait que l'incapable a exprimés à l'égard du traitement et auxquels il n'est pas obligatoire de se conformer aux termes de la disposition 1 du paragraphe (1); c) les facteurs suivants : 1. S'il est vraisemblable ou non que le traitement, selon le cas : i. améliorera l'état ou le bien-être de l'incapable, ii. empêchera la détérioration de l'état ou du bien-être de l'incapable,

person's condition or well-being is likely to deteriorate. 2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment. 3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her. 4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.	iii. diminuera l'ampleur selon laquelle ou le rythme auquel l'état ou le bien-être de l'incapable se détériorera vraisemblablement. 2. S'il est vraisemblable ou non que l'état ou le bien-être de l'incapable s'améliorera, restera le même ou se détériorera sans le traitement. 3. Si l'effet bénéfique prévu du traitement l'emporte ou non sur le risque d'effets néfastes pour l'incapable. 4. Si un traitement moins contraignant ou moins perturbateur aurait ou non un effet aussi bénéfique que celui qui est proposé.

***Adult Guardianship and Trusteeship Act* SA 2008, c A-4.2, S 92**

Exercise of decision-making authority **92(1)** Subject to sections 88 and 90, a specific decision maker selected under section 87 has the authority to make a decision on behalf of the adult respecting the matter for which the specific decision maker has been selected. **(2)** In making a decision for an adult, a specific decision maker shall consult the adult to the extent possible. **(3)** A specific decision maker shall make a decision that is in the adult's best interests. **(4)** In determining whether a decision is in an adult's best interests, a specific decision maker shall consider (a) any wishes known to have been expressed by the adult while the adult had capacity, (b) any values and beliefs known to have been held by the adult while the adult had capacity, and (c) the matters referred to in section 93(1) or (2), as the case may be.	

***Health Care (Consent) and Care Facility (Admission) Act* RSBC 1996, c 181, S 19**

Duties of a temporary substitute decision maker **19** (1) A person chosen under section 16 to give or refuse substitute consent to health care for an adult must	

(a) before giving or refusing substitute consent, consult, to the greatest extent possible, (i) with the adult, and (ii) if the person chosen under section 16 is a person authorized by the Public Guardian and Trustee, with any near relative or close friend of the adult who asks to assist, and (b) comply with any instructions or wishes the adult expressed while he or she was capable. (2) If the adult's instructions or wishes are not known, the person chosen under section 16 must decide to give or refuse consent in the adult's best interests. (3) When deciding whether it is in the adult's best interests to give, refuse or revoke substitute consent, the person chosen under section 16 must consider (a) the adult's current wishes, and known beliefs and values, (b) whether the adult's condition or well-being is likely to be improved by the proposed health care, (c) whether the adult's condition or well-being is likely to improve without the proposed health care, (d) whether the benefit the adult is expected to obtain from the proposed health care is greater than the risk of harm, and (e) whether a less restrictive or less intrusive form of health care would be as beneficial as the proposed health care.	

Consent to Treatment and Health Care Directives Act **RSPEI 1996 c 17.2, S 13**

13. (1) A substitute decision-maker shall act in accordance with the following principles: (a) if the person knows that the patient has made a directive that contains instructions applicable to the circumstances, they must be followed, subject to clause (c); (b) if the person does not know of any such instructions, he or she shall act in accordance with any wishes applicable to the circumstances that he or she knows the patient expressed, orally or in writing, when capable, and believes the patient would still act on if capable; (c) if the person knows of, and there is evidence satisfactory to the person and the health practitioner of, wishes applicable to the circumstances that the patient expressed, orally or	

