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 in Appeal)

- and -

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

Respondents
(Appellants)

FACTUM OF THE RESPONDENT, HASSAN RASOULI

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PART I – OVERVIEW

1. The appellant physicians ("the Physicians") say they have a common law right to terminate mechanical ventilation ("MV") for the respondent Hassan Rasouli and thus end his life. They say they may do this unilaterally, with neither patient consent nor court order.

2. The respondent, Hassan Rasouli, says the application judge, below, was correct in ruling that consent is required and that the proper forum to seek review of the withholding of consent by his statutory decision-maker is the Consent and Capacity Board.

3. In the alternative, Mr. Rasouli says that the appellants have misstated the common law position.

PART II – THE FACTS

4. Mr. Rasouli accepts as substantially correct the facts as stated in the Physicians' factum, with some additions and corrections, as follows.

5. On April 29, 2010, Mr. Rasouli and his family permanently immigrated to Canada from Iran. Mr. Rasouli is a 59 year old retired mechanical engineer and a devout Shia Muslim. Ms. Salasel is a physician qualified to practice in Iran. They have two children. The family was and remains full of hope for their new life in Canada. Without many relatives in Canada, the family bond

is especially strong.[1]

6. Mr. Rasouli's current treatment plan, which was medically indicated and implemented with the consent of his statutory decision maker ("SDM"), has kept Mr. Rasouli alive. He is stable, although he has not regained consciousness ("the Current Treatment Plan").[2]

7. Ms. Salasel's evidence is that the Physicians or other members of the medical team initially asked for her consent, and not merely her acquiescence, to the Proposed Treatment Plan, which consent, on behalf of Mr. Rasouli, she refused.[3]

8. Being an experienced Iranian physician for over 27 years, as well as Mr. Rasouli's wife who knows him well, Ms. Salasel believes that Mr. Rasouli has recovered some cognitive functions. Ms. Salasel and their daughter, Mojgan Rasouli, led evidence of improving cognitive functions and interaction.[4]

9. These observations are consistent with the neurological assessments by Dr. Swartz

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[1]Affidavit of Parichehr Salasel sworn February 10, 2011("Salasel Affidavit"), paras. 2, 4-5 6-7, 10-12, and 21, appeal book, tab 19, pp. 162-164

[2]Salasel Affidavit, para. 41, appeal book, tab 19, pp.167

[3]Salasel Affidavit, para. 70, appeal book, tab 19, p. 171

[4]Affidavit of Dr. Mahmood Fazl sworn February 14, 2011, para. 4, appeal book, tab 15, p. 150; Salasel Affidavit, paras. 46-49, 50, 53-60, appeal book, tab 19, pp.167-169; Affidavit of Mojgan Rasouli ("Mojgan Affidavit"), paras. 16, 27-28, exhibit book, tab 10, pp. 642 and 644; "Exhibit C" to Mojgan Affidavit, File Name: "Jan-29-2011."

regarding Mr. Rasouli's changes in his brainstem reflexes, between October 17, 2010 and February 10, 2011.[5]

10. The Physicians have diagnosed Mr. Rasouli as being in a persistent vegetative state ("PVS") but, as described below, the known rate of misdiagnosis for PVS is high. The Physicians in this case recommended withdrawal of life support only four weeks after loss of consciousness, while the British Medical Association has recommended that the irreversibility of PVS should not be confirmed until after 6 months.

11. It is common ground that, without MV, Mr. Rasouli will soon die from apnea/asphyxia/failure to breathe. Thus, the Proposed Treatment Plan places Mr. Rasouli in grave and imminent danger. It appears Mr. Rasouli will not last more than five days without MV.[6]

12. On November 21, 2010, the Physicians informed Ms. Salasel that they wished to withdraw MV and to transfer Mr. Rasouli from the CrCU to the Hospital's palliative care unit ("PCU") to see to his comfort until his certain death (the "Proposed Treatment Plan").[7]

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[5]Affidavit of Dr. Richard Swartz sworn February 14, 2011 ("Dr. Swartz Affidavit"), para. 24, appeal book, tab 6, p.58; Transcript of Cross-Examination of Dr. Richard Swartz, on February 15, 2010 ("Swartz transcript"), Qs. 119-123, respondents' compendium, tab 1, pp. 43-46

[6]Salasel Affidavit, paras. 61, 87 and 90, appeal book, tab 19, pp. 169 and 173; Dr. Swartz Affidavit, para. 14, appeal book, tab 6, p. 56

[7]Dr. Cuthbertson Affidavit, para. 30-31, appeal book, tab 9, p. 101-102; Salasel Affidavit, para. 66, appeal book, tab 19, p. 170

13. The Proposed Treatment Plan contravenes Mr. Rasouli's religious beliefs. In the view of Shia Muslims, access to health care is a fundamental right of individuals. A person is entitled to remain alive until all signs of life are gone. Preventable death must be prevented.[8]

14. Ms. Salasel objected to the Proposed Treatment Plan. Eventually, the Physicians told Ms. Salasel that they did not need her consent. Through counsel, the Physicians issued a written ultimatum that they would implement the Proposed Treatment Plan unless she obtained a restraining order from the Superior Court, by a specified date. In taking this position, the Physicians denied that the CCB has the statutory first-instance jurisdiction to determine whether, in not consenting to withdrawal of MV, Ms. Rasouli is acting in Mr. Rasouli's best interests.[9]

The Medical Literature on PVS and MCS or "Locked-In State"

15. With respect, the Physicians overstate the hopelessness of Mr. Rasouli's medical situation, in submitting: "It is as certain as anything ever is in medicine that [Mr. Rasouli] will never recover any degree of consciousness."[10]

16. PVS is not irreversible (although the Physicians' counsel made that submission below

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[8]Salasel Affidavit, para. 90, appeal book, tab 19, p. 173; Affidavit of Ayatollah Seyed Reza Hosseini Nassab affirmed February 7, 2011, paras. 9, 11, 13, exhibit book, tab 12, p. 657, respondents' compendium, tab 2, p. 52

[9] Letter from Underwood to Schible, exhibit book, vol. 1, tab 9(d), p. 638, appeal book and compendium, tab 20, p. 175

[10]Appellants' factum, para. 17

and the application judge accepted it). Patients in PVS may regain consciousness and even physical independence. In cross-examination, Dr. Swartz agreed with the following scientific facts and data:

(a) a patient in PVS is *completely* unable to demonstrate consciousness; they are unaware of their surrounding or of themselves, implying loss of the capacity to experience pain or suffering;[11]

(b) a patient in minimally conscious state (MCS), by contrast, has *some* reaction to the environment and *some* response to external stimulus;[12]

(c) positron emission tomographic scans, which, according to literature, have shown higher metabolic levels in the brains of patients in a Locked-In State than in patients in PVS, have not been conducted on Mr. Rasouli;[13]

(d) less than 10% of patients in PVS with non-traumatic brain injury (as is this case) regain consciousness after three months; [14]

(e) patients in MCS have a better chance of regaining consciousness and even to become independent;[15]

(f) the survival of patients in PVS is related to the quality and intensity of the medical

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[11]Swartz transcript, Qs. 3 and 53, exhibit book, tab 4, pp. 461 and 478-479, respondents' compendium, tab 1, pp. 5 and 22-23

[12]Swartz transcript, Q. 5, exhibit book, tab 4, p. 46, respondents' compendium, tab 1, p. 6

[13]Swartz transcript, Q. 24, exhibit book, tab 4, pp. 468-469; respondents' compendium, tab 1, pp. 12-13

[14]Swartz transcript, Q. 36, exhibit book, tab 4, p. 473; respondents' compendium, tab 1, p. 17

[15]Swartz transcript, Qs. 41-42, exhibit book, tab 4, p. 474-475; respondents' compendium, tab 1, pp. 18-19

treatment and nursing care they receive; [16]and

(g) the author of the article relied upon by the Physicians, "Medical Aspects of the Persistent Vegetative State (The Multi-Society Task Force on PVS)" (the "Task Force Report"), which is authoritative, has written subsequently that the rate of misdiagnosing MCS as PVS is 29% for non-traumatic brain injury patients.[17]

17. The Physicians have declined an invitation to produce any medical literature showing that this rate of misdiagnosis is inaccurate.[18]

18. To summarize, medical literature accepted by the Physicians to be authoritative supports the statistically significant possibility that Mr. Rasouli may regain consciousness even if he is in PVS. There an even more significant possibility that Mr. Rasouli is in a "locked-in state," being a characteristic of MCS. A patient in MCS has a higher chance of making a marked recovery than a patient in PVS. MCS is commonly misdiagnosed as PVS.

Ms. Salasel's Decision-making on behalf of Mr. Rasouli

19. On behalf of Mr. Rasouli, Ms. Salasal believes that Mr. Rasouli will recover and, in

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[16]Swartz transcript, Question 44, exhibit book, tab 4, p. 476; respondents' compendium, tab 1, pp. 19-20

[17]"The Vegetative State, Medical Facts, Ethical and Legal Dilemmas," by Bryan Jennett, Exhibit 1 to Cross-Examination of Dr. Richard Swartz, on February 15, 2010, exhibit book, tab 4A, p. 522; respondent's compendium, tab 3, p. 75; Swartz transcript, Question 58, exhibit book, tab 4, p. 479-480; respondent's compendium, tab 1, pp. 23-24

[18]Swartz transcript, Qs. 37-40, 62-65 and 80-91, exhibit book, pp. 473-474, 481, 486-490; respondents' compendium, tab 1, pp. 17-18, 25, and 30-34

any event, that death would be a deterioration of Mr. Rasouli's medical condition; that it is in Mr. Rasouli's best interest not to die at this time; and that preventing his death is of both medical benefit and general benefit to him.[19]

20. Ms. Salasel is willing to accept the decision of the CCB, after a fair hearing, as to what is in Mr. Rasouli's best interests in the present circumstances. However, the Physicians refuse to set up such a hearing. Because of the Physicians' ultimatum, an application to the Superior Court was necessary to avoid irreparable harm.[20]

PART III - ISSUES, LAW AND ARGUMENT

21. The main issue in this appeal is whether the application judge was correct in holding that the Physicians' proposed withdrawal of MV from Mr. Rasouli, as part of a larger plan to transfer him to the Hospital's PCU and provide him, there, with palliative care, constitutes "treatment" under the *HCCA*. If so, then the CCB has jurisdiction over a disputed failure to consent.

22. Another important issue is whether, in fact, the Proposed Treatment Plan is in Mr. Rasouli's best interests? Mr. Rasouli submits that it is not.[21]

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[19]Salasel Affidavit, paras. 64 and 89-90, appeal book, tab 19, pp. 170 and 173

[20]Salasel Affidavit, paras. 91-93, appeal book, tab 19, pp. 173-174

[21]The Physicians suggest (at para. 15 of their factum) that Mr. Rasouli has asserted a prior capable wish. This is incorrect. Ms. Salasel made clear (at para. 23 of her Affidavit sworn February 10, 2011) that she and Mr. Rasouli "never discussed end of life issues". Himel J. correctly records (at para. 7 of the reasons for decision) that there is "no evidence" of prior capable wishes. Mr. Rasouli, through his SDM, expects the CCB to rule in accordance with his best interests and the CCB

23. The Physicians' emphasis on the question of their duty assumes that the *HCCA* does not apply. Doctors have a duty to comply with the *HCCA*. They have a duty to respect the prior capable wishes of all their patients, and they must accept that their patients' best interests are to be considered in accordance with the statutory test and not clinical considerations only.[22]

24. The Physicians assert they have a duty to discontinue treatment that is outside the standard of care. This assumes that they are right about Mr. Rasouli's best interests and that non-clinical issues are irrelevant.

25. If in fact it is in Mr. Rasouli's best interests to continue living for another three months or another three weeks, to see if he continues recovering or fails to recover, or that positron emission tomographic scans be taken and analysed first, then it is not abusive to require that MV continue. Indeed, unless the Physicians are right about best interests, they would be acting contrary to the standard of care and their professional duty by refusing to continue the Current Treatment Plan. Hence, the legislature has required that doctors either obtain consent or demonstrate before a neutral, specialized tribunal that they are right about a patient's best interests before acting to hasten a

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is bound by statute to do so.

