Court of Appeal No.: C53442

COURT OF APPEAL OF ONTARIO

IN THE MATTER OF An Appeal from the Order of the Honourable Madam Justice Himel, made March 9, 2011, in the Superior Court of Justice in action number CV-11-419084

BETWEEN:

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-

BETWEEN:

DR. BRIAN CUTHBERTSON and DR. GORDON RUBENFELD

Applicants
(Appellants)

-and-

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

Respondents
(Respondents)

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PART I: OVERVIEW

1. This case raises fundamental questions about whether doctors should be afforded the unilateral authority to impose palliative care and withdraw life-sustaining treatment without consent of the patient or their substitute decision-maker, without consideration of the principles and processes set out in the Health Care Consent Act, and where the likely result amounts to physician-imposed death of the patient without due process.

2. The appellants' position that doctors have the unilateral authority to impose and withdraw medical treatment without consent, without due process and without any oversight represents the utmost in hubris which is contrary to the principles set out in the HCCA in relation to consent to treatment.

3. The appellants' position is completely contrary to the highest traditions of the medical profession and the fiduciary obligations owed by doctors to their patients.

4. EPC submits that the appellants' newly proposed plan of treatment including palliative care and the withdrawal of mechanical ventilation requires consent.

5. The appellants wrongly assume that palliative care is not a form of treatment to which consent is required. The HCCA makes clear that palliative care does require consent. The definition of treatment under the HCCA includes palliative care expressly as well as a plan of treatment and withdrawal of treatment.[1]

6. Had the Legislature intended that consent not be required for palliative care and the withdrawal of life-sustaining treatment, the HCCA would have included these as excluded acts for which no consent is required and would not have included them as part of the definition of treatment under the HCCA.[2]

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[1] Health Care Consent Act 1996, S.O. 1996, c. 2, Sch A., s.2 ("HCCA") at s. 2

[2] HCCA s. 2 & 3

7. Depriving patients of their right to consent to palliative care and the withdrawal of life-sustaining treatment amounts to physician-imposed death to the patient without due process.

8. The HCCA provides for a comprehensive statutory scheme related to the giving and refusing of consent to treatment, including palliative care and the withdrawal and withholding of treatment in accordance with a patient's prior express wishes or best interests. It also sets out a statutory process to resolve disputes arising from situations where consent is refused by a substitute decision-maker in a manner that the doctor believes is contrary to the prior express wishes or best interests of the patient as defined by s.21 of HCCA.

9. The statutory framework established by the HCCA provides for a timely, cost-effective and specialized Tribunal process to resolve disputes related to the refusal of a substitute decision-maker to consent to or withdraw treatment at the end of life in a manner that affords patients and doctors due process and a level of protection against terminal treatment decisions unilaterally imposed by doctors. In Ontario, it is the forum in which such disputes must be resolved.

10. The requirements of the HCCA and the Board process also preclude patients from demanding their own treatment and clogging the ICUs with medically unnecessary treatments, as hospitals fear.[3]

11. Subjective quality of life assessments by some doctors that medically dehumanize people with disabilities at the end of life may dictate decisions to unilaterally impose palliative care or withdraw life-sustaining treatment in a manner that disregards the inherent human dignity of the patient.

12. Care must be taken to guard against these prejudicial and possibly terminal assessments and unilateral treatment decisions based on them. The same applies to treatment

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[3] HCCA s. 2 & 37; *Rasouli at* ¶45; C.D. (Re), 2007 CanLii 32892 (ON C.C.B) at ¶ 44

decisions based solely on an assessment of clinical considerations and not on the patient's best interests as defined by the HCCA.

13. Principles of due process and fundamental justice require that doctors be subject to oversight in proposing and withdrawing treatments in a manner likely to result in the death of the patient. This principle has been widely recognized and applied in Canada, the USA and the UK.[4]

A. Treatment includes Withdrawal of Treatment

14. Treatment and a plan of treatment as defined in the HCCA include the withdrawal and withholding of treatment as well as palliative care.[5]

15. Consent is required to implement palliative care and withdraw life-sustaining treatment because they fall under the definition of treatment under the HCCA and because they impact the physical integrity of the patient. Absent consent, such physical contact with a patient by a physician is an assault except in emergency situations as prescribed by the HCCA.

16. A requirement of consent to impose palliative care and withdraw treatment as part of a plan of treatment promotes the autonomy, dignity and self-determination of vulnerable people at the end of life in a manner consistent with Charter values and the values of the HCCA and is in keeping with Canada's Constitutional and international obligations including under the Charter and United Nations' Convention on Persons with Disabilities.[6]

17. The Legislature clearly turned its mind to circumstances where consent is not required under the emergency power and excluded act provisions of the HCCA, but chose not to

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[4] *Sawatzky v. Riverview Health Centre Inc.*, 1998 CarswellMan 515 (Man. QB)at ¶1 at Appellant's Brief of Authorities at tab 18; *Golubchuk (Committee of) v. Salvation Army Grace General Hospital*, 2008 CarswellMan 57 (Man. QB) at ¶ 1 at Appellant's Brief of Authorities at tab19; *Airedale NHS Trust v. Bland*, 1993 WL 963744 (House of Lords) at pg. 859, ¶ F at Appellants' Brief of Authorities at tab 3; *Rasouli* at ¶ 64-65, 69-70, 79-80

[5] HCCA s.2; *Scardoni et al. v. Hawryluck*, 2004 Carswell (Ont. SCJ) at ¶¶ 19-21; *Rasouli* at ¶ 24

[6] *Manitoba (Director of Child & Family Services) v. C (A.)* 2009 CarswellMan 293 (SCC) at ¶¶ 97-108; United Nations. Convention on the Rights of Persons with Disabilities. New York, 13 December 2006 at articles 1, 17, 25(a)(d)(f)

include the imposition of palliative care, the withdrawal of treatment or futile care as excluded acts under the HCCA.[7]