in writing, when capable, and believes the patient would still act on them if capable, and if the wishes are demonstrably more recent than the instructions contained in a directive, the wishes must be followed; (d) if the person does not know of any such instructions or wishes or if it is impossible to comply with such instructions or wishes, he or she shall act in the patient's best interests; (e) so far as is practicable, the person shall attempt to involve the patient in consideration of the decision. (2) In deciding what a patient's best interests are, the substitute decision-maker shall take into consideration (a) the values and beliefs that the person knows the patient held when capable and believes he or she would still act on if capable; (b) the patient's current wishes, if they can be ascertained; and (c) the following factors: (i) whether the treatment is likely to (A) improve the incapable person's condition or well-being, (B) prevent the incapable person's condition or well-being from deteriorating, or (C) reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate, (ii) whether the patient's condition or well-being is likely to improve, remain the same or deteriorate without the treatment, (iii) whether the benefit the patient is expected to obtain from the treatment outweighs the risk of harm to him or her, (iv) whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.	

***Advance Health Care Directives Act* SNL 1995 c A-4.1, S 12**

Best interests of the maker **12.** (1) A substitute decision maker shall act (a) in accordance with the directions provided in an advance health care directive; (b) in accordance with the wishes expressed by the maker to the substitute decision maker prior to the maker's incompetency where they are known to the substitute decision maker; or (c) when the substitute decision maker has no knowledge of the maker's wishes, in accordance with what the substitute decision maker, in his or her discretion, reasonably believes to be in the best interests of the maker. (2) A substitute decision maker named in an advance health care directive may not delegate the authority to make health care decisions. (3) Where more than 1 substitute decision maker is named in an advance health care directive and the advance health care directive does not indicate whether they are to act jointly or in succession to one another, they shall be considered to be appointed to act successively, in the order named in the advance health care directive. (4) Where more than 1 substitute decision maker is named in an advance health care directive to act jointly rather than successively, the following rules shall apply, unless the advance health care directive provides otherwise (a) where 2 substitute decision makers are named a decision requires unanimity to be given effect; (b) where more than 2 decision makers are named the decision of the majority shall be considered to be the decision of all; and (c) where 1 or more of them dies before or after the coming into effect of the advance health care directive or is unwilling or, after reasonable inquiries, unavailable to make a health care decision, the remainder of them may make the decision and the decision of the majority of the remainder shall be considered to be the decision of all.	

***Hospitals Act* RSNS 1989 c208, S 54**

Consent to hospital treatment 54 (1) No person admitted to a hospital or a psychiatric facility shall receive treatment unless he consents to such treatment. (2) Where a patient in a hospital or a psychiatric facility is found by declaration of capacity to be incapable of consenting to treatment, consent may be given or refused on behalf of the patient by a substitute decision-maker who has capacity and is willing to make the decision to give or refuse the consent from the following in descending order: (a) a person who has been authorized to give consent under the Medical Consent Act or a delegate authorized under the Personal Directives Act; (b) the patient's guardian appointed by a court of competent jurisdiction; (c) the spouse of the patient; (d) an adult child of the patient; (e) a parent of the patient; (f) a person who stands in loco parentis to the patient; (fa) an adult sibling of the patient; (fb) a grandparent of the patient; (fc) an adult grandchild of the patient; (fd) an adult aunt or uncle of the patient; (fe) an adult niece or nephew of the patient; (g) any other adult next of kin of the patient; or (h) the Public Trustee. (3) Where a person in a category in subsection (2) fulfils the criteria for a substitute decision-maker as outlined in subsection (5) but refuses to consent to treatment on the patient's behalf, the consent of a person in a subsequent category is not valid. (4) Where two or more persons who are not described in the same clause of subsection (2)	

claim the authority to give or refuse consent under that subsection, the one under the clause occurring first in that subsection prevails. (5) A person referred to in clauses (c) to (g) of subsection (2) shall not exercise the authority given by that subsection unless the person (a) excepting a spouse, has been in personal contact with the patient over the preceding twelve-month period or has been granted a court order to shorten or waive the twelve-month period; (b) is willing to assume the responsibility for consenting or refusing consent; (c) knows of no person of a higher category who is able and willing to make the decision; and (d) makes a statement in writing certifying the person's relationship to the patient and the facts and beliefs set out in clauses (a) to (c). (6) The attending physician is responsible for obtaining consent from the appropriate person referred to in subsection (2). *R.S., c. 208, s. 54; 2000, c. 29, s. 16; 2001, c. 5, s. 4; 2005, c. 42, s. 86; 2008, c. 8, s. 35.*	

