Court File No. C53442

COURT OF APPEAL FOR ONTARIO

B E T W E E N :

HASSAN RASOULI, by his Litigation Guardian
and substitute decision maker, PARICHEHR SALASEL

Applicant
(Respondent)

- and -

SUNNYBROOK HEALTH SCIENCES CENTRE,
DR. BRIAN CUTHBERTSON and DR. GORDON RUBENFELD

Respondents
(Appellants)

AND

B E T W E E N:

DR. BRIAN CUTHBERTSON and DR. GORDON RUBENFELD

Applicants
(Appellants)

- and –

HASSAN RASOULI and his substitute decision maker
PARICHEHR SALASEL

Respondents
(Respondents)

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PART I - THE ORDER APPEALED FROM

1. This is an appeal from the order dated March 9, 2011 made by the Honourable Madam Justice Himel of the Superior Court of Justice, which determined that doctors require consent when withdrawing life-support.

PART II - OVERVIEW

2. This case raises the important question of whether the law requires doctors to obtain consent before they withdraw life-support from a patient who is in a state of permanent and irreversible unconsciousness. In the court below, Himel, J. held that life-support may never be withdrawn without the consent of the patient (or, if incapable, his or her substitute decision-maker). Whether or not the treatment could provide a benefit to the patient was a factor ignored in her analysis.

3. The decision below is based on an interpretation of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A, and specifically the definition of the term "treatment" under that act. The judge found that the withdrawal of treatment is included in the statutory definition of "treatment" and that life-support is treatment. As a result, she found, consent to its withdrawal is required. Where consent is refused by a substitute decision-maker, doctors cannot withdraw the treatment without resort to an application to the Consent and Capacity Board.

4. The appellants respectfully submit that the judge erred in treating the case as one that turns upon the law of informed consent. She erred, in particular, in construing the *Health Care Consent Act* to confer a right to require treatment instead of a right to refuse treatment.

5. The appellants submit that if a person is to receive life-support against medical advice, it must be on account of a legal duty on the part of the doctors to provide it. Whether they have such a duty must turn upon whether the treatment will provide a benefit to the patient. It cannot be based on the law of consent.

6. At common law, patients have a right of informed consent only with respect to treatment that is proposed by a doctor. The *Health Care Consent Act* does not depart from the common law in this regard. As the judge correctly found, the *Health Care Consent Act* does not confer upon patients the right to choose their own treatment: they may choose only whether or not to receive treatment that is proposed by a health practitioner. This conclusion means that the *Health Care Consent Act* can have no application to this case because the appellants do not propose to continue life-support.

7. Instead, the judge made an untenable distinction between treatment that is withheld and treatment that is withdrawn and found that the *Health Care Consent Act* confers the right to refuse the withdrawal of treatment but not its withholding. In this, with respect, she erred. The Act treats a withholding and a withdrawal of treatment identically, as is appropriate.

8. Whether a doctor declines to provide treatment at all or declines to continue to provide it, the decision is governed by a single consideration: the presence or absence of medical indications for the treatment or, in other words, the potential for benefit to the patient.

9. Since the law of consent is irrelevant to the case, the judge should have applied common law principles in determining whether, <u>on the particular facts of this case</u>, Mr. Rasouli's attending doctors have a legal duty to provide treatment. As a result of her finding that the *Health Care Consent Act* applied, she did not need to construe the common law.

Nevertheless, she did consider the relevant common law cases only to find the common law in Canada on the issue to be unclear.

10. In fact, the common law is not unsettled, as cases from across the common law world demonstrate. The law as it applies to treatment provided at the end of life is no different than the law that applies to treatment provided at any other time in a person's life. The medical standard of care always applies. Doctors are obliged to offer treatment that can benefit the patient, and they are obliged not to offer treatment that is futile.

11. The judge correctly found that life-support in the i.c.u. is medically indicated only for patients with reversible conditions. This means that it is not normally provided when the only purpose it could fulfil is to prolong the patient's death from an underlying disease.

12. Mr. Rasouli is in a persistent vegetative state, which is a condition of irreversible unconsciousness. It is respectfully submitted that the judge ought to have followed the authoritative case law that has held that such patients cannot benefit from life-support and that doctors should not be ordered to provide it. Instead, she made no finding on this critical point.

13. The effect of the judge's decision is to make the fact that treatment is futile irrelevant to the question of whether treatment must continue. This cannot be right. It treats prolonging death and prolonging life as if they were the same.

14. If the decision below stands, the result is that doctors in the position of the appellants have a legal duty, pursuant to the statute, to provide life-support and a legal duty, pursuant to the common law standard of care, not to provide it.

15. An application to the Consent and Capacity Board does not offer a way out. The judge erred in stating that the Board will apply a "best interests" test to determine whether life-support should continue. In cases where the patient is found to have had the wish to receive all possible treatment, as the respondents here allege, the Board is obliged to give overriding effect to the patient's wish. The patient's best interests are irrelevant.

PART III - THE FACTS

OVERVIEW

16. In October 2010, while an in-patient at Sunnybrook Health Sciences Centre, Hassan Rasouli suffered a bacterial meningitis following surgery to remove a brain tumour. The infection spread throughout his brain, causing severe and diffuse damage. Although he remains alive, he has been without consciousness since October 17, 2010.

17. With the passage of time, Mr. Rasouli now meets the clinical criteria for a diagnosis of persistent vegetative state ("PVS"). It is as certain as anything ever is in medicine that he will never recover any degree of consciousness.

18. Mr. Rasouli is kept alive by a mechanical ventilator, which is connected to a tube that has been surgically inserted into his trachea. He is tube-fed. Because of the life-sustaining care that he is receiving in Sunnybrook's i.c.u., the Critical Care Unit, it is likely that, if the current course of treatment continues, he will die slowly from one of the many complications related to being permanently confined to a hospital bed and on a ventilator.

19. When the extent of his injuries and the gravity of his prognosis were apparent, Mr. Rasouli's attending doctors, which include the appellants, advised his family that the medical team was not prepared to continue to offer mechanical ventilation or to offer resuscitation in

the event of a cardiac arrest. They proposed palliative care only. Mr. Rasouli's wife, Parichehr Salasel, did not accept the decision and moved for a permanent injunction to prevent a withdrawal of life support.