18. The HCCA expressly provides for a regulation-making authority but the Legislature has chosen not to pass any regulation in respect of palliative care, the withdrawal of treatment, or the withdrawal of futile care as an act that does not require consent. It remains open for the Legislature to do so and this Court should not attempt to establish or revert to common law rules that are contrary to the legislative objectives and terms of the HCCA and which have such broad public policy implications. Such matters are best left to the Legislature with the benefit of informed debate from a wide variety of stakeholders.[8]

19. EPC does not suggest that doctors should be required to propose non-therapeutic or unethical treatment, but where treatment has been proposed and implemented as part of a plan of treatment, consent is required to withdraw that treatment, particularly where death is the anticipated outcome of the withdrawal of that treatment. The Court below clearly endorsed this principled approach.[9]

20. The HCCA creates a comprehensive code with regard to the giving and refusing of consent to treatment and with respect to resolving disputes arising in relation to such decisions.[10]

21. The common law has been superseded in Ontario by the enactment of the HCCA in relation to consent to treatment decisions including the unilateral imposition of palliative care and withdrawal of life-sustaining treatment as part of a proposed plan of treatment.[11]

22. Should the common law apply to such treatment decisions, it must be interpreted in a manner consistent with Charter values and the principles set out in the HCCA which

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[7] HCCA s. 3

[8] HCCA s. 85 (a)(f)(g); Sullivan, Ruth. Driedger on the Construction of Statues (3rd Edition) Toronto: Butterworths, 1994. ("Driedger) pg. 313-315;

[9] *Rasouli* at ¶ 24

[10] HCCA s. 2, 10, 21, 37 & 75, Manitoba at 123-126

[11] HCCA s. 1 & 7; *Manitoba* at ¶¶ 123-126

require consent to implement a plan of palliative care such as the appellants propose here and to withdraw life-sustaining treatment that forms part of that plan of treatment.[12]

23. In the event of a dispute regarding the refusal of consent to withdraw treatment by a substitute decision-maker, the Consent and Capacity Board is the proper forum to resolve those disputes expeditiously and with patients having the right to have counsel appointed as per the HCCA to protect their interests and ensure due process. The Board is in a better position than doctors or substitute decision-makers to carry out an objective assessment of a patient's best interests under s. 21 of the HCCA and to resolve such disputes.[13]

24. The requirement of consent under the HCCA ensures that patients' express wishes are respected and in the event that there is no express applicable wish, that the best interests of the patient as defined by Section 21 of the HCCA are considered. This requires substitute decision-makers, doctors and the Board to consider the patient's wishes, values and beliefs relative to the proposed treatment/withdrawal.[14]

25. A doctor is not entitled to rely on clinical considerations alone in assessing a patient's best interests in relation to the giving or refusing of consent to treatment or to the withdrawal of ongoing treatment under the HCCA.[15]

26. This principle is fundamental to end of life decision-making and has been widely recognized including in cases of Jehovah's Witnesses refusing blood transfusions for religious reasons, despite the fact that the doctor believes that this is contrary to their medical best interests. It has also been recognized by injunctions to restrain doctors from withdrawing life support treatment in Canada and internationally.[16]

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[12] *Manitoba (Director of Child & Family Services) v. C.(A.)* 2009 CarswellMan 293 (SCC) at ¶¶ 97-108; *Pepsi-Cola Canada Beverages (West) Ltd. v. R.W.D.S.U., Local 558*, 2002 CarswellSask 22 (SCC) at ¶¶ 18-20; *R. v. Salituro* 1991 CarswellOnt 124 (SCC) at ¶ 52;
[13] HCCA s 37; *M. (A.) v. Benes* at ¶ 46
[14] HCCA s.21; *Scardoni* at ¶ 44
[15] HCCA s 21; *W.(D), Re* (2004) CanLii 56526 (Ont. CCB) ¶¶ 30-31
[16] HCCA s 21; *Manitoba at* ¶¶ 39-45; *Sawatzky* at ¶1; *Golubchuk* at ¶ 1

27. Concerns about the devaluation and vulnerability of persons with disability and those at the end of life and about quality of life assessments made by some doctors about people with disabilities represent significant contextual factors that must inform decisions to impose or to withdraw treatment, particularly at the end of life and without consent.

28. Failure to consider such factors has too often resulted in stereotypical and dehumanizing medicalized perceptions of people with disabilities that are an affront to their human dignity. It has also resulted in terminal treatment decisions.[17]

29. Doctors owe the highest fiduciary duty to their patients that makes unilateral decision-making to impose or withdraw treatment and end the life of the patient improper, unethical and unlawful.[18]

30. The appellants take the position that they do not require consent to propose and implement the withdrawal of life-sustaining treatment and replace it with a palliative plan of care for the patient. They claim they are not bound, for this end of life decision, to respect the statutory principles and processes created to govern the giving and refusing of consent to a plan of treatment.

PART II: FACTS

31. EPC adopts and relies upon the facts as set out in the factum of the respondent but also highlights the following facts:

32. Mr. Rasouli was admitted to the Sunnybrook hospital and underwent surgery to remove a benign brain tumour. Following this, he experienced complications which caused his medical condition to deteriorate.[19]

33. The doctors proposed a plan of treatment which included mechanical ventilation to treat bouts of apnea. These treatments were proposed and deemed to be medically appropriate

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[17] Endicott, Oliver R., "Legalizing Physician – Assisted Death: Can Safeguards Protect the Interests of Vulnerable Person?", July 2000. Prepare under sponsorship of the Canadian Bar Association "Law for the Future Fund" for Council of Canadians with Disabilities ("Endicott") at p. 23-24

[18] *Norberg v. Wynrib*, 1992 CarswellBC 155(SCC) at ¶¶64-66; Endicott at pg. 8

[19] Affidavit of Dr. Cuthbertson at ¶¶ 10-15

as part of Mr. Rasouli's current plan of treatment until a short time prior to this Court application.[20]