[22] Notably, even if the *HCCA* did not apply, arguably at common law, *Sweiss* v. *Alberta*, 2009 ABQB 691 at para. 63, the patient's "best interests" is not limited to clinical considerations. See reasons for decision, appellant's authorities, tab 20, at paras. 97 and 102.

patient's preventable death.[23]

26. The question herein is not, as the Physicians suggest (at para. 71 of their factum), whether they have a legal duty to keep Mr. Rasouli alive indefinitely. The question, rather, is whether it is in Mr. Rasouli's best interests that he die now. At some point, if he does not improve and if the current diagnosis is confirmed, it may well be in his best interests to be allowed to die. However, this point has not been reached.

27. The Physicians were not obliged to accept Mr. Rasouli as a patient but they did. They have a legal duty to do what is in Mr. Rasouli's best interests. There is a genuine disagreement about what that is. The CCB is the best forum, and the required forum, to answer this question.[24]

28. If there is as much as a 10% chance of regaining some level of consciousness, it may be in Mr. Rasouli's best interest to be kept alive longer. Secondly, the Physicians assume that a patient's best interests are limited to clinical considerations. No one views their life in this manner, particularly at the end of one's life. The *HCCA* does not limit the question of best interests to clinical

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[23]The Physicians (at para. 75 of their factum) accept as correct that in England, the courts have adopted the rule that the doctors' decisions are to be brought to the court's attention in PVS cases. Therefore, the position in England, as described in *Airedale NHS Trust* v. *Bland*, [1993] A.C. 789 (H.L.) ("*Bland*"), was not strikingly different from requiring that the Physicians persuade the CCB, at first instance, of the correctness of their momentous proposal. That level of oversight is of great social value, for which a few days' delay in obtaining a decision is a small price to pay. As described below, England has subsequently legislated, in any event.

considerations. The Physicians feel that Mr. Rasouli would not benefit medically from continued MV. But the Proposed Treatment Plan is not limited to withdrawing MV, in any event. The Physicians propose a comprehensive treatment plan, being palliative care, the first step of which is to withdraw MV.

***The Health Care Consent Act, 1996* (the "*HCCA*")**

29. The objectives of the *HCCA* 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.[25]

30. The *HCCA* defines "plan of treatment" as a plan that deals with one or more of the health problems that a person has or is likely to have in the future and 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.[26]

31. The inclusion of the "withholding or withdrawal" of treatment appears to be unique to Ontario, among Canadian provinces, and is consistent with the Act's stated objective in section 1 to cover all settings.

32. The *Legislation Act, 2006*, provides that a statute shall be interpreted as being remedial and shall be given such fair, large and liberal interpretation as best ensures the attainment of its objects.[27]

33. The *HCCA* defines "treatment" broadly and non-exclusively as "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."[28]

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[25] *Health Care Consent Act, 1996*, s. 1

[26] *Health Care Consent Act, 1996*, s. 2(1)

[27] *Legislation Act, 2006*, S.O. 2006, c. 21, s. 64(1)

[28] *Health Care Consent Act, 1996*, s. 2(1)

34. The application judge noted the definition is circular. It is submitted that this is intended so as to make the definition as broad as possible. In summary, "plan of treatment" is statutorily defined as what a doctor thinks should happen next.[29]

35. The Physicians say that what should happen next is that MV should be withdrawn and palliative care should commence. In view of Mr. Rasouli's "current health condition," and in order to avoid the further slow deterioration that is anticipated, possible infections, *etc*., the Physicians say that it is in Mr. Rasouli's medical best interest that MV be withdrawn. It follows that the Physicians propose to withdraw MV for a "health-related purpose." This qualifies as "treatment" under the *HCCA*.

36. There is no reason to suspect that the *HCCA* did not intend to protect patient autonomy and dignity near the end of life.

37. Section 10(1)(b) of *HCCA* provides that a health practitioner who proposes a treatment for an incapable person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless he or she has obtained his or her statutory SDM's consent on the patient's behalf in accordance with this Act. The list of SDMs is found at s. 20 of the Act.[30]

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[29]Reasons for Decision, at para. 29

[30]*Health Care Consent Act, 1996*, ss. 10(1)(b) and 20

38. *Significant changes* to the Current Treatment Plan, such as those involved in the Proposed Treatment Plan, can only be implemented with Mr. Rasouli's consent or that of his statutory SDM.[31]

39. Consistent with the fact that patient autonomy is paramount, the *HCCA* provides that statutory SDMs shall give or refuse consent to a treatment in accordance with any known prior capable wish and, only in the event that no prior capable wish is known, then, in accordance with the incapable person's best interests, as defined by the statute.[32]

40. With respect to "best interests," the *HCCA* requires statutory SDMs to take the following 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.

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[31] *Health Care Consent Act, 1996*, s. 12

[32] *Health Care Consent Act, 1996*, s. 21(1)

> 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.[33]

41. Mr. Rasouli, through his SDM, submits that this comprehensive matrix of considerations sets up a decision-making process that is not static but rather one which must be in constant flux as the patient's situation either changes or fails to change.

42. Notably, the concept of "best interests" in the *HCCA* is not limited to clinical indications. Moreover, the *HCCA* does not limit "treatment" to that which seeks to cure, improve or reverse the patient's underlying illness.

43. SDMs must consider whether "treatment" might slow down a condition's deterioration. There can be no doubt that MV is slowing down Hassan Rasouli's deterioration. Without it, he would promptly die.

44. The definition of "treatment" itself specifies the eight circumstances—paragraphs (a) to (h)—that are not included within the definition "treatment" despite said definition. Moreover, s. 3 of the Act contains the definition of an "excluded act."[34]

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[33] *Health Care Consent Act, 1996*, s. 21(2)

[34] *Health Care Consent Act, 1996*, definition of "treatment" in s. 2(1) and s. 3

45. The legislature also provided that emergency treatment does not require consent.[35]

46. The *HCCA* provides a comprehensive and quick mechanism for doctors to obtain a determination from the CCB as to whether an SDM is complying with s. 21 of the Act, *i.e.*, by providing or refusing consent to proposed treatment in accordance with any known prior capable wish, and if there is no such wish, then in accordance with the patient's best interests, as defined. The CCB may substitute its opinion for that of the SDM and give directions which, if they are not followed by an established deadline, can result in the substitution of the SDM as statutory SDM.[36]

47. A party to a proceeding before the CCB may appeal the Board's decision to the Superior Court of Justice on a question of law or fact or both. That appeal is also subject to strict timelines.[37]

48. Yet, the Superior Court of Ontario is to give deference to the CCB's findings of fact or mixed law and fact, including what is in a patient's best interests for the purposes of s. 21(2). The CCB is considered to have special expertise that is not possessed by a judge hearing an appeal. In consequence, the legislature has entrusted to the CCB, and not to the court, the task of deciding, at first instance, whether an SDM is complying with s. 21 of the *HCCA*. The Superior Court should not interfere with the CCB's decision unless it is unreasonable in light of the findings of fact on which it

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[35] *Health Care Consent Act, 1996*, ss.25-27

[36] *Health Care Consent Act, 1996*, ss. 37 and 75

[37] *Health Care Consent Act, 1996*, s. 80

is based or dependent on an incorrect determination of a question of law.[38]

49. Clinical judgment is not an end in itself. The exercise of that judgment is geared towards the patient's best interests, while respecting his or her autonomy. A patient has the right to reject good medical advice. Even unquestionably sound clinical judgment is not a sufficient condition precedent for proceeding without consent.