PERSISTENT VEGETATIVE STATE

20. PVS involves an irreversible loss of consciousness due to traumatic or, as in Mr. Rasouli's case, non-traumatic brain injury. Many PVS patients can breathe spontaneously, and a range of spontaneous movements and reactions to external stimuli can also be preserved. The typical PVS patient may engage in activities such as opening and moving eyes, crying, smiling, frowning, yawning, chewing, swallowing, moving limbs spontaneously without purpose, and grunting. Although this behaviour can produce the illusion of voluntary acts, this is not so – these are merely reflex responses, which are compatible with complete unawareness.

> Affidavit of Richard Swartz , Appeal Book, Tab 6, pages 54-55, para. 8 and Exhibit "C", Appeal Book, Tab 8 at page 79.

21. The diagnosis of PVS is made primarily on the basis of clinical observation. There are well-recognised criteria for the diagnosis, which are stated in the report by the Multi-Society Task Force on PVS entitled "Medical Aspects of the Persistent Vegetative State", which was published in the *New England Journal of Medicine* in 1994.

22. According to the report:

> The vegetative state can be diagnosed according to the following criteria: (1) no evidence of awareness of self or environment and an inability to interact with others; (2) no evidence of sustained, reproducible, purposeful, or voluntary behavioural responses to visual, auditory, tactile, or noxious stimuli; (3) no evidence of language comprehension or expression; (4) intermittent wakefulness manifested by the presence of sleep-wake cycles; (5) sufficiently preserved hypothalamic and brain-stem

> autonomic functions to permit survival with medical and nursing care; (6) bowel and bladder incontinence; and (7) variably preserved cranial-nerve reflexes (pupillary, oculocephalic, corneal, vestibulo-ocular, and gag) and spinal reflexes.

As the report also states, PVS can be judged permanent three months after the date of injury in a non-traumatic case. That is because the prospects for any recovery decline markedly after three months.

> Affidavit of Dr. Swartz, Appeal Book, Tab 6, page 57, para. 16 and Exhibit "C", Appeal Book at page 79.

MR. RASOULI'S NEUROLOGICAL STATUS

23. Bacterial meningitis is an infection of the cerebro-spinal fluid. In this case, the infection spread to the ventricles of Mr. Rasouli's brain (a condition known as ventriculitis). Ventriculitis is extremely destructive, and almost uniformly fatal. In Mr. Rasouli's case, the white blood cells responded by attacking the infection, but they also indiscriminately attacked the infected brain tissue. This led to death of brain tissue through a generalized inflammation of the brain (cerebritis) and multi-focal infarcts (strokes) of the brain tissue. Inflammation near the back of the brain caused clotting and narrowing of the artery leading to the brainstem, resulting in infarction of that brain structure. His spinal cord (including peripheral nerve roots) may also have been damaged by the infection.

> Affidavit of Dr. Swartz, Appeal Book, Tab 6, pages 57-58, para. 18.

24. On a neurological examination carried out on October 17, 2010, Dr. Richard Swartz, the patient's attending neurologist, determined that Mr. Rasouli demonstrated no evidence of awareness of himself or his environment, no response to visual, auditory, tactile or noxious stimuli, and no evidence of language comprehension or expression. Mr. Rasouli's observed responses were confined to reflex responses of a type generally accepted by clinicians to be

compatible with PVS. He showed no responses that are either atypical of the diagnosis or are incompatible with it. On motor examination, he demonstrated flaccid quadriparesis with reduced tone and absent motor reflexes.

Affidavit of Dr. Swartz, Appeal Book, Tab 6, page 58, paras. 19-22.

25. As of October 17, Mr. Rasouli satisfied all the criteria for PVS except for the persistence of his condition which, by definition, must be at least three months. It was overwhelmingly likely that Mr. Rasouli lacked any degree of awareness and also overwhelmingly likely that he would never recover any.

Affidavit of Dr. Swartz, Appeal Book, Tab 6, pages 54-56, paras. 6, 11-12.

26. There have been four further reassessments of Mr. Rasouli by Dr. Swartz, the latest being on February 10, 2011. These revealed minimal changes in his neurological status, all of which were compatible with a diagnosis of PVS. The fact that his status has not changed materially since he lost consciousness suggests that there will be no further material improvements.

Affidavit of Dr. Swartz, Appeal Book, Tab 6, pages 58-59 at para. 24 and Exhibit "B", Tab 7, pages 63-76.

27. A full separate assessment was conducted on January 20, 2011 by a staff neurologist (Dr. Jon Ween) who had not previously been involved in Mr. Rasouli's care. He concurred with Dr. Swartz's findings and diagnosis.

Affidavit of Jon Ween, sworn February 13, 2011, Appeal Book, Tab 13, pages 143-144 paras. 4-5, 7-8 and 10 and Exhibit "B" at Tab 14, pages 146-148.

28. Mr. Rasouli has undergone a variety of diagnostic tests, including imaging of the brain, all of which support Dr. Swartz's clinical findings and the clinical diagnosis of PVS.

Affidavit of Dr. Swartz, Appeal Book, Tab 6, pages 59-60 paras. 25-26.

29. Mr. Rasouli has also regularly been examined by the critical care doctors who are primarily responsible for his care. In all, there have been thirteen such doctors. None of them has made any observations inconsistent with a diagnosis of PVS.

Affidavit of Dr. Cuthbertson, Appeal Book, Tab 9, page 105, para. 45.

Cross-examination of Dr. Cuthbertson, Questions 6-8, Appeal Book, Tab 12, p.138, line 7 to p.139, line 19.

THE FAMILY'S OBSERVATIONS

30. Mr. Rasouli's family members say that they have seen him engage in certain movements, such as raising his left eyebrow, blinking, crying, raising and moving his hands, swinging his knees, and trying to stretch his body. It is clear that Mr. Rasouli's family loves him very much, and that they desperately want to believe that he is conscious and improving. Unfortunately, it is also clear this has coloured their interpretation of his behaviour.

Affidavit of Parichehr Salasel, Tab 19, pp. 167-169, paras. 46-49, 53-60.

31. A PVS patient will often engage in movements that create the illusion that the patient is conscious when in fact these movements are involuntary reflex actions. The movements that the family have observed do not undermine Mr. Rasouli's diagnosis. Although they assert that he is responding to their commands, they lack the training and experience that are required to distinguish between involuntary movements and true signs of neurological change or responsiveness.

Affidavit of Dr. Swartz, Appeal Book, Tab 6, pages 54-55, 58-59, at paras. 8 and 24 and Exhibit "C", Tab 8, at page 79;

Affidavit of Dr. Cuthbertson, Appeal Book, Tab 9, page 107 at para. 58;

Affidavit of Dr. Fazl, Appeal Book, Tab 15, page 150 at para. 5.