Health Care Directives Act **CCSM c H27, S 13**
Loi sur les directives en matière de soins de santé**, CPLM c H27, S 13**

Principles 13 A proxy shall act in accordance with the following principles: 1. If a directive appointing the proxy expresses the maker's health care decisions, those decisions must be complied with, subject to principle 3. 2. If the maker's decisions are not expressed in a directive, the proxy shall act in accordance with any wishes that he or she knows the maker expressed when the maker had capacity, and believes the maker would still act on if capable. 3. If the proxy knows of wishes applicable to the circumstances that the maker expressed when the maker had capacity, and believes the maker would still act on them if capable, and if the	**Principes** 13 Les mandataires doivent se conformer aux principes suivants : 1. Sous réserve du principe 3, le mandataire nommé dans des directives doit respecter les décisions qui y sont inscrites, le cas échéant. 2. En l'absence de décisions prises dans les directives, le mandataire agit conformément aux volontés qu'il sait avoir été exprimées par l'auteur au moment où celui-ci jouissait de toutes ses capacités s'il croit que l'auteur donnerait suite à ces décisions si celui-ci en était capable. 3. Le mandataire qui connaît les volontés, applicable aux circonstances, exprimées par l'auteur quand celui-ci jouissait de toutes ses capacités est

wishes are more recent than the decisions expressed in a directive, the wishes must be followed. 4. If the proxy has no knowledge of the maker's wishes, the proxy shall act in what the proxy believes to be the maker's best interests.	tenu de les respecter s'il croit que l'auteur leur donnerait suite si celui-ci en était capable et que les volontés sont plus récentes que les décisions exprimées dans des directives. 4. Le mandataire qui ne connaît pas les volontés de l'auteur agit conformément à ce qu'il considère être dans l'intérêt véritable de l'auteur.

***Alberta Personal Directives Act* RSA 2000 c P-6, S 14**

Agent's authority **14(1)** Unless a personal directive provides otherwise, an agent has authority to make personal decisions on all personal matters of the maker. **(2)** An agent must follow any clear instructions provided in the personal directive that are relevant to the personal decision to be made. **(3)** If the personal directive does not contain clear instructions that are relevant to the decision to be made, the agent must (a) make the decision that the agent believes the maker would have made in the circumstances, based on the agent's knowledge of the wishes, beliefs and values of the maker, or (b) if the agent does not know what the maker's wishes, beliefs and values are, make the decision that the agent believes in the circumstances is in the best interests of the maker.	

***Health Care Directives and Substitute Health Care Decision Makers Act* SS 1997, c H-0.001, S 12**

Wishes or best interests to be followed 12 A proxy shall act: (a) according to the wishes expressed by the person making the directive prior to that person's incapacity to make a health care decision, if the proxy has knowledge of the person's wishes; or (b) according to what the proxy believes to be in the best interests of the person making the directive, if the proxy has no knowledge of the person's wishes.	

***Personal Directives Act* SNS 2008 c 8, S 15**

Making of decisions by delegate 15 (1) Subject to the Hospitals Act and the Involuntary Psychiatric Treatment Act, all decisions made by a delegate must be made in accordance with subsection (2). (2) In making any decision, a delegate shall (a) follow any instructions in a personal directive unless (i) there were expressions of a contrary wish made subsequently by the maker who had capacity, (ii) technological changes or medical advances make the instruction inappropriate in a way that is contrary to the intentions of the maker, or (iii) circumstances exist that would have caused the maker to set out different instructions had the circumstances been known based on what the delegate knows of the values and beliefs of the maker and from any other written or oral instructions; (b) in the absence of instructions, act according to what the delegate believes the wishes of the maker would be based on what the delegate knows of the values and beliefs of the maker and from any other written or oral instructions; and (c) where the delegate does not know the wishes, values and beliefs of the maker, make the personal-care decision that the delegate believes would be in the best interests of the maker. (3) Subject to the Hospitals Act and the Involuntary Psychiatric Treatment Act, all decisions made by a statutory decision-maker must be made in accordance with subsection (4). (4) A statutory decision-maker shall (a) act according to what the statutory decision-maker believes the wishes of the person represented would be based on what the statutory decision-maker knows of the values and beliefs of the person represented and from any other written or oral instructions; and (b) where the statutory decision-maker does not know the wishes, values and beliefs of the person represented, make the personal-care decision that the statutory decision-maker believes would be in the best interests of the person represented.	