34. Prior to implementation of the current plan of treatment, the doctors sought and received consent from the respondent to proceed with the proposed plan of treatment, including with respect to mechanical ventilation.[21]

35. It was open to the doctors to include as part of the proposed plan of treatment a requirement to withhold or withdraw mechanical ventilation. This was not done at the outset of treatment and so no consent was given to the withdrawal of mechanical ventilation at that time. The respondent was not told at that time that the doctors might assert the right to make a unilateral change in the treatment plan without her consent.[22]

36. The doctors subsequently sought consent to remove the mechanical ventilation and reinstate it at various points in time and received that consent from the respondent.[23]

37. The doctor's proposed new plan of treatment includes palliative care and permanent removal of mechanical ventilation.[24]

38. The respondent refused to consent to this newly proposed plan of treatment as she believes that it is not in Mr. Rasouli's best interests and that it is contrary to his wishes, values, beliefs and religious preferences. Only at that time did the doctors assert their right to unilaterally make this decision without consent.[25]

39. As a result of the refusal of consent by the respondent, the doctors indicated that consent was not required to implement their proposed plan of palliative care and to permanently remove mechanical ventilation. The proposed plan of treatment represents a departure

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[20] Affidavit of Dr. Cuthbertson at ¶¶ 11-12, 22 and 43; Affidavit of Dr. Swartz at ¶ 14; Affidavit of Salasel (Feb 10) at ¶34

[21] Affidavit of Salasel (Feb 10) at ¶¶ 37-39; Affidavit of Dr. Cuthbertson at ¶¶ 54 and 56

[22] *Rasouli* at ¶¶ 33-42; Affidavit of Salasel (Feb 10) at ¶ 40

[23] *Rasouli* at ¶¶ 33-42; Affidavit of Dr. Cuthbertson at ¶¶21-23, 43; Affidavit of Dr. Swartz at ¶ 14; Affidavit of Salasel (Feb 10) at ¶¶61-62, 65

[24] *Rasouli* at ¶¶ 33-42; Affidavit of Dr. Cuthbertson at ¶ 8; Affidavit of Blair Henry at ¶ 11; Affidavit of Salasel (Feb 10) at ¶ 66

[25] *Rasouli* at ¶¶ 33-42; Affidavit of Salasel (Feb 10) at ¶¶ 68,70, 86-90, 92-93; Responding Affidavit of Salasel (Feb 13) at ¶37

from the current plan which was proposed as medically appropriate and consented to by the respondent.[26]

40. The doctors stated that they would proceed with the newly proposed plan of palliative care, permanent withdrawal of mechanical ventilation and related treatment without consent unless a restraining order was obtained from the Court. The doctors refused to refer the dispute over consent to the proposed new treatment plan to the Consent and Capacity Board for determination.[27]

41. It is acknowledged by the doctors that Mr. Rasouli will likely die in the event that the proposed treatment plan is implemented. [28]

PART III - ISSUES AND THE LAW

A. Governing Principles of interpretation:

42. It is essential that the terms of the HCCA and the common law are applied in a manner consistent with sections 2, 7 and 15 of the *Charter* and their underlying values. Decisions made by doctors and the Board to unilaterally impose or withdraw treatment ultimately resulting in a patient's death engage Charter values, principles of fundamental justice and due process and the protections enshrined in the HCCA.[29]

43. Given the objectives of the HCCA to promote dignity, autonomy and self-determination in health-care decision-making, it is not appropriate that doctors be the sole gatekeepers of what health-care treatments can be unilaterally imposed or withdrawn from people without due process as the appellants suggest.[30]

44. Permitting doctors to unilaterally impose or withdraw treatments without consent and contrary to a patient's best interests and the HCCA effectively legalizes physician-

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[26] Affidavit of Salsel (Feb 10) at ¶ 38-39, 66-70; Affidavit of Dr. Cuthbertson at ¶ 54 and 56

[27] Affidavit of Salasel (Feb 10) at ¶ 91-93

[28] Affidavit of Dr. Cuthbertson at ¶ 43, 48-49; Affidavit of Dr. Swartz at ¶ 14

[29] *Manitoba at* ¶¶ 97-108; *B.(R.) v. Children's Aid Society of Metropolitan Toronto*, 1995 CarswellOnt 105 (SCC) at ¶¶ 74-78, 107

[30] HCCA s. 1, 10, 11, 21; *B.(R.) v. Children's Aid Society of Metropolitan Toronto* at ¶ 74-78; *M. (A.) v Benes*, 1999 CarswellOnt 3529 (Ont. CA) at ¶ 45-46

imposed death by permitting doctors to unilaterally impose their will, by act or omission, to cause the death of the patient based on their subjective assessment that the patient's life is of insufficient quality or value to warrant continued existence.[31]

45. Efforts to camouflage these choices under the guise of medical futility doctrine and the notion that death is in the patient's best interests are misleading and improper as they disregard the best interests test that must be applied under s.21 of the HCCA in respect of decisions to consent to or refuse treatment.[32]

46. Given economic constraints, an aging population and limited health-care resources, making doctors the sole gatekeepers for the imposition of palliative care and withdrawal of life-supporting treatment could permit medical treatment decisions to be made in a manner contrary to the values and rights set out in the Charter and HCCA without the opportunity to subject such decisions to Charter scrutiny or due process, even where they result in death to the patient.[33]

B. Vulnerability of People with Disabilities

47. The history of people with disabilities in Canada is a history of marginalization, exclusion and social devaluation. At the heart of this history, is the perception of people with disabilities as abnormal, or as existing in tragic and unbearable circumstances because of the nature of their medical conditions. [34]

48. As a consequence of that dehumanizing perception, people with disabilities have been exposed to victimization, discrimination and exclusion from full participation in mainstream Canadian society. They are also often subject to stereotypical assumptions about their quality of life which are contrary to their own views about their life and experiences. [35]