32. On January 24, 2011, Mr. Rasouli appeared to move his hand when Ms Salasel asked him to do so in Farsi. Mr. Rasouli's attending neurosurgeon, Dr. Fazl, was present and witnessed this. It was his impression that this was not voluntary but rather was a nerve reflex action. To confirm his impression, Dr. Fazl (who speaks Farsi) subsequently conducted two further assessments of Mr. Rasouli, also speaking to him in Farsi. After these assessments, Dr. Fazl was certain that the movements that he had observed were involuntary movements that happened to coincide with Ms Salasel's verbal prompt, and did not indicate consciousness or awareness.

Affidavit of Dr. Fazl, Appeal Book, Tab 15, pages 150-1511 at paras. 4, 6, 8 and Exhibits "A", "B" and "C", Tabs 16-18, pages 153-154, 156-157, 159-160.

33. Dr. Fazl's conclusions are the same as all of the other doctors who have examined Mr. Rasouli, conclusions that have not been challenged on cross-examination or contradicted by any medical expert.

Affidavit of Dr. Cuthbertson, Appeal Book, Tab 9, pages 107-108, paras. 58-59;

Affidavit of Dr. Fazl, Appeal Book, Tab 15, page 150 at para. 5.

THE DECISION TO WITHDRAW LIFE-SUPPORT

34. By November, Mr. Rasouli's treating doctors (drawn from critical care, neurology, neurosurgery and infectious diseases) had all concluded that, by reason of his irreversible loss of consciousness, he could receive no medical benefit from life-sustaining treatment, including mechanical ventilation. It was decided that such treatment should no longer be

offered. Having reached that decision, the attending doctors proceeded compassionately and carefully as follows:

(i) They carefully explained the rationale for the decision to the patient's family, and sought the family's acquiescence in a series of meetings, which included medical staff, nurses, a social worker and an ethicist;

(ii) Inquiries were made to see if another hospital might be prepared to assume Mr. Rasouli's care;

(iii) A second neurological opinion was obtained;

(iv) The family was given the opportunity to obtain their own neurological opinion; and

(v) The family was given the opportunity, before treatment was discontinued, to apply to the court for an injunction.

Affidavit of Dr. Cuthbertson, Appeal Book, Tab 9, pages 101-105, paras. 30-35, 39-41 and Exhibit "A", Tab 10 pages 111-124, 127-128

Cross Examination of Brian Cuthbertson conducted on February 14, 2011, Question 20, Appeal Book, Tab 12, p. 140 line 25 to p. 141 line 8.

Affidavit of Parichehr Salasel affirmed February 10, 2011, Exhibit "D", Appeal Book, Tab 20 at 176

35. While there have been times that Mr. Rasouli's family has shown an acceptance and understanding of his prognosis, and has not opposed the withdrawal of mechanical ventilation, the family has subsequently always retreated from this position.

Affidavit of Blair Henry, Appeal Book, Tab 21, pages 180-181, paras. 10-11.

36. The family declined to obtain an independent neurological opinion. They advised Dr. Martin Chapman, one of the attending doctors, that they did not intend to do so because they felt that it would not vary from the opinions already given.

Affidavit of Dr. Cuthbertson, Appeal Book, Tab 9, page Exhibit "A", Appeal Book, Tab 10, page 128.

PART IV - ISSUES AND THE LAW

THE HEALTH CARE CONSENT ACT

37. The judge below construed the *Health Care Consent Act* as if it confers a right to treatment instead of a right not to be treated except with one's consent. In this, it is respectfully submitted, she erred.

38. The Act was enacted primarily to provide a legal regime under which medical decisions may be made on behalf of incapable persons by designated surrogates, in accordance with stipulated criteria, and subject to review by the Consent and Capacity Board.

39. The Act also provides for a general right of informed consent to medical treatment that benefits both capable and incapable persons. As a corollary, it provides protection from liability to physicians who provide treatment with informed consent.

40. The law of informed consent, both statutory and common law, has as its purpose ensuring that treatment is not administered without the patient's consent.

41. The *Health Care Consent Act* has no application where the doctors do not offer to provide treatment.

42. Section 10 of the Act sets out the circumstances requiring consent:

> **10.** (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,
>
> (a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or
>
> (b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act.

43. In this case, the judge concluded:

> "Treatment" under the *HCCA* includes the withdrawal of life support. Therefore, doctors require consent when withdrawing life-support in Ontario.
>
> Reasons for Decision, Appeal Book, Tab 3, page 38, para. 103.

44. "Treatment" is defined in the Act as follows:

> "Treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment….
>
> *Health Care Consent Act, 1996*, s. 2(1).

45. "Plan of treatment" is defined as follows:

> "plan of treatment" means a plan that,
>
> (a) is developed by one or more health practitioners,
>
> (b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and
>
> (c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition.
>
> *Health Care Consent Act, 1996*, s. 2(1),
>
> Reasons for Decision, Appeal Book, Tab 3, page 19, para. 28.

46. The judge found that, on a plain reading, withholding or withdrawal of treatment are included in a "plan of treatment" and thus they also fall within the extended definition of "treatment".

> Reasons for Decision, Appeal Book, Tab 3, page 20, para. 33.

47. The judge did note that there was a potential problem with the concept that the withdrawal of treatment requires consent for she noted as follows:

> The respondents submit that adopting this interpretation will result in patients being able to pick and choose their own treatment.

But, she found, the wording of the *Health Care Consent Act* precludes this possibility:

> Since a plan of treatment is by definition a plan that is "developed by one or more health practitioners", patients themselves cannot develop it. Medical services or treatments desired by patients could only be included in a plan of treatment under the HCCA if one or more health practitioners adopted it into the plan. In other words, treatment cannot be included in a plan of treatment for the purposes of the HCCA until it is proposed by a health practitioner. This condition prevents a patient from picking and choosing their own treatment as the only treatment a doctor would require

> consent to withhold or withdraw would be one proposed by the doctor or by another health practitioner.
>
> Reasons for Decision, Appeal Book, Tab 3, pages 22-23, paras. 42, 45.

48. There are the following problems with the judge's interpretation of the operative definitions:

(i) It treats a withdrawal of treatment as having a therapeutic purpose;

(ii) It conflates treatments that are withdrawn and the administration of active treatment; and

(iii) It results in different effects being given to the withdrawal and to the withholding of treatment.