50. Ultimately, the Physicians' judgment of medical best interest is based on the balance of benefits and risks of continued care/treatment. Ms. Salasel's position is that she concludes, on behalf of Mr. Rasouli, that the risk of slow deterioration as a result being confined to a hospital bed is a *risk worth taking* for a further period of time to show further cognitive improvement and to respect his religious beliefs and personal values. This is in his "best interests."

51. MV is not a heroic or invasive treatment, such as surgery. Mr. Rasouli's death is easily preventable through the continuance of the very "treatment" the Physicians recommended and implemented.

The Consent and Capacity Board

52. The CCB is the proper forum to decide what should be done in Mr. Rasouli's best interests. As this court stated in *M. (A.) v. Benes*:

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[38] *Scardoni v. Hawryluck*, 2004 CarswellOnt 424, 5 E.T.R. (3d) 226, 12 Admin. L.R. (4th) 67, 69 O.R. (3d) 700, paras. 34-35, authorities of the intervenor, tab 17

> A case will come before the Board only when the health practitioner disagrees with the S.D.M.'s application of the best interests test under s. 21(2). The Board will then have before it two parties who disagree about the application of s. 21: the S.D.M., who may have better knowledge than the health practitioner about the incapable person's values, beliefs and non-binding wishes; and the health practitioner, who is the expert on the likely medical outcomes of the proposed treatment. The disagreement between the S.D.M. and the health practitioner potentially creates tension and the Act recognizes this by providing for a neutral expert Board to resolve the disagreement. Indeed, after hearing submissions from all parties, the Board is likely better placed than either the S.D.M. or the health practitioner to decide what is in the incapable person's best interests. Thus, the Board should not be required to accord any deference to the S.D.M.'s decision. [39]

53. The CCB hears disputes about medical consent, including where a physician is seeking consent to remove life support.[40] The position of the Physicians, however, is that going to the CCB is, for physicians, purely optional (para. 95 of their factum).

54. Mr. Justice Cullity's *obiter* comments in the leading decision *Scardoni* v. *Hawryluck* speak strongly in favour of concluding that the CCB has first-instance jurisdiction in the present circumstances.[41]

55. There is a public interest aspect. Patients, patients' families and the public at large are entitled to reassurance that doctors are not hastening their patients' preventable deaths without

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[39] *M. (A.) v. Benes* (1999), 46 O.R. (3d) 271 (C.A.), at 283; quoted in *Scardoni v. Hawryluck*, *supra,* at para. 36, authorities of the intervenor, tab 17

[40] For instance, see *JM (re)*, 2011 CanLII 7955 (ON C.C.B.), respondents' authorities, tab 1, where the issue was decided by a panel comprised of a medical member, a legal member and a lay member.

[41] *Scardoni, supra*, at paras. 42 and 44

consent or oversight.[42]

56. Further, the *Criminal Code* imposes a legal duty upon a health practitioner to provide the necessaries of life to a patient under his or her charge, such as the continuation of life-sustaining treatment. The declaration sought by the Physicians in their counter-application to confer immunity improperly interferes with the Attorney-General's exercise of prosecutorial discretion.[43]

57. The Physicians seek to discriminate unfairly against patients who are in PVS. Such patients, they say, should not have the guarantee that they will receive medical care that either respects their prior capable wish or, alternatively, accords with their "best interests" under the *HCCA* (*i.e.*, as decided by their SDM or the CCB). Such patients would receive no consideration other than the clinical judgment (and perhaps world views and sensitivities) of a particular physician, often not of the patient's choosing. Such patients' mental and physical disability would be the basis upon which essential legal protections are denied. This is contrary to principles of fundamental justice.

58. The *HCCA* should be interpreted in a manner that is consistent with *Charter* values, including security of the person.[44]

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[42]*Sawatzky v. Riverview Health Centre Inc.*, 1998 CarswellMan 515 (Q.B.), paras. 35-36 and 39, appellants' authorities, tab 18

[43]Notice of application of the Physicians, issued February 4, 2011, appeal book, tab 5, p. 49; *Criminal Code*, R.S.C, 1985, c. C-46, Section 215(1)(c); *London Health Sciences Centre v. K. (R.) (Litigation Guardian of)*, 1997 CarswellOnt 4331, 152 D.L.R. (4th) 724, paras. 18-20, respondents' authorities, tab 2

[44]*M. (A.) v. Benes*, para. 22, intervenor's authorities, tab 5

59. A purposive interpretation of the *HCCA* is not consistent with the argument that physicians can determine, unilaterally, when the *HCCA* does and does not apply.

Madam Justice Himel's Reasons For Decision

60. The application judge correctly concluded that, in interpreting the *HCCA*, one should apply the natural meaning of the words therein.[45]

61. The Physicians argue (at paras. 2 and 13 of their factum) that Himel J. "ignored" or made "irrelevant" as a factor whether or not MV could provide a benefit to Mr. Rasouli. However, as Her Honour found that the CCB has statutory first-instance jurisdiction over this matter, she would not want to decide facts beyond what was necessary to interpret the statute.

62. Her Honour found (at paras. 31-33 of the reasons for decision) that the provision of life support, such as MV, falls within the definitions of "preventive" and "therapeutic." This is because the goal of life support is to prevent suffering and premature death and to treat reversible illness, respectively. Her Honour also concluded that it is the intended purpose of the care in question that matters. Therefore, the withdrawal and withholding of life support also comes within these definitions.