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[31] *Manitoba* at ¶ 144; *Re S.D.* 1983 CarswellBC 6 (BC SC) at ¶¶ 38 - 43; *Rodriguez v. British Columbia*, 1993 CarswellBC 228 (SCC) at ¶¶ 14, 15 & 19; Endicott at pg. 9, ¶ 4

[32] *Manitoba* at ¶ 81; HCCA s. 21; Endicott at pg. 4-7 & 9

[33] *Rasouli* at ¶¶ 84-93;

[34] *Battlefords and District Co-operative Ltd. v. Gibbs*, 1994 CanLii 4550 (SK CA.) at pg.13; *Eldridge v. British Columbia (Attorney General), 1997 CarswellBC 1939 (SCC) at* ¶ 56;

[35] *Battlefords* at pg.12-13; Endicott at pg. 4-7; *R. v. Latimer* 1995 CarswellSask 88 (SK CA) at ¶¶ 74-79;

49. The dehumanization and vulnerability of people with disabilities can have deadly consequences in the health-care setting. The shift within our culture from an ethic of preserving life towards an ethic that emphasizes quality of life and dying has been observed by many as a significant concern for the safety of vulnerable people:

> *There is a strident cry in America to terminate the lives of other people - deemed physically or mentally defective... Assuredly, one test of civilization is its concern with the survival of the unfittest, a reversal of Darwin's formulation... In this case, the court must decide what its ward would choose, if he were in a position to make a sound judgment*[36].

50. EPC submits that negative perceptions of the lives of people with disabilities are pervasive even amongst the most educated and influential within the health-care system as reflected by the following comments by the former Ethics Chair of the Canadian Medical Association.

> *It remains a reality that for many members of our society (and of other societies around the world and down through history) the lives of persons with disabilities continue to be regarded as less valuable than the lives of other persons. Furthermore, this assessment is often reflected in the opinions of academics who hold themselves out as advisors to those who make public policy. For example, University of Victoria ethicist, Professor E.-H. Kluge, described the outcome of the Dawson case as having inflicted upon Stephen "the injury of continued existence".*[37]

51. People with disabilities, including those who are aged and determined to be incapable under the HCCA, are at greater risk of being victimized than non-disabled people. The physical and psychological challenges facing these individuals as a result of their disability, often requires them to be more dependent on caregivers and physicians and thus makes them more vulnerable to abuse.[38]

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[36] *Re S.D.* 1983 CarswellBC 6 (BC SC) at ¶¶ 35-38; Endicott at pg.12 ¶ 1, pg. 36 ¶ 5

[37] Endicott at pg. 10

[38] *Rodriguez* at ¶ 14, 15 & 19; *Re S.D.* [1983] B.C.J. No.38 (BC Supreme Court) at p.9, 11; *Latimer* ¶¶.74-79; Endicott at pg.10-12

C. Protection of Life, Liberty and Security of Vulnerable People

52. The medical profession has historically been as opposed to causing death as the law. The Hippocratic Oath (400 b.c.e.) includes the following vow:

> *"To please no one will I prescribe a deadly drug or give advice which may cause his death".*
> *Historically, however, where an individual was perceived to have a significant disability, both law and medicine have tended to make exceptions to their own life-preserving rules, or at least to be very uncertain about their application.*[39]

53. The Supreme Court of Canada has defined the scope of liberty to include the personal autonomy of individuals to make important decisions affecting their private lives. The HCCA requirement that informed consent be obtained prior to undertaking medical treatment reflects the paramount importance of individual autonomy and liberty to give or refuse consent to treatment according to the individual's wishes, values, beliefs and assessment of their own best interests.[40]

54. The Supreme Court of Canada has indicated that interference with the physical and psychological integrity of an individual represents a breach of security of the person. It is an assault to physically touch a person through medical treatment or its withdrawal without their consent.[41]

55. A doctor's unilateral imposition of palliative care and withdrawal of life-preserving medical treatment without consent and contrary to a patient's wishes, values, beliefs and best interests, represents a clear violation of the physical and psychological integrity of the patient, and the requirements of the HCCA to obtain consent and to act in accordance with a patient's wishes and best interests.[42]

56. Principles of fundamental justice require that when a patient is incapable of expressing their own views that the state must require compelling evidence that withdrawal of

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[39] *Endicott* at p.8, ¶¶ 5-6

[40] HCCA s. 10 & 21; *R. v. Morgentaler*, 1988 CarswellOnt 45 at ¶¶ 285-286,290; *Manitoba* at ¶¶ 39-45, 86, 97-108

[41] Manitoba at ¶¶ 39-45, 81;

[42] HCCA s. 2, 10, 21; *B.(R.) v. Children's Aid Society of Metropolitan Toronto,* 1995 CarswellOnt 105 (SCC) at ¶71-78, 83, 107 *Manitoba* at ¶¶ 153-154; *Morgentaler* at ¶¶ 19-25, 285-286 & 290

treatment is in fact what the patient would have requested had they been competent, or that it is in their best interests as defined by s.21 of the HCCA.[43]

D. Consideration of Patient's Values, Beliefs and Religious Preferences

57. The HCCA requires careful consideration of the values, beliefs and religious preferences of persons on whose behalf decisions with respect to medical treatment are made in assessing their best interests. This assessment should not be undertaken in a formalistic or highly technical manner.[44]

58. Subjugating a person's express religious preferences, values and beliefs and the choices based on them to some other point of view is a threat to individual autonomy, dignity and self-determination which should not be countenanced. Such an approach is contrary to the objectives and test of best interests under the HCCA. It also violates the doctor's ethical obligations to respect patient autonomy.[45]

59. It trivializes a person's religious beliefs, at a time when they would most expect to derive comfort and security from them. Such an approach is contrary to s.21 of the HCCA and Charter values.[46]