49. *As to the first interpretation issue*. The judge is of course correct that life-support is a "treatment", as defined. What she failed to appreciate is that the withdrawal of life-support is not a "treatment". If it were, then every time a treatment is withdrawn, the doctor acts for a therapeutic purpose. The opposite is true: treatment is withdrawn when it can no longer serve a therapeutic purpose (e.g., because the treatment would be futile). Similarly, the judge's interpretation would imply that every withholding of a treatment is done for a therapeutic purpose. This is to strain words too far.

> Reasons for Decision, Appeal Book, Tab 3, pages 19-20, paras. 29-33.

50. *As to the second interpretation issue*. There is implicit in the judge's approach, but never made explicit in her reasons, a distinction between "withholding" and "withdrawing" treatment. The judge has found, it appears, that "treatment" that a doctor proposes <u>to withdraw</u> is treatment that is "developed" by a health practitioner, which attracts consent. The illogical result is that treatment that a doctor proposes no longer to provide is treated as if it were the same as treatment that a doctor proposes to continue to provide. Of course, it is

the opposite that is true. The judge attempted, but failed, to square the circle. She has found, effectively, that a patient may demand treatment that the doctor does not propose to provide.

51. The correct approach would instead have been to find that the Act requires consent only to a plan of treatment developed by a health practitioner that provides for active treatment to be administered. It ought also to have been found that the health practitioner may include in a proposed plan of treatment the proviso that the active treatment that is proposed will, in specified circumstances, be withheld or withdrawn[1]. The patient's consent is subject to that proviso. This is the interpretation that is required by the wording of the definition of "plan of treatment", which, to repeat, is one that:

> …provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition.
>
> (Emphasis added.)

This interpretation also subserves the overall purpose of the Act, which is to ensure that treatment is not administered without consent.

> Health Care Consent Act, 1996, s. 2(1)(c).

52. Alternatively, and consistent with the patient's legal right to refuse treatment under any and all circumstances, the patient may give consent to the administration of a specified treatment but direct that, in specified circumstances, the treatment is to be withheld or withdrawn. The plan of treatment must be treated as circumscribed to that extent.

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[1] E.g., the doctor might say, "You can have a course of chemo, but the treatment will be discontinued after six rounds if your blood tests remain abnormal."

53. *As to the third interpretation issue*. Another insuperable problem for the judge's interpretation is that, as she herself noted, a plan of treatment may provide for treatment to be withdrawn or withheld. She cannot be correct that consent is required in order for treatment to be withdrawn but not in order for it to be withheld. Such an interpretation creates an inconsistency within the Act.

54. Moreover, from a medical point-of-view, withholding and withdrawing treatment are treated in exactly the same way. All medical treatment is properly offered, is withheld, or is withdrawn in accordance with a single criterion: whether the treatment in question is medically indicated at the time that it is under consideration.

55. Doctors regard every treatment as a "trial by treatment". If the patient fails to respond to the treatment, or the patient's condition changes, the medical indications for treatment may change. A plan of treatment is therefore always subject to revision. If a given treatment has ceased to provide a benefit, the doctor will appropriately withhold it, or withdraw it, even if the patient wishes it to continue. The *Health Care Consent Act* cannot be interpreted otherwise.

56. It is respectfully submitted that the judge simply failed to understand that the overriding consideration in medical decision-making is, at all times, the existence of medical indications for treatment. Doctors must be permitted under the law to withhold treatment that is not medically indicated and also to withdraw treatment that is no longer medically indicated due to a change in the patient's circumstances.

57. The judge also failed to appreciate that a plan of treatment respecting life support is no different in principle than any other. It is not the appellants' position that no consent is

needed for end-of-life decisions. It is only their position that there is a distinction between end-of-life treatment that can benefit the patient (and which the doctor will offer) and end-of-life treatment that cannot or can no longer benefit him or her (and which the doctor will not offer). The patient has a right to informed consent in respect of the first and not in respect of the second. In the case of an incapable person, the substitute decision-maker provides the consent, if applicable. Contrary to the judge's finding, the purposes of the Act, and in particular the purpose set out in s. 1(e), are perfectly fulfilled on this reading[2].

58. The judge thus erred in holding that the appellants' interpretation, if accepted, would entail that no consistent rules regarding withdrawal of life support exist in Ontario.

Reasons for Decision, Appeal Book, Tab 3, pages 21-22, paras. 37, 40.

59. To the contrary, it is the judge's approach that creates an exception for end-of-life decisions because it is (apparently) only these that she finds give rise to a patient veto.

60. If the Act is to be interpreted consistently, then under the interpretation given to it by the judge, one would have to conclude that doctors must obtain their patients' consent to any withdrawal of treatment, including treatment that, if continued, would harm the patient. For this absurdity to be avoided, the Act must apply only where the doctor has offered a treatment.

61. The judge also failed to appreciate the distinction between withholding and withdrawing treatment is as unworkable in practice as it is undesirable in theory.

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[2] Section 1(e) provides: "The purposes of this Act are …(e) to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment, admission to a care facility or a personal assistance service…."

62. From time to time, Mr. Rasouli has not required ventilatory support in order to breathe, and it has been withdrawn for a time, and then re-instituted when needed. On the judge's approach, which seems to recognize that treatment can be withheld without consent, it would be open to the doctors not to re-institute ventilation after a pause in treatment. The respondent Ms Salasel would no doubt, and with some justification, take the position that this is an artificial distinction.

63. Similarly, some substitute decision-makers have made the argument in other cases that a "Do Not Resuscitate" order constitutes a withdrawal of treatment, rather than a withholding, because until that order is made the patient is automatically treated as subject to resuscitation in the event of an arrest.

64. Doctors should not have to ask themselves the metaphysical question whether their decision is properly conceived as a withholding and alternatively a withdrawal of treatment. The expectation must be that they will always look solely to the patient's best interests in determining appropriate treatment.

65. For the same reason, they should not have to concern themselves about whether to institute treatment that may or may not provide benefit, such as life-support, lest they bind themselves to provide it for so long as the patient desires it, even once it is clear that no such benefit can be achieved.

INFORMED CONSENT AT COMMON LAW

66. The interpretation the appellants urge should be given to the *Health Care Consent Act* is wholly consistent with the common law of informed consent.