63. In any event, MV is being provided to prevent Mr. Rasouli's death and, in that regard,

[45]Reasons, paras. 25-27, 33, 52

MV has been, and continues to be, very effective and not futile.

64. Moreover, the Physicians factum (at paras. 48-49) ignores that a "therapeutic" purpose is only one of the purposes listed in the Act that may qualify anything to be "treatment." In any event, looking at the Proposed Treatment Plan comprehensively, transferring Mr. Rasouli to the PCU falls within the "palliative" and "health-related" purposes.

65. The Physicians also argue (at para. 7 of their factum) that Himel J. made an "untenable distinction" between treatment that is withheld and treatment that is withdrawn and that Her Honour "found that the *Health Care Consent Act* confers the right to refuse the withdrawal of treatment but not its withholding". (A similar charge is made at paras. 48, 53 and 62.) According to the Physicians, Himel J. held that "consent is required in order for treatment to be withdrawn but not in order for it to be withheld." In fact, Himel J. did not lay down such a rule. Her Honour noted that Mr. Justice Cullity in the *Scardoni* decision indicated that such a distinction might be made; however, the important point, in Her Honour's view, is that the "treatment" either is or has been proposed by a physician. Where no physician has proposed a particular form of care as appropriate, then it is not "treatment" being withheld under the Act. Her Honour did not hold that physicians may withhold "treatment," as defined, without consent. Thus, Her Honour's reasons are not, as the Physicians appear to be suggesting, internally inconsistent.

The Withdrawal and Withholding of MV Should Not Be Considered in Isolation

66. Withdrawing MV from Mr. Rasouli, transferring him to the PCU, and providing active

palliative care to him there, are activities that involve a series of interferences with Mr. Rasouli's bodily integrity and religious beliefs.

67. The Physicians say Mr. Rasouli receives "no benefit" from living another day, the implication being that he receives no benefit from having his religious beliefs respected.

68. The Physicians argue (at para. 49 of their factum) that Himel J. has reached an "illogical result" in 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". They complain that Himel J. did not ask whether the continued provision of MV, considered in isolation, has been "developed" by a physician. But the Physicians have "developed" the Proposed Treatment Plan for health-related reasons. To fragmentize the proposed "treatment" (*i.e.*, to ignore the fact that MV is being withdrawn as part of a larger plan) would allow avoidance of the *HCCA* at will.[46]

69. Himel J. was satisfied that her interpretation of the *HCCA* does not allow patients to "order treatment" by taking the law of informed consent beyond its proper place. Her Honour held: "[T]he only treatment a doctor would require consent to withhold or withdraw would be one proposed by the doctor or by another health practitioner."[47]

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[46]At paras. 22 and 24 of her reasons, Himel J. quoted and agreed with para. 42 of the *Scardoni* decision

[47]Reasons, para. 45

70. The Physicians propose to do many things to Mr. Rasouli's vulnerable body; withdrawing MV is only the first step. This is not a case where a patient or SDM seeks to abuse the law of informed consent.[48]

Alternative Submissions about the Common Law Position

71. Respectfully, it is incorrect, as the Physicians allege, that (a) at common law, the law of informed consent is not engaged in these circumstances and (b) the medical standard of care in Ontario mirrors the Physicians' view of what the common law is.[49]

72. The Physicians' argue that, at common law, they can decide not to commence MV in the first place and that they can also withdraw MV unilaterally. Thus, they have no duty to continue futile treatment and, in these circumstances, the law of informed consent is not engaged. The Physicians argue that, although a practice in England[50] has developed to require that doctors' decisions to withdraw life-sustaining treatment "be brought to the court's attention" (para. 75 of their factum), the "decision is to be made on the basis of medical indications alone" and the court will not direct treatment (para. 75). The suggestion is that the court will oversee the decision but defer to the expert. The Physicians say they are accountable to the patient for any breach of the standard of care (para. 87 of their factum), which appears to be saying that the doctor may withdraw any treatment

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[48] In any event, the definition of "treatment" is not limited to things that are administered as part of a plan of treatment (or to treatment withdrawn or withheld as part of such a plan).

[49]See Physicians' factum, paragraphs 75 and 80-82

[50]See a series of Practice Notes at [1994] 2 All ER 413, [1996] 4 All ER 766, [2001] 2 FLR 158, and [2006] 2 FLR 373, respondents' authorities, tab 3

if it is medically reasonable. The Physicians' legal basis for these propositions lies in the *Bland* decision and those cases that follow it.[51]

73. Respectfully, *Bland* does not stand for these propositions. The English authorities do not undermine the law of informed consent. Rather, as a result of a peculiar situation in England, following the statutory elimination of the court's *parens patriae* jurisdiction over incapable adults, the court was unable to say in *Bland* that it could provide consent to the doctor's proposal to withdraw life-sustaining treatment on behalf of the incapable patient. Thus, in England, the incapable person was in a position where medical treatment that might be readily consented to could not be consented to by any authorized next of kin or even the court. As a result, the court held that physicians could fall back on the principle of necessity to act unilaterally. Notably, this was done as a matter of public policy and in the best interest of the patient as the only way in which the incapable patient could receive necessary treatment. This applied to incapable adults only. With children, for whom the court's *parens patriae* jurisdiction had not been abrogated, the law remained that doctors had to obtain court approval. This would have been the situation with incapable adults also, but for the apparently unintended consequences of a legislative change.

74. In *Bland*, Lord Goff stated that the House of Lords in *In re F. (Mental Patient Sterilisation)* [1990] 2 AC 1 "came reluctantly to the conclusion" that the court did not have jurisdiction over the incapable adult.[52]

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[51] *Airedale NHS Trust v. Bland*, [1993] AC 789 (H.L.), appellants' authorities, tab 3

[52] *Bland*, *supra*, page 862

75. The court considered that there were "safeguards," one of which was that the British Medical Association recommended that the PVS diagnosis as "irreversible" should not be considered "confirmed" for non-trauma cases until at least six months after the injury, with the effect that the decision to withdraw life-sustaining treatment would not be made within that period. The British Medical Association also recommended that, generally, the wishes of the patient's immediate family "will be given great weight" (p. 870). Notably, Lord Goff referred to the recommended court applications from physicians as "the present requirement" (p. 874).[53]

76. Also in *Bland*, Lord Lowry (at p. 875) stated he "never heard a rational, or indeed any, explanation" regarding why the state/the court's *parens patriae* jurisdiction over incapable adults was abolished by statute, and stating he "sincerely hope[d]" that the jurisdiction would soon be restored as the absence of that jurisdiction was "most unfortunate." Lord Lowry noted that, in the circumstances, the doctor proposing to withdraw treatment "will be judge in his own cause."