60. Madam Justice Wilson in *Morgentaler* stated as follows:

> *"The idea of human dignity finds expression in almost every right and freedom guaranteed in the Charter. Individuals are afforded their right to choose their own religion and their own philosophy of life, the right to choose with whom they will associate and how they will express themselves, the right to choose where they would live and what occupation they will pursue. These are examples of the basic theory underlying the Charter, namely that the state will respect choices made by individuals and to the greatest extent possible, will avoid subordinating these choices to any one conception of the good life."*[47]

61. She further noted in *Jones*:

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[43] HCCA s. 2, 10, 21; *Manitoba* at ¶¶ 97-108 & 144
[44] HCCA s.21; *Manitoba* at ¶ 154
[45] *R. Jones, [1986] 2 S.C.R. 284* at ¶ 61; *Manitoba* at ¶ 153-154
[46] HCCA s. 21; *Manitoba* at ¶ 153-154
[47] *R. v. Morgentaler at* ¶ *288*

> *"I believe that the framers of the Constitution in guaranteeing "liberty" as a fundamental value in a free and democratic society had in mind the freedom of the individual to develop and realize his potential to the full, to plan his own life to suit his own character, to make his own choice for good or ill, to be non-conformist, idiosyncratic and even eccentric - to be in today's parlance, "his own person" and accountable as such. John Stewart Mill described it as "pursuing our own good in our own way." This, he believed, we would be free to do "so long as we do not attempt to deprive others of theirs or impede their efforts to obtain it." He added:*
>
> *Each is the proper guardian of his own health, whether bodily or mental and spiritual. Mankind are greater gainers by suffering each other to live as seems good to themselves than by compelling each to live as seems good to the rest.*[48]

E. The HCCA Statutory Scheme

62. The purpose of the HCCA is to implement a system of rules with respect to consent to treatment that apply consistently in all settings, to enhance the autonomy, dignity and self-determination of incapable persons and to set out a process of substitute decision-making that is respectful of prior express wishes of patients and that enables designated substitute decision-makers to act on prior express wishes, or in the patient's best interests with respect to treatment decisions affecting them.[49]

63. Like *Criminal Code* prohibitions against homicide, failing to provide necessaries of life, counselling or assisting suicide, the HCCA serves as a safeguard to protect against unwanted assisted death, deprivation of dignity and autonomy of vulnerable people.[50]

64. The HCCA requires informed consent before medical treatment can be undertaken and where a substitute decision-maker is required to give or refuse consent to treatment, the substitute decision-maker shall make such decisions to give or refuse consent to treatment in accordance with any known wish applicable to the circumstances that was previously expressed while the patient was capable, and if no such wish is known shall act in the person's best interests. The assessment of best interests under the HCCA is not

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[48] *Jones* at ¶76

[49] HCCA s. 21

[50] Endicott at p. 23-24.

exhaustive and is much broader than mere clinical considerations. It requires analysis of the patient's wishes, values and beliefs. [51]

65. Doctors have a positive obligation to assess the risks, benefits and possible outcomes of a proposed treatment and that assessment should take place at the time the proposal of treatment is made in order to ensure that the substitute decision-maker is in a position to provide informed consent to the proposed treatment.[52]

66. In the event that consent to withdraw treatment is not obtained at the commencement of a proposed plan of treatment, then it must be obtained for a proposed change to that plan of treatment.[53]

67. The appellants suggest that consent is not required because they are not proposing mechanical ventilation as part of a plan of treatment any longer. They completely ignore the fact that the treatment has been proposed as medically appropriate and is ongoing. Now, they are seeking to change the plan of treatment to one of palliative care and the permanent removal of mechanical ventilation. Such a change in the plan of treatment absolutely requires consent according to the HCCA.[54]

68. The appellants further state that end of life decisions are theirs alone, without regard to the patient's prior express wishes, values and beliefs. They deny that the patient's inherent autonomy entitles them to make any contribution to the definition of their own best interests or well-being.[55]

F. The HCCA supersedes and replaces the common law

69. Few common law jurisdictions have a HCCA and a specialized Tribunal charged with the responsibility to resolve disputes over the giving and refusing of consent to treatment including over the withdrawal of treatment at the end of life.

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[51] HCCA s. 10 & 21(1); *Manitoba* at ¶ 81
[52] HCCA s. 2 & 10; *Manitoba* at ¶ 144; *Rasouli* at ¶ 51
[53] HCCA s. 2 & 10
[54] HCCA s. 2 & 10
[55] HCCA s. 21; *Manitoba* at ¶¶ 39-45

70. The enactment of a statute which displaces the common law is not unique. It is very common. Examples include the enactment of wrongful death statutes in the UK which allowed causes of action for wrongful death to be brought by a spouse, child or estate of a deceased.

71. There was no English common law tort of wrongful death. Any jurisdiction that lacked a wrongful death statute precluded plaintiffs from bringing such an action under the common law. Where such a statute existed, the compensation for remedies available were limited to those set out in the statute.

72. Further examples include the enactment of human rights statutes, employment standards statutes and family law statutes to replace and/or supersede common law rules.[56]

73. The Court below properly acknowledged that it must take a purposive approach to the interpretation of the statutory language under the HCCA. This necessarily requires an assessment of the ordinary meaning of the text, the purpose and scheme of the act and the consequences of adopting this meaning as opposed to the plausibility of any modified meaning if it is to be adopted.[57]

74. Legislative sovereignty renders the HCCA paramount over the common law in respect of the giving and refusing of consent to treatment including the withdrawal of treatment which forms part of a plan of treatment.[58]

75. The Legislature expressly included withholding and withdrawal of treatment in the definition of plan of treatment, and turned its mind specifically to treatments not requiring consent and identified only emergency treatment.[59]

76. The Legislature also specifically turned its mind to which aspects of the common law were not modified by the HCCA and identified only the common law duty of a caregiver to restrain a person at risk of serious bodily harm.[60]