67. As the judge noted, English case law has consistently held that doctors do not need consent to withdraw or withhold treatment. She cited *Re R*, [1991] 4 All E.R. 177, where the Court of Appeal (per Lord Donaldson, M.R.) stated at pp. 184, 187:

> It is trite law that in general a doctor is not entitled to treat a patient without the consent of someone who is authorised to give that consent… However consent by itself creates no obligation to treat. It is merely a key which unlocks a door…No doctor can be required to treat a child, whether by the court in the exercise of its wardship jurisdiction, by the parents, by the child or anyone else. The decision whether to treat is dependent upon an exercise of his own professional judgment, subject only to the threshold requirement that, save in exceptional cases usually of emergency, he has the consent of someone who has authority to give that consent.
>
> *Re R,* Appellants' Authorities, Tab 1.

68. In another decision of the English Court of Appeal, it was observed that a patient's undoubted right of self-determination does not entitle him or her to insist on receiving a particular medical treatment of whatever type. The court endorsed the proposition that the doctor, exercising his or her professional clinical judgment, decides what treatment options are clinically indicated, i.e., will provide a clinical benefit for the patient. The doctor offers those treatment options to the patient, and the patient decides whether or not to accept them. If the patient requests a form of treatment that the doctor concludes is not clinically indicated, the doctor has no legal obligation to provide it. Thus treating a patient in a manner that the doctor considers to be in his best interests may conflict with the patient's own wishes.

> *R. on the application of Burke v. The General Medical Council*, [2005] E.W.C.A. Civ 1003, Appellants' Authorities, Tab 2 at paras. 31, 50, 55.

THE DUTY TO TREAT IN RELATION TO PVS PATIENTS

69. Since the law of informed consent, whether statutory or common law, applies only to treatment that is proposed by a health practitioner, and since the appellants do not propose to

provide life-support to Mr. Rasouli, the judge below ought to have looked elsewhere in the law for guidance.

70. In England and other jurisdictions, including Canada, the courts have grappled with the question of a doctor's duty to patients in a persistent vegetative state, and in other cases where treatment would be futile.

71. In the leading case of *Airedale NHS Trust v. Bland*, [1993] AC 789, the House of Lords properly framed the question as being whether doctors have a legal duty to keep a patient alive. This required a consideration of duties arising under the criminal law and under the medical standard of care. In the result, it was held not unlawful for doctors to cease providing medical treatment to a PVS patient although it was known that shortly thereafter the patient would die.

72. The Law Lords held that the doctor's duty is to treat the patient as long as it is in his best interests to have the treatment. But if that ceases to be the case, because the treatment is useless, it is not the duty of the doctor to continue to provide it. If the patient is totally unconscious, and there is no prospect of any improvement, life-prolonging treatment is properly regarded as being, in medical terms, useless. The discontinuation of life-support in those circumstances is the same as the decision not to commence such treatment: in each case the doctor is simply allowing the patient to die of his pre-existing condition.

Airedale NHS Trust v. Bland, Appellants' Authorities, Tab 3, at 866, 868-869.

73. In the *Bland* case, the patient's substitute decision-maker consented to the withdrawal of life-sustaining treatment. But that was not so in *Re G*, [1995] 2 FCR 46, a decision of the Family Division of the English High Court of Justice. There, the patient was in a PVS as a

result of a motor accident. His mother was opposed to the withdrawal of life-sustaining treatment because of her belief that the medical evidence that his condition was irreversible was not conclusive. She continued to hope for his recovery. The court held that treatment decisions must be based on the doctor's assessment of the patient's best interests which, in this case, consisted in the withdrawal of treatment.

> *Re G*, [1995] 2 FCR 46, Appellants' Authorities, Tab 4, at 3-4
>
> See also: *Re D (Medical Treatment)*, [1998] 1 FLR 411, Appellants' Authorities, Tab 5 at 420-421
>
> *Re H (adult: incompetent)* (1997), 38 BMLR 11, Appellants' Authorities, Tab 6 at 13-14, 16
>
> *NHS Trust A v. M*, [2001] 1 All ER 801 Appellants' Authorities, Tab 7 at pp. 808-809, 812.

74. In a decision of the English Court of Appeal, *Re J (a minor)*, [1992] 4 All E.R. 614, a sixteen month old child, profoundly disabled both mentally and physically, was said by her doctor to be unlikely to survive mechanical ventilation if she should become unable to breathe spontaneously. Her mother desired that treatment should be given in that event. The local authority asked the court to determine the matter. The court of first instance, exercising its inherent jurisdiction, directed the treatment. The Court of Appeal reversed. Lord Donaldson, M.R. said this, at pp. 622-623:

> The fundamental issue in this appeal is whether the court in the exercise of its inherent power to protect the interests of minors should ever require a medical practitioner or health authority acting by a medical practitioner to adopt a course of treatment which in the bona fide clinical judgment of the practitioner concerned is contraindicated as not being in the best interests of the patient. I have to say that I cannot at present conceive of any circumstances in which this would other than an abuse of power as directly or indirectly requiring the practitioner to act contrary to the fundamental duty which he owes to his patient. This, subject to obtaining any necessary consent, is to treat the patient in accordance with his own best clinical judgment, notwithstanding that other practitioners who are not called upon to treat the patient may have formed a quite different judgment or that the court, acting on expert evidence, may disagree with him.

Re J, Appellants' Authorities, Tab 8.

75. The judge below observed that, in England, there is no legal process by which decisions are made for incapable persons by surrogates. It therefore falls to the doctors to decide on their patients' behalf. She noted that, in England, in PVS cases, the courts have adopted the rule that the doctors' decisions are to be brought to the court's attention. While this is correct, it is to be noted that the English case law endorses the principle that the relevant decision is to be made on the basis of medical indications alone, and the courts will neither make the decision for the incapable person nor direct the doctor as to the treatment to be provided. The courts have been prepared to find in appropriate cases that the doctor does not have a duty to keep the patient alive.

Reasons for Decision, Appeal Book, Tab 3, pages 26-28, paras. 56-57, 61.

76. The approach adopted in the English cases – that the decision is to turn on the benefit to the patient – is consistent with the decisions of courts in other countries, apart from Canada, which have similar legal systems.

Auckland Area Health Board v. Attorney General, [1993] 1 NZLR 235 (High Court), Appellants' Authorities, Tab 9;

Clarke v. Hurst, 1992 (4) SA 630, Appellants' Authorities, Tab 10;

Law Hospital NHS Trust v. Lord Advocate (No. 2), 1996 S.L.T. 869 (Outer House), Appellants' Authorities, Tab 11;

Thaddeus Mason Pope, "Involuntary Passive Euthanasia in U.S. Courts: Reassessing the Judicial Treatment of Medical Futility Cases", 2008 9 Marquette Elder's Advisor 229, Appellants' Authorities, Tab 12.