77. Lord Brown-Wilkinson (at p. 883) provided further detail as to how the statutory abolishment occurred. He noted that this abolishment has been suggested to be an accident but the result was that the court had "no power on Anthony Bland's behalf either to consent or refuse consent." Thus, it was the "lacuna in the law" that forced the conclusion based on concepts of necessity (i.e., because the common law had to find a way to permit the doctor to act and provide

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[53]See also a series of Practice Notes at [1994] 2 All ER 413, [1996] 4 All ER 766, [2001] 2 FLR 158, and [2006] 2 FLR 373, respondents' authorities, tab 3

necessary care without committing battery) that the doctor could act without consent from anyone, subject to the practice direction that was implemented. Lord Brown-Wilkinson at p. 885 also stated that he hoped for Parliamentary review of the situation.

78. In Ontario, the court's *parens patriae* jurisdiction over incapable adults has not been abrogated by statue. There is no reason for this Court to hold that hastening the preventable death of a totally vulnerable citizen would not engage that jurisdiction, if the *HCCA* is found to not apply to these circumstances. It would then follow that, as a matter of law (as with children in England), because the Court is in a position to consent to treatment on behalf of incapable patients, court approval must be obtained. In other words, because court approval can be obtained and the medical situation is not, truly, one of emergency, it does not make sense to hold that, in the best interest of patients, the doctor can resort to the principle of necessity to act unilaterally.

79. It bears mention that Lord Brown-Wilkinson got his wish. The *Mental Capacity Act 2005*, which came into force October 1, 2007, created the Court of Protection, giving it powers analogous to the CCB. Now, in England, where there is any doubt or dispute about the patient's best interests, an application must be made to the Court of Protection for a decision as to whether withholding or withdrawing life-sustaining treatment is in the patient's best interests.[54]

80. It is curious that the Physicians argue that the medical standard of care in Ontario

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[54] *Code of Practice*, issued by the Lord Chancellor on 23 April 2007 in accordance with sections 42 and 43 of the *Mental Capacity Act 2005*, sections 5.33 and 5.36

mirrors what they advance as the common law position.[55]

81. The Physicians' own evidence is that the medical standard of care is set out in a policy statement of the College of Physicians and Surgeons of Ontario (CPSO) entitled "Decision Making for the End of Life."[56]

82. This document states that the requirements of informed consent at the end of life are the same as the requirements in other situations and that when a patient is not capable, an SDM makes the decisions.[57] It specifies that dying patients may have wishes relating to matters other than treatment and that physicians should try to honour those wishes, including those arising from values, belief, religion and culture.[58] The same policy states that the *HCCA* provides a structure for managing conflicts about treatment decisions for incapable patients that cannot be resolved in other ways.[59]

83. It is hard to see how this view of the medical standard of care assists the position of the Physicians.

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[55]See Physicians' factum, paragraphs 80-82

[56]Affidavit of Dr. Cuthbertson, Exhibit "B," appeal book, tab 9, p. 106, para. 50, and tab 11, pages 132-137 This statement of the standard of care is confirmed at paragraphs 81-82 of the Physicians' factum.

[57]p. 132, right column

[58]p. 132, left column

[59]p. 136, left column

Conclusion

84. Robins J.A. of this court has stated,

> The right to determine what shall, or shall not, be done with one's own body, and to be free from nonconsensual medical treatment, is a right deeply rooted in our common law. This right underlies the doctrine of informed consent. With very limited exceptions, every person's body is considered inviolate, and, accordingly, every competent adult has the right to be free from unwanted medical treatment. The fact that serious risks or consequences may result from a refusal of medical treatment does not vitiate the right of medical self-determination. The doctrine of informed consent ensures the freedom of individuals to make choices about their medical care. It is the patient, not the doctor, who ultimately must decide if treatment - any treatment - is to be administered...The common law right to bodily integrity and personal autonomy is so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order of protection. This right forms an essential part of an individual's security of the person and must be included in the liberty interests protected by s.7. Indeed, in my view, the common law right to determine what shall be done with one's own body and the constitutional right to security of the person, both of which are founded on the belief in the dignity and autonomy of each individual, can be treated as coextensive.[60]

PART IV – ADDITIONAL ISSUES

85. There is none.

PART V – RELIEF SOUGHT

86. Mr. Rasouli seeks an order dismissing the appeal with costs.

87. In the alternative, should the appeal be allowed, Mr. Rasouli seeks an order staying

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[60] *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.), paragraphs 33 and 41, respondents' authorities, tab 5

the related order and declaration(s), to permit Mr. Rasouli the opportunity to consider an application for leave to appeal to the Supreme Court of Canada and pending the determination of any such appeal, if leave is granted.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

Date: May 2, 2011

J. GARDNER HODDER
LSUC #24990G

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Lawyers for the Applicant,
Respondent in Appeal

CERTIFICATE

I, J. GARDNER HODDER, lawyer for the respondent in appeal, Mr. Hassan Rasouli, certify that:

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

2. The estimated time of my oral argument is 1.5 hours.

Date: May 2, 2011

_____

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SCHEDULE "A"
Authorities referred to

Case law

Sweiss v. *Alberta*, 2009 ABQB 691, appellants' authorities, tab 20

Airedale NHS Trust v. Bland, [1993] A.C. 789 (H.L.), appellants' authorities, tab 3

Scardoni v. Hawryluck, 2004 CarswellOnt 424, 5 E.T.R. (3d) 226, 12 Admin. L.R. (4th) 67, 69 O.R. (3d) 700, authorities of the intervenor, tab 17

JM (re), 2011 CanLII 7955 (ON C.C.B.), respondent's authorities, tab 1

Sawatzky v. Riverview Health Centre Inc., 1998 CarswellMan 515 (Q.B.), appellants' authorities, tab 18

London Health Sciences Centre v. K. (R.) (Litigation Guardian of) , 1997 CarswellOnt 4331, 152 D.L.R. (4th) 724 (Sup. Ct.), respondent's authorities, tab 2