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[56] *Machtinger v. HOJ Industries Ltd*; 1992 CarswellOnt 892 (SCC) at ¶23-26
[57] Rasouli at ¶ 25-28
[58] HCCA s. 1, 2, 3, 7, 10, 25, 84; Driedger pg. 297-316
[59] HCCA s. 2, 10 & 25

77. Courts are bound to give effect to the purpose and meaning of legislation, regardless of its impact on the common law. As stated by Martin J. A.:

> *It is true that the legislation is an encroachment on the common-law doctrine....but if it is clear that it was the intention of the Legislature in passing a statute to abrogate the common law, it must give way, and the provisions of the statute must prevail.*[61]

78. The appellants' suggestion that the HCCA seeks to codify the existing common law is incorrect. Were it the case, the Legislature would have reproduced the common law without changing it in respect of consent to the imposition of palliative care or the withdrawal of life support. That is not the purpose or the effect of the HCCA.[62]

> *As the Woelk and Waldick cases emphasize, when legislation is enacted to reform the common law, it is important to analyse carefully the purpose and scope of the intended reform. Because the legislation is meant to operate within an existing framework of established concepts and principles, it must be interpreted with those concepts and principles in mind. But in so far as the legislation is designed to effect specific changes, the weight of past understandings must not be allowed to defeat that purpose.*[63]

79. The HCCA is a comprehensive code that sets out a full statement of the law in respect of consent to treatment and the withdrawal of treatment and puts in place a process by which to resolve disputes in this regard.[64]

80. Once such a code is in place, subsequent elaboration and enforcement of the law must be carried out within the institutional framework contemplated by the code and is governed by principles and policies derived from the code itself.[65]

81. In interpreting the code, concern for the internal coherence of the statute must take precedence over the common law. As much as possible, the policies and values relied on in interpretation are derived from the code itself rather than the common law.[66]

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[60] HCCA s. 1& 7
[61] Driedger pg. 298
[62] HCCA s. 3, 7 & 25; *Manitoba* at ¶¶ 123-126; Dreidger pg. 302;
[63] Driedger pg. 303
[64] HCCA s. 37; *Manitoba* at ¶¶ 123-126
[65] Driedger pg. 303-304
[66] Driedger pg. 304

82. Where legislation introduces a new right or duty and provides a procedure for its enforcement, the Court will not create a new common law remedy or extend existing remedies in a novel way to supplement the statutory regime.[67]

83. The advantages of the HCCA procedures in relation to the Consent and Capacity Board include the requirement of a hearing within seven days, a decision within one a day after a hearing, a specialized Tribunal, the ability for patients to be represented by counsel at hearings and the existence of a legal aid panel to meet this requirement.[68]

84. This dispute resolution process and the fact that treatment must be proposed by a doctor address hospital concerns about hospital ICUs becoming overwhelmed and about patients demanding treatments that doctors do not believe are medically justified including with respect to palliative care and withdrawal of life support.[69]

G. Impact of case law from other jurisdictions

85. Most cases decided in Canada, the USA and the UK have not been subject to the HCCA. As such, their relevance to the case at bar must be critically assessed. Moreover, these cases have not been determined with consideration of Canadian constitutional values as enshrined in the Charter which must necessarily inform both the interpretation of the HCCA and the application of the common law if it is found to apply.

86. In the event that it is determined that the HCCA does not represent a comprehensive code that governs disputes in relation to the proposal of a palliative care treatment plan or the withdrawal of life support, then the common law must be interpreted in a manner that includes and gives effect to the principles established under section 21 of the HCCA in order to assess a patient's best interests in a manner consistent with the HCCA and Charter values.

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[67] Driedger pg. 307-312; *Seneca College of Applied Arts and Technology v. Bhadauria*, 1981 CarswellOnt 17at ¶ 26
[68] HCCA s.37; Rasouli at ¶¶ 47-50
[69] Rasouli at ¶45

H. The purpose of consent

87. Consent is required to implement or withdraw treatment in order to ensure that patients understand the risks, benefits and consequences of the treatment and because of the physical impact of the doctors' conduct which would be an assault in the absence of consent. Consent is not required where a doctor proposes no treatment at first instance, however, where treatment is undertaken, consent is then required to withdraw that treatment or else the doctor's physical contact with the patient to effect the withdrawal would amount to an assault.[70]

88. The requirement of consent meets a number of public interest considerations including protection of patients, reassurance of families, reassurance of the public and ensuring collaboration and oversight relative to terminal medical treatment decisions made by doctors.[71]

89. Contrary to the appellants' assertions, this case is not about the right to be treated. It is fundamentally about the requirement of consent to impose new treatment or to withdraw a treatment which is already underway in order to replace it with a new plan of treatment.[72]

90. To the extent that the common law may apply to these circumstances, the common law standard of care has been modified by the enactment by the HCCA and establishment of the Consent and Capacity Board.

91. The appellants assert that there is no requirement to make application before the Consent and Capacity Board, although, they claim that doctors have the discretion to do so.

92. Doctors must be subject to oversight with respect to decisions to unilaterally impose palliative care and to withdraw life support. The HCCA indicates that the Board has jurisdiction over such disputes. If not, then Courts must fill this role. To the extent that

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[70] Rasouli at ¶¶ 80-81
[71] Rasouli at ¶ 79
[72] Rasouli at ¶10

the concept of a standard of care is relevant in this context, EPC submits that the HCCA reflects the appropriate standard of care in relation to decisions to withdraw life-sustaining treatment by requiring doctors to apply to the Consent and Capacity Board where consent is refused and particularly where death of the patient is the anticipated outcome.[73]

93. There are many disadvantages with court oversight at first instance. First, the Court process is untimely, expensive and puts the burden on the patient, family or substitute decision-maker to initiate the application at their own cost. The Court does not offer counsel to the patient which is available as a matter of right under the HCCA.[74]

L. Doctors owe a fiduciary duty to patients

94. Doctor's owe the highest fiduciary duty to their patients that makes unilateral decision-making to impose palliative care and withdraw treatment and to end the life of the patient improper, unethical and unlawful.