77. There are also Canadian cases that take the same approach, including the only appellate decision on point, *Child and Family Services of Central Manitoba v. L.(R.),* [1997] M.J. No. 568 (Man. C.A.). In that case, the court considered whether a doctor required either consent or a court order to issue a non-resuscitation order where the infant patient was in a PVS. The court held, at para. 17:

> Whether or not such a direction should be issued is a judgment call for the doctor to make having regard to the patient's history and condition and the doctor's evaluation of hopelessness of the case. The wishes of the patient's family or guardian should be taken into account, but neither their consent nor the approval of a court is required.
>
> *Child and Family Services of Central Manitoba v. L.(R.)*, [1997] M.J. No. 568 (Man. C.A.), Appellants' Authorities, Tab 13
>
> See also: *Children's Aid Society of Ottawa–Carleton v. M.C.,* [2008] O.J. No. 3795 (S.C.J.) , Appellants' Authorities, Tab 14
>
> *Rotaru v. Vancouver General Hospital Intensive Care Unit,* [2008] B.C.J. No. 456 (B.C.S.C.) , Appellants' Authorities, Tab 15
>
> *Re I.H.V. Estate*, [2008] AJ No. 545 (Q.B.) , Appellants' Authorities, Tab 16
>
> Ellen Picard and Gerald Robertson, *Legal Liability of Doctors and Hospitals in Canada* (4th ed. 2007), at 345-346, Appellants' Authorities, Tab 17.

78. While citing some of the foregoing authorities, the judge below also cited several cases in which an interim injunction was granted either to restrain a "Do Not Resuscitate" order (*Sawatzky*) or to restrain the removal of mechanical ventilation (*Golubchuk* and *Sweiss*). The interim injunctions were granted for the following reasons:

(i) because there was an arguable right to treatment under the Charter (*Sawatzky)*;

(ii) under a theory that removal of ventilatory support would involve physical touching, to which consent is required (*Golubchuk*); or

(iii) on the ground that it was in the patient's best interests for an order to go for five days to allow the family to arrange an independent medical assessment (*Sweiss*).

None of these cases were decided on a final basis because of the intervening death (or consent) of the patient.

Sawatzky v. Riverview Health Centre Inc., [1998] M.J. No. 506, Appellants' Authorities, Tab 18

Golubchuk v. Salvation Army Grace General Hospital, 2008 MBQB 49, Appellants' Authorities, Tab 19

Sweiss v. Alberta Health Services, 2009 ABQB 691, Appellants' Authorities, Tab 20.

79. It is submitted that the great preponderance of authority, and the correct approach under the common law, is embodied in the following principles:

(a) Patients are not entitled to demand whatever treatment they may desire, but have a right of informed consent only with respect to treatment that is proposed by a doctor; and

(b) In turn, doctors are bound to propose only such treatment as may benefit a patient, and are therefore bound not to propose treatment that is futile.

It follows that a patient may not insist upon receiving treatment that is futile, including life-support.

THE STANDARD OF CARE IN ONTARIO

80. The standard of care in Ontario mirrors the common law principles referred to in the immediately foregoing paragraph.

81. The standard of care is expressed in the relevant policy of the College of Physicians and Surgeons of Ontario ("CPSO"). Compliance with the policies of the CPSO must entail compliance with the medical standard of care.

82. The CPSO's policy entitled "Decision-Making for the End of Life" was adopted in 2006. It stipulates that doctors are not obliged to provide treatments that will almost certainly not be of benefit to the patient, either because the underlying illness or disease makes

recovery or improvement virtually unprecedented, or because the patient will be unable to experience any permanent benefit. Both those conditions apply to Mr. Rasouli in his present and continuing circumstances.

> Affidavit of Dr. Cuthbertson, Exhibit "B", Appeal Book, Tab 10, page 134.

83. As the judge correctly noted, life-support in general is intended to prevent premature death and treat reversible illness. The appellants would add that the treatment Mr. Rasouli is receiving cannot reverse his condition. Moreover, because he is unconscious, he can derive no benefit from merely being kept alive.

> Reasons for Decision, Appeal Book, Tab 3, pages 19-20, para. 31.

84. The applicable Sunnybrook policy, entitled "Decisions about Life Support Interventions", is to the same effect as the CPSO policy.

> Affidavit of Blair Henry, Exhibit "A", Appeal Book, Tab 22, page 186.

85. The Sunnybrook policy shows an acute sensitivity to the gravity of a decision to end life-support and requires broad consultation among the treating doctors, communication with the patient's family, and the consideration of the transfer of the patient to another facility where the family disagrees with the medical decision and so desires.

> Affidavit of Blair Henry, Exhibit "A", Appeal Book, Tab 22, pages 187-189.

86. The CPSO policy states:

> The requirements of informed consent at the end of life are the same as the requirements in other situations ….

The judge below quotes this statement approvingly. She failed to appreciate, however, that the policy as a whole promotes the same approach as the appellants urge in this case. That is,

the right of informed consent arises only if the doctor proposes treatment, not if it is withheld or withdrawn. In some end-of-life cases, doctors may propose active treatment or offer the option of active treatment. In those cases, consent must be obtained. In other cases, where treatment would be futile, it is not to be offered.

> Reasons for Decision, Appeal Book, Tab 3, pages 25-26, para. 51.

87. There is no question but that doctors are fully accountable for a decision not to offer treatment just as they are accountable for any other medical decisions they make. They are accountable to the patient for any breach of the standard of care; they are accountable to the CPSO for a breach of its policy; and they are accountable to the Hospital for a breach of its policy.

THE JURISDICTION OF THE CONSENT AND CAPACITY BOARD

88. It is respectfully submitted that the judge below erred in concluding that the Consent and Capacity Board is the appropriate forum for determining whether life support can be withdrawn despite a substitute decision-maker's instructions to the contrary.

89. Under the *Health Care Consent Act*, the Board has jurisdiction only in cases where a health practitioner has proposed a treatment and the patient's consent is required but the patient lacks capacity to provide it. If consent by the patient's substitute decision-maker is refused, the health practitioner who proposed the treatment may apply for a determination of whether the SDM has complied with the statutory criteria in refusing consent. The relevant section reads as follows:

> 37. (1) If consent to a treatment is given or refused on an incapable person's behalf by his or her substitute decision-maker, and if the health practitioner who proposed the treatment is of the opinion that the substitute decision-maker did not comply with

> section 21, the health practitioner may apply to the Board for a determination as to whether the substitute decision-maker complied with section 21.