***Personal Directives Act* SNWT 2005 c 16, S 3**
***Loi sur les directives personnelles*, LTN-O 2005, c 16, S 3**

3 3. (1) This Act applies to personal directives made in the Northwest Territories after the coming into force of this Act. (2) A personal directive made in another jurisdiction has the same effect as if it were made in accordance with this Act if (a) a lawyer entitled to practice law in that jurisdiction has certified in writing that the directive meets the requirements relating to the formalities of execution for personal directives under the legislation of that jurisdiction; or (b) the directive would have met the applicable requirements of section 6 had it been made in the Northwest Territories. (3) A personal directive made in another jurisdiction that is not described by paragraph (2)(a) or (b) has no legal effect in the Northwest Territories.	3. (1) La présente loi s'applique aux directives personnelles faites aux Territoires du Nord-Ouest après son entrée en vigueur. (2) La directive personnelle faite dans un lieu autre que les Territoires du Nord-Ouest produit le même effet que si elle avait été faite en conformité avec la présente loi dans l'un ou l'autre des cas suivants: a) un avocat autorisé à exercer le droit dans ce lieu a certifié par écrit que la directive respectait les formalités de passation d'une directive personnelle prévue dans la loi du lieu; b) la directive aurait respecté les exigences applicables de l'article 6 si elle avait été faite aux Territoires du Nord-Ouest. (3) La directive personnelle qui a été faite dans un lieu autre que les Territoires du Nord-Ouest et qui n'est pas visée à l'alinéa (2)a) ou b) est sans effet juridique aux Territoires du Nord-Ouest.

***Care Consent Act* being Schedule B of the *Decision Making Support and Protection to Adults Act* SY 2003 c 21Decision Making Support and Protection to Adults Act SY 2003 c 21, S 20**

***Loi sur le consentement aux soins, annexe b, Loi sur la prise de décisions, le soutien et la protection des adultes*, LY 2003, c 21, S 20**

Decision-making duties	**Obligations relatives à la prise de décision**
20(1) A substitute decision-maker shall give or refuse consent in accordance with the wishes of the care recipient. (2) Subsection (1) does not apply where (a) the wish was not expressed by the care recipient while capable and after attaining the age of 16; (b) compliance with the wish is impossible; or (c) the substitute decision-maker believes the care recipient would not still act on the wish if capable because of changes in knowledge, technology, or practice in the provision of care not foreseen by the care recipient.	**20**(1) Un décisionnaire remplaçant doit donner ou refuser son consentement conformément à la volonté du bénéficiaire des soins. (2) Le paragraphe (1) ne s'applique pas dans les cas suivants : a) la volonté n'a pas été exprimée par le bénéficiaire des soins alors qu'il en était capable et après avoir atteint l'âge de 16 ans; b) il est impossible de donner suite à cette volonté; c) le décisionnaire remplaçant croit que le bénéficiaire des soins ne donnerait pas toujours suite à sa volonté s'il en était capable en raison de changements dans les connaissances, la technologie ou la pratique relative à la fourniture des soins que le bénéficiaire des soins n'avait pas prévus.