95. In Norberg, the Supreme Court of Canada concluded as follows:

> *The doctor-patient relationship can be conceptualized as a creature of contract or of tort but its most fundamental characteristic, rooted in the trust inherent in the relationship, is its fiduciary nature. The foundation and ambit of the fiduciary obligation are conceptually distinct from the foundation and ambit of contract and tort... The essence of a fiduciary relationship, by contrast, is that one party exercises power on behalf of another and pledges himself or herself to act in the best interests of the other. When breach occurs, the balance favours the person wronged.*[75]

96. This duty imposes upon doctors an obligation to act in the utmost good faith in the discharge of their obligations to patients including in their full disclosure of the possible benefits, risks and consequences of treatment and its withdrawal and in ensuring that patients and substitute decision-makers are afforded the information required in order to make decisions based on truly informed consent.[76]

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[73] Rasouli at ¶¶ 50, 78-83

[74] HCCA at s. 5

[75] *Norberg* at ¶64-66

[76] Manitoba *at* ¶ 144

97. The appellants' position on this appeal is fundamentally at odds with the fiduciary obligations owed by doctors to their patients.

> *Human beings are perhaps never more frightening than when they are convinced beyond doubt that they are right.*[77]
>
> *It may also be necessary to hang a man or pull down a house. But we take good care not to make the hangman and the housebreaker the judges of that. If we did, no man's neck would be safe and no man's house stable. But we do make the doctor the judge, and fine him anything from sixpence to several hundred guineas if he decides in our favor.*[78]

The HCCA helps to address these problems.

Part IV Conclusion

98. EPC submits that the appeal should be dismissed as doctors do not have the unilateral authority to impose palliative care treatment and withdraw life-sustaining treatment without consent, without regard to the HCCA and in a manner contrary to a patient's best interests. Such conduct amounts to physician-imposed death of the patient without due process.

99. If the Appellants' assertions are given effect, the result will be the erosion of two principles fundamental to our society; equal access to medical care and speedy access to justice. Only patients whose substitute decision-makers have the resources to seek an injunction will be treated fairly.

Hugh Scher, Mark Handelman & Caroline Schulz

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[77] Laurens Van der Post *The Lost World of the Kalahari*

[78] George Bernard Shaw *The Doctor's Dilemma*

SCHEDULE "A"

CASE LAW

1. *B. (R.) v. Children's Aid Society of Metropolitan Toronto*, 1995 CarswellOnt 105 (SCC)
2. *Battlefords and District Co-operative Ltd. v. Gibbs*, 1994 CanLii 4550 (SCC.)
3. *C.D. (Re)*, 2007 CanLii 32892 (ON C.C.B)
4. *Eldridge v. British Columbia (Attorney General)*, 1997 CarswellBC 1939 (SCC)
5. *M. (A.) v Benes*, 1999 CarswellOnt 3529 (Ont. CA)
6. *Machtinger v. HOJ Industries Ltd*, 1992 CarswellOnt 892 (SCC)
7. *Manitoba (Director of Child & Family Services) v. C.(A.)* 2009 CarswellMan 293 (SCC)
8. *Norberg v. Wynrib*, 1992 CarswellBC 155 (SCC)
9. *Pepsi-Cola Canada Beverages (West) Ltd. v. R.W.D.S.U., Local 558*, 2002 CarswellSask 22 (SCC)
10. *R v. Jones*, [1986] 2.S.C.R. 284 (SCC)
11. *R. v. Latimer*, 1995 CarswellSask 88, (Sask – CA)
12. *R. v. Morgentaler*, 1988 CarswellOnt 45, (SCC)
13. *R. v. Salituro*, 1991 CarswellOnt 124, (SCC)
14. *Rasouli (Litigation Guardian of) v. Sunnybrook Health Sciences Centre*, 2011 CarswellsONt 1650 (SCJ)
15. *Re S.D.* 1983 CarswellBC 6 (BC SC)
16. *Rodriguez v. British Columbia*, 1993 CarswellBC 228 (SCC)
17. *Scardoni et al. v. Hawryluck*, 2004 Carswell ONT 424 (SCJ)
18. *Seneca College of Applied Arts & Technology v. Bhadauria*, 1981 CarswellOnt 117, (SCC)
19. *W.(D), Re* (2004) CanLii 56526 (Ont. CCB)

TEXT

20. Sullivan, Ruth. Driedger on the Construction of Statues (3rd Edition) Toronto: Butterworths, 1994. Pg. 297-316

ARTICLES

21. Endicott, Oliver R., “Legalizing Physician – Assisted Death: Can Safeguards Protect the Interests of Vulnerable Person?”, July 2000. Prepare under sponsorship of the Canadian Bar Association “Law for the Future Fund” for Council of Canadians with Disabilities at p. 23-24

SCHEDULE "B"
Relevant Statutes

Health Care Consent Act, 1996
S.O. 1996, CHAPTER 2
Schedule 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).

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. 1996, c. 2, Sched. A, s. 3 (1).

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. 1996, c. 2, Sched. A, s. 3 (2).

Wishes

5. (1) A person may, while capable, express wishes with respect to treatment, admission to a care facility or a personal assistance service. 1996, c. 2, Sched. A, s. 5 (1).

Manner of expression

(2) Wishes may be expressed in a power of attorney, in a form prescribed by the regulations, in any other written form, orally or in any other manner. 1996, c. 2, Sched. A, s. 5 (2).

Later wishes prevail

(3) Later wishes expressed while capable prevail over earlier wishes. 1996, c. 2, Sched. A, s. 5 (3).