90. In this case, the Board is not the appropriate forum because the appellants have determined that the treatment in question is not in the patient's best interests and will not be offered and accordingly the SDM's consent to treatment has not been sought.

91. In an application by a health practitioner under s. 37(1), the Board must apply the same criteria (those stated in s. 21 of the *Health Care Consent Act*) as bind the decision of the SDM. Section 21(1) provides:

> 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.

Thus the Board is required to treat a person's wishes as prevailing over the medical indications for the treatment in question[3].

92. It is obvious from the criteria the Board must apply that it is not the Board's role to determine if medical treatment is indicated. The Act presupposes that if the treatment were considered not to be indicated, the health practitioner would not propose it.

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[3] For an apposite illustration of this fact, see *SS (Re)*, 2011 CanLII 5000 (C.C.B.), Appellants' Authorities, Tab 21.

93. Thus it is inappropriate for a health practitioner to apply to the Board in respect of a treatment which the practitioner believes to be medically contraindicated. Instead, the practitioner ought not to offer the treatment at all.

94. The judge failed to appreciate this fact because she misinterpreted the *Health Care Consent Act* as grounding the Board's decision not in the patient's wishes, but in the patient's best interests. However, this test applies only in the event that the incapable person has previously expressed no wish applicable to the circumstances.

> Reasons for Decision, Appeal Book, Tab 3, pages 23-24, para. 47.

95. The judge was impressed by fact that some doctors have on some past occasions applied to the Board notwithstanding that it was their recommendation that treatment should be withheld or withdrawn. But that this was their choice cannot bind other doctors in other circumstances to act in the same way. In many cases, including end-of-life cases, medical decisions concerning whether or not treatment should be offered legitimately take into account the patient's wishes; in others, not. Depending on the view they take of that question in particular cases, doctors have the option of an application to the Board.

96. In some cases, an application by doctors to the Board may also be motivated by a desire to obtain the protection afforded by s. 29 of the *Health Care Consent Act* for treatment administered in accordance with consent.

PART V – ORDER REQUESTED

97. The appellants respectfully request that the appeal be allowed, and that the order in the court below be set aside, and that an order be made that the appellants do not require consent to the withdrawal of life support.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

Dated: April 1, 2011

Harry Underwood

Andrew McCutcheon

Lawyers for the Appellants

CERTIFICATE

I, HARRY UNDERWOOD, lawyer for the appellants, certify that:

1. An order under subrule 61.09(2) (original record and exhibits) is not required.

2. The estimated time of my oral argument is 2 ½ hours, not including reply.

April 1, 2011

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SCHEDULE "A"
LIST OF AUTHORITIES

1. *Re R*, [1991] 4 All E.R. 177 (C.A.)
2. *R. on the application of Burke v. The General Medical Council*, [2005] E.W.C.A. Civ 1003 (C.A.)
3. *Airedale NHS Trust v. Bland*, [1993] AC 789 (H.L.)
4. *Re G*, [1995] 2 FCR 46 (Fam.D.)
5. *Re D (Medical Treatment)*, [1998] 1 FLR 411 (Fam.D.)
6. *Re H (adult: incompetent)* (1997), 38 BMLR 11 (Fam.D.)
7. *NHS Trust A v. M*, [2001] 1 All ER 801 (Fam.D.)
8. *Re J (a minor)*, [1992] 4 All E.R. 614 (C.A.)
9. *Auckland Area Health Board v. Attorney General*, [1993] 1 NZLR 235 (High Court)
10. *Clarke v. Hurst*, 1992 (4) SA 630 (Durban and Coast Local Division)
11. *Law Hospital NHS Trust v. Lord Advocate (No. 2)*, 1996 S.L.T. 869 (Outer House)
12. Thaddeus Mason Pope, "Involuntary Passive Euthanasia in U.S. Courts: Reassessing the Judicial Treatment of Medical Futility Cases", 2008 9 Marquette Elder's Advisor 229
13. *Child and Family Services of Central Manitoba v. L.(R.)*, [1997] M.J. No. 568 (C.A.)
14. *Children's Aid Society of Ottawa–Carleton v. M.C.*, [2008] O.J. No. 3795 (S.C.J.)
15. *Rotaru v. Vancouver General Hospital Intensive Care Unit*, [2008] B.C.J. No. 456 (B.C.S.C.)
16. *Re I.H.V. Estate*, [2008] AJ No. 545 (Q.B.)
17. Ellen Picard and Gerald Robertson, *Legal Liability of Doctors and Hospitals in Canada* (4th ed. 2007)
18. *Sawatzky v. Riverview Health Centre Inc.*, [1998] M.J. No. 506 (Q.B.)
19. *Golubchuk v. Salvation Army Grace General Hospital*, 2008 MBQB 49 (Q.B.)
20. *Sweiss v. Alberta Health Services*, 2009 ABQB 691 (Q.B.)
21. *SS (Re)*, 2011 CanLII 5000 (C.C.B.)

SCHEDULE "B"
RELEVANT STATUTES

***Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A**

Purposes

1. The purposes of this Act are,

(a) to provide rules with respect to consent to treatment that apply consistently in all settings;

(b) to facilitate treatment, admission to care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters;

(c) to enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed and persons who are to receive personal assistance services by,

(i) allowing those who have been found to be incapable to apply to a tribunal for a review of the finding,

(ii) allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on their behalf concerning treatment, admission to a care facility or personal assistance services, and

(iii) requiring that wishes with respect to treatment, admission to a care facility or personal assistance services, expressed by persons while capable and after attaining 16 years of age, be adhered to;

(d) to promote communication and understanding between health practitioners and their patients or clients;

(e) to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment, admission to a care facility or a personal assistance service; and

(f) to permit intervention by the Public Guardian and Trustee only as a last resort in decisions on behalf of incapable persons concerning treatment, admission to a care facility or personal assistance services. 1996, c. 2, Sched. A, s. 1.