(3) Where a wish does not clearly anticipate the specific circumstances that exist, it is to be used for guidance as to the beliefs and values of the person making the wish.	(3) Lorsqu'une volonté exprimée ne prévoit pas clairement les circonstances précises qui existent, elle doit servir de guide quant aux croyances et aux valeurs de la personne qui l'a exprimée.
(4) Where subsection (1) does not apply, the substitute decision-maker shall give or refuse consent in accordance with the beliefs and values of the care recipient.	(4) Lorsque le paragraphe (1) ne s'applique pas, le décisionnaire remplaçant doit donner ou refuser son consentement conformément aux croyances et valeurs du bénéficiaire des soins.
(5) Where subsection (1) does not apply and the care recipient's beliefs and values remain unknown despite compliance with section 19, the substitute decision-maker shall give or refuse consent in accordance with the best interests of the care recipient.	(5) Lorsque le paragraphe (1) ne s'applique pas et que les croyances et les valeurs du bénéficiaire des soins restent inconnues malgré le respect de l'article 19, le décisionnaire remplaçant doit donner ou refuser son consentement conformément à l'intérêt du bénéficiaire des soins.
(6) When deciding whether it is in the care recipient's best interests to give or refuse consent, the substitute decision-maker must consider (a) the care recipient's current wishes; (b) whether the care recipient's condition or well-being is likely to be improved by the proposed care or will not deteriorate because of it; (c) whether the care recipient's condition or well-being is likely to improve without the proposed care or is not likely to deteriorate without it; (d) whether the benefit the care recipient is expected to obtain from the proposed care is greater than the risk of harm or other negative consequences; and (e) whether the benefit of a less restrictive or less intrusive form of available care is greater than the risk of harm or other negative consequences.	(6) Pour décider s'il est dans l'intérêt du bénéficiaire des soins de donner ou de refuser son consentement, le décisionnaire remplaçant doit prendre en considération ce qui suit : a) la volonté actuelle du bénéficiaire des soins; b) si l'état ou le bien-être sont susceptibles d'être améliorés par les soins proposés ou ne se détérioreront pas en raison de ceux-ci; c) si l'état ou le bien-être du bénéficiaire des soins sont susceptibles d'être améliorés sans les soins proposés ou ne sont pas susceptibles de se détériorer sans ceux-ci; d) si l'avantage que les soins proposés devraient procurer au bénéficiaire des soins est plus important que les risques de préjudice ou d'autres conséquences négatives; e) si l'avantage d'une forme de soins disponible moins restrictive ou moins intrusive est plus important que le risque de préjudice ou d'autres conséquences négatives.

***Adult Guardianship and Co-decision Making Act* SS 2000 c A-5.3, S 25**

Duties of personal decision-maker 25 A personal decision-maker shall exercise the duties and powers assigned by the court diligently, in good faith, in the best interests of the adult and in a manner so as to: (a) ensure that the adult's civil and human rights are protected;	

(b) encourage the adult to: (i) participate to the maximum extent in all decisions affecting the adult; and (ii) act independently in all matters in which the adult is able to; and (c) limit the personal decision-maker's interference in the life of the adult to the greatest extent possible.	

Psychiatric Treatment Act **SNS 2005, c 42, S 39-40**

Basis for decision 39 The substitute decision-maker shall make the decision in relation to specified psychiatric treatment and other related medical treatment (a) in accordance with the patient's prior capable informed expressed wishes; or (b) in the absence of awareness of a prior capable informed expressed wish or if following the patient's prior capable informed expressed wish would endanger the physical or mental health or safety of the patient or another person, in accordance with what the substitute decision-maker believes to be in the patient's best interests. *2005, c. 42, s. 39.* **Determining best interest** 40 In order to determine the best interest of the patient for the purpose of clause 39(b), regard shall be had to whether (a) the mental condition of the patient will be or is likely to be improved by the specified psychiatric treatment; (b) the mental condition of the patient will improve or is likely to improve without the specified psychiatric treatment; (c) the anticipated benefit to the patient from the specified psychiatric treatment and other related medical treatment outweighs the risk of harm to the patient; and (d) the specified psychiatric treatment is the least restrictive and least intrusive treatment that meets the requirements of clauses (a), (b) and (c).	