M. (A.) v. Benes (1999), 46 O.R. (3d) 271 (C.A.), intervenor's authorities, tab 5

Series of Practice Notes at [1994] 2 All ER 413, [1996] 4 All ER 766, [2001] 2 FLR 158, and [2006] 2 FLR 373, respondent's authorities, tab 3

Code of Practice, issued by the Lord Chancellor on 23 April 2007 in accordance with sections 42 and 43 of the *Mental Capacity Act 2005*, sections 5.33 and 5.36, respondent's authorities, tab 4

Fleming v. Reid (1991), 4 O.R. (3d) 74 (C.A.), respondent's authorities, tab 5

Articles

Excerpt from Wolbring (2006) "The triangle of Enhancement Medicine, Disabled people and the concept of Health: A new challenge for HTA, health research and health policy" a 220 page report. Published by the Health Technology Assessment Unit of the Alberta Heritage Foundation for medical research http://www.ihe.ca/documents/HTA-FR23.pdf page 47-50, included here at the request of the intervenor, respondent's authorities, tab 6

SCHEDULE "B"
Text of Statutory Provisions and Regulations

Canadian Charter of Rights and Freedoms, Part I of the *Constitution Act, 1982*

Fundamental Freedoms
2. Everyone has the following fundamental freedoms:
(a) freedom of conscience and religion;
(b) freedom of thought, belief, opinion and expression, including freedom of the press and other media of communication;
(c) freedom of peaceful assembly; and
(d) freedom of association.

Life, Liberty and Security of Person
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.

Equality before and under law and equal protection and benefit of law
15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Health Care Consent Act, 1996, S.O. 1996, c. 2, Sched. 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.

Interpretation
2.(1) In this Act,

"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")

"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.

Meaning of "excluded act"
3. (1) In this section,
"excluded act" means,
(a) anything described in clause (b) or (g) of the definition of "treatment" in subsection 2 (1), or
(b) anything described in clause (h) of the definition of "treatment" in subsection 2 (1) and prescribed by the regulations as an excluded act.

Excluded act considered treatment
(2) If a health practitioner decides to proceed as if an excluded act were a treatment for the purpose

of this Act, this Act and the regulations apply as if the excluded act were a treatment within the meaning of this Act.

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.

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 CCB on an application for review of the health practitioner's finding, or by a court on an appeal of the CCB'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.

Included consent
12. Unless it is not reasonable to do so in the circumstances, a health practitioner is entitled to presume that consent to a treatment includes,
(a) consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different from the nature, expected benefits, material risks and material side effects of the original treatment; and
(b) consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered.

List of persons who may give or refuse consent
20. (1) If a person is incapable with respect to a treatment, consent may be given or refused on his or her behalf by a person described in one of the following paragraphs:
1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.
2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.
3. The incapable person's representative appointed by the Board under section 33, if the representative has authority to give or refuse consent to the treatment.
4. The incapable person's spouse or partner.
5. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully

entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent.
6. A parent of the incapable person who has only a right of access.
7. A brother or sister of the incapable person.
8. Any other relative of the incapable person.

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.

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.

Emergency treatment
Meaning of "emergency"
25. (1) For the purpose of this section and section 27, there is an emergency if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm.

Emergency treatment without consent: incapable person

(2) Despite section 10, a treatment may be administered without consent to a person who is incapable with respect to the treatment, if, in the opinion of the health practitioner proposing the treatment,
(a) there is an emergency; and
(b) the delay required to obtain a consent or refusal on the person's behalf will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm.

Emergency treatment without consent: capable person
(3) Despite section 10, a treatment may be administered without consent to a person who is apparently capable with respect to the treatment, if, in the opinion of the health practitioner proposing the treatment,
(a) there is an emergency;
(b) the communication required in order for the person to give or refuse consent to the treatment cannot take place because of a language barrier or because the person has a disability that prevents the communication from taking place;
(c) steps that are reasonable in the circumstances have been taken to find a practical means of enabling the communication to take place, but no such means has been found;
(d) the delay required to find a practical means of enabling the communication to take place will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm; and
(e) there is no reason to believe that the person does not want the treatment.

Examination without consent
(4) Despite section 10, an examination or diagnostic procedure that constitutes treatment may be conducted by a health practitioner without consent if,
(a) the examination or diagnostic procedure is reasonably necessary in order to determine whether there is an emergency; and
(b) in the opinion of the health practitioner,
(i) the person is incapable with respect to the examination or diagnostic procedure, or
(ii) clauses (3) (b) and (c) apply to the examination or diagnostic procedure.

Record
(5) After administering a treatment in reliance on subsection (2) or (3), the health practitioner shall promptly note in the person's record the opinions held by the health practitioner that are required by the subsection on which he or she relied.

Continuing treatment
(6) Treatment under subsection (2) may be continued only for as long as is reasonably necessary to find the incapable person's substitute decision-maker and to obtain from him or her a consent, or refusal of consent, to the continuation of the treatment.

Same

(7) Treatment under subsection (3) may be continued only for as long as is reasonably necessary to find a practical means of enabling the communication to take place so that the person can give or refuse consent to the continuation of the treatment.

Search
(8) When a treatment is begun under subsection (2) or (3), the health practitioner shall ensure that reasonable efforts are made for the purpose of finding the substitute decision-maker, or a means of enabling the communication to take place, as the case may be.

Return of capacity
(9) If, after a treatment is begun under subsection (2), the person becomes capable with respect to the treatment in the opinion of the health practitioner, the person's own decision to give or refuse consent to the continuation of the treatment governs.

No treatment contrary to wishes
26. A health practitioner shall not administer a treatment under section 25 if the health practitioner has reasonable grounds to believe that the person, while capable and after attaining 16 years of age, expressed a wish applicable to the circumstances to refuse consent to the treatment.

Emergency treatment despite refusal
27. If consent to a treatment is refused on an incapable person's behalf by his or her substitute decision-maker, the treatment may be administered despite the refusal if, in the opinion of the health practitioner proposing the treatment,
(a) there is an emergency; and
(b) the substitute decision-maker did not comply with section 21.

Application to depart from wishes
36. (1) If a substitute decision-maker is required by paragraph 1 of subsection 21 (1) to refuse consent to a treatment because of a wish expressed by the incapable person while capable and after attaining 16 years of age,
(a) the substitute decision-maker may apply to the Board for permission to consent to the treatment despite the wish; or
(b) the health practitioner who proposed the treatment may apply to the Board to obtain permission for the substitute decision-maker to consent to the treatment despite the wish.