Interpretation

2. (1) In this Act,

"attorney for personal care" means an attorney under a power of attorney for personal care given under the Substitute Decisions Act, 1992; ("procureur au soin de la personne")

"Board" means the Consent and Capacity Board; ("Commission")

"capable" means mentally capable, and "capacity" has a corresponding meaning; ("capable", "capacité")

"care facility" means,

(a) a long-term care home as defined in the Long-Term Care Homes Act, 2007, or

(b) a facility prescribed by the regulations as a care facility; ("établissement de soins")

"community treatment plan" has the same meaning as in the Mental Health Act; ("plan de traitement en milieu communautaire")

"course of treatment" means a series or sequence of similar treatments administered to a person over a period of time for a particular health problem; ("série de traitements")

"evaluator" means, in the circumstances prescribed by the regulations,

(a) a member of the College of Audiologists and Speech-Language Pathologists of Ontario,

(b) a member of the College of Dietitians of Ontario,

(c) a member of the College of Nurses of Ontario,

(d) a member of the College of Occupational Therapists of Ontario,

(e) a member of the College of Physicians and Surgeons of Ontario,

(f) a member of the College of Physiotherapists of Ontario,

(g) a member of the College of Psychologists of Ontario, or

(h) a member of a category of persons prescribed by the regulations as evaluators; ("appréciateur")

"guardian of the person" means a guardian of the person appointed under the Substitute Decisions Act, 1992; ("tuteur à la personne")

"health practitioner" means a member of a College under the Regulated Health Professions Act, 1991, a naturopath registered as a drugless therapist under the Drugless Practitioners Act or a member of a category of persons prescribed by the regulations as health practitioners; ("praticien de la santé")

Note: On a day to be named by proclamation of the Lieutenant Governor, the definition of "health practitioner" is amended by striking out "a naturopath registered as a drugless therapist under the Drugless Practitioners Act". See: 2009, c. 26, ss. 10 (2), 27 (2).

"hospital" means a private hospital as defined in the Private Hospitals Act or a hospital as defined in the Public Hospitals Act; ("hôpital")

"incapable" means mentally incapable, and "incapacity" has a corresponding meaning; ("incapable", "incapacité")

"mental disorder" has the same meaning as in the Mental Health Act; ("trouble mental")

"personal assistance service" means assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning or any other routine activity of living, and includes a group of personal assistance services or a plan setting out personal assistance services to be provided to a person, but does not include anything prescribed by the regulations as not constituting a personal assistance service; ("service d'aide personnelle")

"plan of treatment" means a plan that,

(a) is developed by one or more health practitioners,

(b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and

(c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition; ("plan de traitement")

"psychiatric facility" has the same meaning as in the Mental Health Act; ("établissement psychiatrique")

"recipient" means a person who is to be provided with one or more personal assistance services,

(a) in a long-term care home as defined in the Long-Term Care Homes Act, 2007,

(b) in a place prescribed by the regulations in the circumstances prescribed by the regulations,

(c) under a program prescribed by the regulations in the circumstances prescribed by the regulations, or

(d) by a provider prescribed by the regulations in the circumstances prescribed by the regulations; ("bénéficiaire")

"regulations" means the regulations made under this Act; ("règlements")

"treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include,

(a) the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the Substitute Decisions Act, 1992 of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,

(b) the assessment or examination of a person to determine the general nature of the person's condition,

(c) the taking of a person's health history,

(d) the communication of an assessment or diagnosis,

(e) the admission of a person to a hospital or other facility,

(f) a personal assistance service,

(g) a treatment that in the circumstances poses little or no risk of harm to the person,

(h) anything prescribed by the regulations as not constituting treatment. ("traitement") 1996, c. 2, Sched. A, s. 2 (1); 2000, c. 9, s. 31; 2007, c. 8, s. 207 (1); 2009, c. 26, s. 10 (1); 2009, c. 33, Sched. 18, s. 10 (1).

Refusal of consent

(2) A reference in this Act to refusal of consent includes withdrawal of consent. 1996, c. 2, Sched. A, s. 2 (2).

No treatment without consent

10. (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

(a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or

(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).

Opinion of Board or court governs

(2) If the health practitioner is of the opinion that the person is incapable with respect to the treatment, but the person is found to be capable with respect to the treatment by the Board on an application for review of the health practitioner's finding, or by a court on an appeal of the Board's decision, the health practitioner shall not administer the treatment, and shall take

reasonable steps to ensure that it is not administered, unless the person has given consent. 1996, c. 2, Sched. A, s. 10 (2).

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 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.

Protection from liability

Apparently valid consent to treatment

29. (1) If a treatment is administered to a person with a consent that a health practitioner believes, on reasonable grounds and in good faith, to be sufficient for the purpose of this Act, the health practitioner is not liable for administering the treatment without consent. 1996, c. 2, Sched. A, s. 29 (1).

Apparently valid refusal of treatment

(2) If a treatment is not administered to a person because of a refusal that a health practitioner believes, on reasonable grounds and in good faith, to be sufficient for the purpose of this Act, the health practitioner is not liable for failing to administer the treatment. 1996, c. 2, Sched. A, s. 29 (2).

Apparently valid consent to withholding or withdrawal

(3) If a treatment is withheld or withdrawn in accordance with a plan of treatment and with a consent to the plan of treatment that a health practitioner believes, on reasonable grounds and in good faith, to be sufficient for the purpose of this Act, the health practitioner is not liable for withholding or withdrawing the treatment. 1996, c. 2, Sched. A, s. 29 (3).

Emergency: treatment administered

(4) A health practitioner who, in good faith, administers a treatment to a person under section 25 or 27 is not liable for administering the treatment without consent. 1996, c. 2, Sched. A, s. 29 (4).

Emergency: treatment not administered

(5) A health practitioner who, in good faith, refrains from administering a treatment in accordance with section 26 is not liable for failing to administer the treatment. 1996, c. 2, Sched. A, s. 29 (5).

Reliance on assertion

(6) If a person who gives or refuses consent to a treatment on an incapable person's behalf asserts that he or she,

(a) is a person described in subsection 20 (1) or clause 24 (2) (a) or (b) or an attorney for personal care described in clause 32 (2) (b);

(b) meets the requirement of clause 20 (2) (b) or (c); or

(c) holds the opinions required under subsection 20 (4),

a health practitioner is entitled to rely on the accuracy of the assertion, unless it is not reasonable to do so in the circumstances. 1996, c. 2, Sched. A, s. 29 (6).

Application to determine compliance with s. 21

37. (1) If consent to a treatment is given or refused on an incapable person's behalf by his or her substitute decision-maker, and if the health practitioner who proposed the treatment is of the opinion that the substitute decision-maker did not comply with section 21, the health practitioner may apply to the Board for a determination as to whether the substitute decision-maker complied with section 21

HASSAN RASOULI
Plaintiff

and

DR. BRIAN CUTHBERTSON
Defendant

Court File No: C53442

COURT OF APPEAL FOR ONTARIO

Proceeding commenced at TORONTO

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