***Mental Health Act* RSNB 1973 c M-10, S 8.6**
***Loi sur la santé mentale*, LRN-B 1973, c M-10, S 8.6**

8.6(1) For the purposes of sections 17, 20 and 27, consent may be given or refused on behalf of an involuntary patient who has not reached the age of sixteen years, or who has reached the age of sixteen years but is not mentally competent to give or refuse to give consent, by a person who has reached the age of sixteen years, is apparently mentally competent to give or refuse to give consent, is available and willing to make the decision to give or refuse to give the consent and is in one of the following categories: *(a)* in the case of a child in care under the *Family Services Act*, the Minister; *(b)* the patient's guardian appointed by a court of competent jurisdiction; *(b.1)*the patient's attorney for personal care under the *Infirm Persons Act*; *(c)* the patient's spouse; *(d)* a child of the patient; *(e)* a parent of the patient or a person who has lawful authority to stand in the place of a parent; *(f)* a brother or sister of the patient; *(g)* any other next of kin of the patient; *(h)* a psychiatric patient advocate; *(i)* the Public Trustee. 8.6(2) For the purposes of consent in relation to medical treatment that is not routine clinical medical treatment or other psychiatric treatment, consent may be given or refused on behalf of an involuntary patient who has not reached the age of sixteen years, or who has reached the age of sixteen years but is not mentally competent to give or refuse to give consent to the treatment, by a person who has reached the age of nineteen years, is apparently mentally competent to give or refuse to give consent, is available and willing to make the decision to give or refuse to give the consent and is in one of the following categories: *(a)*in the case of a child in care under the *Family Services Act*, the Minister; *(b)* the patient's guardian appointed by a court of competent jurisdiction; *(b.1)* the patient's attorney for personal care under the *Infirm Persons Act*; *(c)* the patient's spouse; *(d)* a child of the patient; *(e)* a parent of the patient or a person who has lawful authority to stand in the place of a parent; *(f)* a brother or sister of the patient; *(g)* any other next of kin of the patient; *(h)* a psychiatric patient advocate; *(i)* the Public Trustee. 8.6(3) If a person in a category in subsection (1) or	8.6(1) Aux fins des articles 17, 20 et 27, un consentement peut être donné ou refusé au nom d'un malade en placement non volontaire âgé de moins de seize ans, ou âgé d'au moins seize ans mais non capable mentalement de donner ou de refuser de donner son consentement, par une personne âgée d'au moins seize ans apparemment capable mentalement de donner ou de refuser de donner son consentement, qui est disponible et qui veut prendre cette décision de le faire et qui correspond à une des catégories suivantes : *a)* le Ministre, s'il s'agit d'un enfant pris en charge en application de la *Loi sur les services à la famille*; *b)* le tuteur du malade nommé par une cour compétente; *b.1)* le fondé de pouvoir aux soins personnels du malade en application de la *Loi sur les personnes déficientes*; *c)* le conjoint du malade; *d)* un enfant du malade; *e)* un parent du malade ou une personne qui peut légalement remplacer un parent; *f)* un frère ou une soeur du malade; *g)* tout autre proche parent du malade; *h)* un défenseur des malades mentaux; *i)* le curateur public. 8.6(2) Aux fins du consentement à un traitement médical autre qu'un traitement médical clinique de routine ou un autre traitement psychiatrique, le consentement peut être donné ou refusé au nom d'un malade en placement non volontaire âgé de moins de seize ans ou qui bien qu'âgé d'au moins seize ans n'est pas capable mentalement de donner ou refuser de donner son consentement au traitement par une personne âgée d'au moins dix-neuf ans apparemment capable mentalement de donner ou de refuser de donner son consentement, qui est disponible et veut prendre cette décision de le faire et qui correspond à une des catégories suivantes : *a)* le Ministre, s'il s'agit d'un enfant pris en charge en application de la *Loi sur les services à la famille*; *b)* le tuteur du malade nommé par une cour compétente; *b.1)* le fondé de pouvoir aux soins personnels du malade en application de la *Loi sur les personnes déficientes*; *c)* le conjoint du malade; *d)* un enfant du malade; *e)* un parent du malade ou une personne qui peut