Restraint, confinement

7. This Act does not affect the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others. 1996, c. 2, Sched. A, s. 7.

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).

Elements of consent

11. (1) The following are the elements required for consent to treatment:

1. The consent must relate to the treatment.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not be obtained through misrepresentation or fraud. 1996, c. 2, Sched. A, s. 11 (1).

Informed consent

(2) A consent to treatment is informed if, before giving it,

(a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and

(b) the person received responses to his or her requests for additional information about those matters. 1996, c. 2, Sched. A, s. 11 (2).

Same

(3) The matters referred to in subsection (2) are:

1. The nature of the treatment.
2. The expected benefits of the treatment.
3. The material risks of the treatment.
4. The material side effects of the treatment.
5. Alternative courses of action.
6. The likely consequences of not having the treatment. 1996, c. 2, Sched. A, s. 11 (3).

Express or implied

(4) Consent to treatment may be express or implied. 1996, c. 2, Sched. A, s. 11 (4)

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. 1996, c. 2, Sched. A, s. 21 (2).

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. 1996, c. 2, Sched. A, s. 25 (1).

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. 1996, c. 2, Sched. A, s. 25 (2).

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. 1996, c. 2, Sched. A, s. 25 (3).

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. 1996, c. 2, Sched. A, s. 25 (4).

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. 1996, c. 2, Sched. A, s. 25 (5).

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. 1996, c. 2, Sched. A, s. 25 (6).

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. 1996, c. 2, Sched. A, s. 25 (7).

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. 1996, c. 2, Sched. A, s. 25 (8).

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. 1996, c. 2, Sched. A, s. 25 (9).

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. 1996, c. 2, Sched. A, s. 37 (1).

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. 1996, c. 2, Sched. A, s. 37 (2).

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. 1996, c. 2, Sched. A, s. 37 (3).

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. 1996, c. 2, Sched. A, s. 37 (4).

Time for compliance

(5) The Board shall specify the time within which its directions must be complied with. 1996, c. 2, Sched. A, s. 37 (5).

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). 1996, c. 2, Sched. A, s. 37 (6).

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. 2000, c. 9, s. 35.

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. 2000, c. 9, s. 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. 2000, c. 9, s. 35.

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. 1996, c. 2, Sched. A, s. 37 (7).

Deemed application concerning capacity

37.1 An application to the Board under section 33, 34, 35, 36 or 37 shall be deemed to include an application to the Board under section 32 with respect to the person's capacity to consent to treatment proposed by a health practitioner unless the person's capacity to consent to such treatment has been determined by the Board within the previous six months. 2000, c. 9, s. 36.

Application hearings

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. 1996, c. 2, Sched. A, s. 75 (1).

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. 1996, c. 2, Sched. A, s. 75 (2).

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. 2010, c. 1, Sched. 9, s. 1.

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. 2006, c. 21, Sched. C, s. 111 (2).

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). 2006, c. 21, Sched. C, s. 111 (2); 2009, c. 33, Sched. 18, s. 10 (2).

Notice of right to request reasons

(5) The Board shall advise all parties to the application that each party has a right to request reasons for the Board's decision. 1996, c. 2, Sched. A, s. 75 (5).

Method of sending decision and reasons

(6) Despite subsection 18 (1) of the *Statutory Powers Procedure Act*, the Board shall send the copy of the decision and, if reasons are required to be issued under subsection (4), the copy of the reasons,

(a) by electronic transmission;

(b) by telephone transmission of a facsimile; or

(c) by some other method that allows proof of receipt, in accordance with the tribunal's rules made under section 25.1 of the *Statutory Powers Procedure Act*. 1996, c. 2, Sched. A, s. 75 (6).

Deemed day of receipt

(7) Despite subsection 18 (3) of the *Statutory Powers Procedure Act*, if the copy is sent by electronic transmission or by telephone transmission of a facsimile, it shall be deemed to be received on the day that it was sent, unless that day is a holiday, in which case the copy shall be deemed to be received on the next day that is not a holiday. 1996, c. 2, Sched. A, s. 75 (7).

Exception

(8) If a party that acts in good faith does not, through absence, accident, illness or other cause beyond the party's control, receive the copy until a date that is later than the deemed day of receipt, the actual date of receipt governs. 1996, c. 2, Sched. A, s. 75 (8).

Meaning of "business day"

(9) In subsection (4),

"business day" means any day other than Saturday or a holiday. 1996, c. 2, Sched. A, s. 75 (9).

Offence: decision contrary to wishes

84. (1) A person who knowingly contravenes paragraph 1 of subsection 21 (1), paragraph 1 of subsection 42 (1) or paragraph 1 of subsection 59 (1) is guilty of an offence and is liable, on conviction, to a fine not exceeding $10,000. 1996, c. 2, Sched. A, s. 84 (1).

Exception

(2) Subsection (1) does not apply if the person acts in accordance with permission given under section 36, 53 or 68 or in accordance with directions given under section 35, 37, 52, 54, 67 or 69. 1996, c. 2, Sched. A, s. 84 (2).

Regulations

85. (1)The Lieutenant Governor in Council may make regulations,

(a) prescribing facilities as care facilities for the purpose of clause (b) of the definition of "care facility" in subsection 2 (1) and providing transitional rules for the application of the Act to such facilities;

(f) prescribing things that do not constitute treatment for the purpose of the definition of "treatment" in subsection 2 (1);

(g) prescribing excluded acts for the purpose of clause 3 (1) (b);

United Nations. Convention on the Rights of Persons with Disabilities.
New York, 13 December 2006

Article 1 – Purpose:

The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Article 17 – Protecting the integrity of the person:

Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others

Article 25 – Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

a. Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

d. Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

f. Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

Court of Appeal No.: C53442

HASSAN RASOULI ET AL
Plaintiff

v.

SUNNYBROOK HEALTH SCIENCES CENTRE ET AL.
Defendant

ONTARIO

SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED
AT TORONTO

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