Notice to substitute decision-maker
(1.1) A health practitioner who intends to apply under clause (1) (b) shall inform the substitute decision-maker of his or her intention before doing so.

Parties
(2) The parties to the application are:
1. The substitute decision-maker.
2. The incapable person.

3. The health practitioner who proposed the treatment.
4. Any other person whom the Board specifies.

Criteria for permission
(3) The Board may give the substitute decision-maker permission to consent to the treatment despite the wish if it is satisfied that the incapable person, if capable, would probably give consent because the likely result of the treatment is significantly better than would have been anticipated in comparable circumstances at the time the wish was expressed.

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.

Parties
(2) The parties to the application are:
1. The health practitioner who proposed the treatment.
2. The incapable person.
3. The substitute decision-maker.
4. Any other person whom the Board specifies.

Power of Board
(3) In determining whether the substitute decision-maker complied with section 21, the Board may substitute its opinion for that of the substitute decision-maker.

Directions
(4) If the Board determines that the substitute decision-maker did not comply with section 21, it may give him or her directions and, in doing so, shall apply section 21.

Time for compliance
(5) The Board shall specify the time within which its directions must be complied with.

Deemed not authorized
(6) If the substitute decision-maker does not comply with the Board's directions within the time specified by the Board, he or she shall be deemed not to meet the requirements of subsection 20 (2).

Subsequent substitute decision-maker
(6.1) If, under subsection (6), the substitute decision-maker is deemed not to meet the requirements of subsection 20 (2), any subsequent substitute decision-maker shall, subject to subsections (6.2) and (6.3), comply with the directions given by the Board on the application within the time specified by the Board.

Application for directions
(6.2) If a subsequent substitute decision-maker knows of a wish expressed by the incapable person with respect to the treatment, the substitute decision-maker may, with leave of the Board, apply to the Board for directions under section 35.

Inconsistent directions
(6.3) Directions given by the Board under section 35 on a subsequent substitute decision-maker's application brought with leave under subsection (6.2) prevail over inconsistent directions given under subsection (4) to the extent of the inconsistency.

P.G.T.
(7) If the substitute decision-maker who is given directions is the Public Guardian and Trustee, he or she is required to comply with the directions, and subsection (6) does not apply to him or her.

Limit on jurisdiction
70.1 (1) The Board shall not inquire into or make a decision concerning the constitutional validity of a provision of an Act or a regulation.

Board to fix time and place of hearing
75. (1) When the Board receives an application, it shall promptly fix a time and place for a hearing.

Hearing to begin within seven days
(2) The hearing shall begin within seven days after the day the Board receives the application, unless the parties agree to a postponement.

Exception
(2.1) Despite subsection (2), the hearing of an application under section 39.2 of the Mental Health Act shall begin within 30 days after the day the Board receives the application, unless the parties agree to a postponement.

Decision
(3) The Board shall render its decision and provide a copy of the decision to each party or the person who represented the party within one day after the day the hearing ends.

Reasons
(4) If, within 30 days after the day the hearing ends, the Board receives a request from any of the parties for reasons for its decision, the Board shall, within four business days after the day the request is received,
(a) issue written reasons for its decision; and
(b) provide a copy of the reasons to each person who received a copy of the decision under subsection (3).

Appeal
80. (1) A party to a proceeding before the Board may appeal the Board's decision to the Superior Court of Justice on a question of law or fact or both.

Time for filing notice of appeal
(2) The appellant shall serve his or her notice of appeal on the other parties and shall file it with the court, with proof of service, within seven days after he or she receives the Board's decision.

Notice to Board
(3) The appellant shall give a copy of the notice of appeal to the Board.

Record
(4) On receipt of the copy of the notice of appeal, the Board shall promptly serve the parties with the record of the proceeding before the Board, including a transcript of the oral evidence given at the hearing, and shall promptly file the record and transcript, with proof of service, with the court.

Time for filing appellant's factum
(5) Within 14 days after being served with the record and transcript, the appellant shall serve his or her factum on the other parties and shall file it, with proof of service, with the court.

Time for filing respondent's factum
(6) Within 14 days after being served with the appellant's factum, the respondent shall serve his or her factum on the other parties and shall file it, with proof of service, with the court.

Extension of time
(7) The court may extend the time for filing the notice of appeal, the appellant's factum or the respondent's factum, even after the time has expired.

Early date for appeal
(8) The court shall fix for the hearing of the appeal the earliest date that is compatible with its just disposition.

Appeal on the record, exception
(9) The court shall hear the appeal on the record, including the transcript, but may receive new or additional evidence as it considers just.

Powers of court on appeal
(10) On the appeal, the court may,
(a) exercise all the powers of the Board;
(b) substitute its opinion for that of a health practitioner, an evaluator, a substitute decision-maker or the Board;
(c) refer the matter back to the Board, with directions, for rehearing in whole or in part.

***Legislation Act, 2006*, S.O. 2006, c. 21**

64. (1) An Act shall be interpreted as being remedial and shall be given such fair, large and liberal interpretation as best ensures the attainment of its objects. 2006, c. 21, Sched. F, s. 64 (1).

***Criminal Code*, R.S., 1985, c. C-46**

Duty of persons to provide necessaries
215. (1) Every one is under a legal duty
(a) as a parent, foster parent, guardian or head of a family, to provide necessaries of life for a child under the age of sixteen years;
(b) to provide necessaries of life to their spouse or common-law partner; and
(c) to provide necessaries of life to a person under his charge if that person
(i) is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and
(ii) is unable to provide himself with necessaries of life.

Assault
265. (1) A person commits an assault when
(a) without the consent of another person, he applies force intentionally to that other person, directly or indirectly;
(b) he attempts or threatens, by an act or a gesture, to apply force to another person, if he has, or causes that other person to believe on reasonable grounds that he has, present ability to effect his purpose; or
(c) while openly wearing or carrying a weapon or an imitation thereof, he accosts or impedes another person or begs.

Aggravated assault
268. (1) Every one commits an aggravated assault who wounds, maims, disfigures or endangers the life of the complainant.

HASSAN RASOULI - and - SUNNYBROOK HEALTH SCIENCES CENTRE *et al*.

Court File No. C53442

COURT OF APPEAL FOR ONTARIO

Proceeding commenced at:
TORONTO

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