(2) refuses to give consent on the involuntary patient's behalf, the consent of a person in a subsequent category is not valid. 8.6(4) If two or more persons who are not described in the same category in subsection (1) or (2) claim the authority to give or refuse to give consent under those subsections, the one under the category occurring first in the subsection prevails. 8.6(5) If no person claims the authority to give or refuse to give consent under subsection (1) or (2) or if two or more persons described in the same category in subsection (1) or (2) claim the authority and they do not agree, the person seeking the consent may file an application in the prescribed form with the chairman of the review board having jurisdiction for an inquiry into whether consent should be given on behalf of the patient. 8.6(6) On receipt of an application under subsection (5), the review board shall, if the wishes of the involuntary patient, expressed when the patient was mentally competent and sixteen or more years of age, are clearly known, give or refuse to give consent in accordance with those wishes and shall otherwise give or refuse to give consent in accordance with the best interests of the patient. 8.6(7) A person referred to in paragraphs (1)(c) to (h) or (2)(c) to (h) shall not exercise the authority given by subsection (1) or (2) unless the person *(a)*has been in personal contact with the involuntary patient over the preceding twelve-month period, *(b)* is willing to assume the responsibility for giving consent or refusing to give consent, *(c)* knows of no conflict or objection from any other person in the list set out in subsection (1) of equal or higher category who claims the authority to make the decision, and *(d)* makes a statement in writing certifying the person's relationship to the patient and the facts and beliefs set out in paragraphs (a) to (c). 8.6(8) A person authorized by subsection (1) or (2) to give or refuse to give consent on behalf of an involuntary patient shall, if the wishes of the patient, expressed when the patient was mentally competent and sixteen or more years of age, are clearly known, give or refuse to give consent in accordance with those wishes and shall otherwise give or refuse to give consent in accordance with the best interests of the patient. 8.6(9) In order to determine the best interests of the patient in relation to medical treatment that is not routine clinical medical treatment or other psychiatric treatment, regard shall be had to	légalement remplacer un parent; *f)* un frère ou une soeur du malade; *g)* tout autre proche parent du malade; *h)* un défenseur des malades mentaux; *i)* le curateur public. 8.6(3) Si une personne d'une catégorie établie au paragraphe (1) ou (2) refuse de donner son consentement au nom du malade en placement non volontaire, le consentement donné par une personne d'une catégorie suivante n'est pas valide. 8.6(4) Si plusieurs personnes qui ne sont pas de la même catégorie du paragraphe (1) ou (2) prétendent avoir l'autorisation de donner ou de refuser de donner leur consentement en application de ces paragraphes, celle d'une catégorie apparaissant la première au paragraphe l'emporte. 8.6(5) Si nulle personne ne prétend avoir l'autorisation de donner ou de refuser de donner son consentement en application du paragraphe (1) ou (2) ou si plusieurs personnes d'une même catégorie décrite au paragraphe (1) ou (2) prétendent l'avoir et ne s'entendent pas, la personne qui cherche à obtenir le consentement peut déposer une demande établie selon la formule prescrite auprès du président de la commission de recours compétente de mener une enquête afin de déterminer si un consentement doit être donné au nom du malade. 8.6(6) Sur réception d'une demande en application du paragraphe (5), la commission de recours doit, si sont bien connus les désirs du malade en placement non volontaire exprimés alors qu'il était capable mentalement et âgé d'au moins seize ans, donner ou refuser de donner son consentement conformément à ces désirs, sinon elle doit donner son consentement ou refuser de le donner conformément à l'intérêt primordial du malade. 8.6(7) Une personne visée aux alinéas (1)c) à h) ou (2)c) à h) ne peut exercer l'autorisation accordée par le paragraphe (1) ou (2) à moins *a)* qu'elle n'ait été en communication avec le malade en placement non volontaire dans les douze mois précédents, *b)* qu'elle ne veuille assumer la responsabilité de donner son consentement ou de refuser de le donner, *c)* qu'elle ne connaisse aucun conflit ni aucune objection de quelqu'autre personne mentionnée au paragraphe (1) de la même catégorie ou d'une catégorie ayant priorité qui revendique l'autorisation de prendre la décision, et *d)* qu'elle ne fasse une déclaration écrite attestant du lien qu'elle a avec le malade et des faits et des croyances établies aux alinéas a) à c).

(a) whether or not the condition of the patient will be or is likely to be substantially improved by the treatment, *(b)* whether or not the condition of the patient will improve or is likely to improve without the treatment, *(c)* whether or not the anticipated benefit from the treatment outweighs the risk of harm to the patient, and *(d)* whether or not the treatment is the least restrictive and least intrusive treatment that meets the requirements of paragraphs (a), (b) and (c). 8.6(10) Whoever seeks a person's consent on an involuntary patient's behalf is entitled to rely on that person's statement in writing as to the person's relationship with the patient and as to the facts and beliefs mentioned in paragraphs (7)(a) to (c), unless it is not reasonable to believe the statement. 8.6(11) The person seeking the consent is not liable for failing to request the consent of a person entitled to give or refuse to give consent on the patient's behalf if the person seeking the consent made reasonable inquiries for persons entitled to give or refuse to give consent but did not find the person.	8.6(8) Une personne autorisée par le paragraphe (1) ou (2) à donner son consentement au nom d'un malade en placement non volontaire doit, si les désirs du malade, exprimés lorsqu'il était capable mentalement et était âgé d'au moins seize ans, sont bien connus, donner son consentement ou refuser de le donner en conformité avec ces désirs, sinon elle doit autrement donner son consentement ou refuser de le donner conformément à l'intérêt primordial du malade. 8.6(9) Afin de déterminer l'intérêt primordial du malade quant au traitement médical autre qu'un traitement médical clinique de routine ou à un autre traitement psychiatrique, il doit être tenu compte du fait *a)* que l'état du malade sera amélioré ou sera vraisemblablement amélioré d'une manière importante par le traitement ou non, *b)* que l'état du malade s'améliorera ou s'améliorera vraisemblablement sans le traitement ou non, *c)* que l'avantage anticipée du traitement l'emporte sur le risque de causer un tort au malade ou non, et *d)* que le traitement est le moins envahissant et le moins contraignant qui rencontre les exigences des alinéas a), b) et c) ou non. 8.6(10) Quiconque cherche à obtenir le consentement d'une personne au nom d'un malade en placement non volontaire a le droit de se fier à la déclaration écrite de cette personne quant à son lien avec le malade de même que quant aux faits et croyances mentionnés aux alinéas (7)a) à c), à moins qu'il ne soit pas raisonnable d'y croire. 8.6(11) La personne qui cherche à obtenir le consentement n'est pas responsable du défaut de demander le consentement de la personne ayant le droit de donner ou de refuser de donner son consentement au nom du malade si elle a fait des recherches raisonnables pour retrouver des personnes ayant le droit de donner ou de refuser de donner leur consentement et ne les a pas trouvées.

***Canadian Charter of Rights and Freedoms,* Part I of the *Constitution Act, 1982,* being schedule B to the *Canada Act 1982* (UK), 1982, c 11, S 7, 2(a)**
***Loi constitutionnelle de 1982,* annexe B de la Loi de 1982 sur le Canada (R-U), 1982, c 11, S 7, 2(a)**

Legal Rights	**Garanties juridiques**
7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.	7. Chacun a droit à la vie, à la liberté et à la sécurité de sa personne; il ne peut être porté atteinte à ce droit qu'en conformité avec les principes de justice fondamentale.
Fundamental Freedoms	**Libertés fondamentales**
2. Everyone has the following fundamental freedoms: (a) freedom of conscience and religion;	2. Chacun a les libertés fondamentales suivantes : (a) liberté de conscience et de religion;