S.C.C. No.

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

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)

\- and -

THE CONSENT AND CAPACITY BOARD

Intervener

NOTICE OF APPLICATION FOR LEAVE TO APPEAL
(Pursuant to Section 40(1) of the *Supreme Court* Act and
Rule 25 of the *Rules of the Supreme Court of* Canada)

TAKE NOTICE THAT DR. BRIAN CUTHBERTSON and DR. GORDON RUBENFELD (the "Applicant Physicians") hereby apply for leave to appeal to the Court, pursuant to Sections 40(1), 40(2), and 58(1)(a) of the *Supreme Court Act,* R.S.C. 1985, c. S-26 as amended and Rule 25 of the *Rules of the Supreme Court of Canada*, SOR\2002-156 as amended, from the Order of the Court of Appeal for Ontario dated June 29, 2011;

AND FURTHER TAKE NOTICE that this Application for Leave to Appeal is made on the following grounds:

1. The Respondent, Hassan Rasouli is a patient being cared for in the Critical Care Unit at Sunnybrook Health Sciences Centre, where he is receiving life support. Mr. Rasouli is in a persistent vegetative state, which is a state of complete and irreversible unconsciousness.

2. All of the doctors who have treated Mr. Rasouli have concluded that he is receiving no medical benefit from being kept alive on life support, and that it should be withdrawn. His wife and substitute decision maker, Parichehr Salasel, disagrees.

3. The court below erred in holding that the applicants cannot, without consent, withdraw treatment that they have concluded offers no medical benefit.

4. The proposed appeal raises the following questions of law, which are of public importance:

   (a) Is there a special category of medical decisions taken at the end of a patient's life to which established medical standards of care do not apply?

   (b) Is patient consent required under any circumstances to the withholding or withdrawal of treatment that the patient's doctor is not prepared to offer (or to continue to offer)?

   (c) Is a patient's right to personal autonomy engaged by a decision to withhold or withdraw life support or other measures required to sustain life when death is otherwise imminent?

   (d) If life support or similar measures can legally be withheld or withdrawn, what process must first be followed by doctors and what redress is available to patients or SDMs in the event of a conflict?

5. These questions are of vital concern to the medical profession, to patients and to their families. They also have importance to the public generally since they engage fundamental values.

6. There are also implications for the public interest insofar as they bear upon the allocation of scarce medical resources in the Canadian medical system.

7. The question of whether doctors should be ordered to continue to provide life sustaining treatment has been considered repeatedly by lower levels of Canadian courts and can be expected, with Canada's aging population, to arise frequently in the future.

8. Canadian decisions dealing with these issues are frequently internally inconsistent, as well as inconsistent with one another. There is a great need for guidance from this Court.

9. These questions often arise in urgent circumstances and must be determined on an injunction application, which is unsatisfactory, particularly when the law is unsettled.

10. Every province except New Brunswick has legislation that requires consent to treatment or health care, or requires doctors to comply with a patient's advance directives or the decisions of their substitute decision makers respecting health care. Therefore, the questions could arise and already have arisen across the country.

11. The Honourable Justices of the Ontario Court of Appeal for Ontario (the "Court of Appeal") erred in law in dismissing the appeal of the Applicant Physicians from the order of the Honourable Madam Justice Himel dated March 9, 2011. These errors include:

(a) The Court of Appeal erred in holding that the *Health Care Consent Act, 1996*, SO 1996, c 2, Sch A (the “Act”) changed the common law of consent to treatment;

(b) The Court of Appeal erred in adopting an unreasonable interpretation of the Act, an interpretation that would require physicians to breach the applicable medical standard of care;

(c) The Court of Appeal misapplied the law of informed consent in order to confer upon patients a right to insist upon the continuation of a particular treatment when the medical standard of care requires it to be withdrawn;

12. The issues raised in this proposed appeal have not been previously addressed by this Court, and are of a nature and significance as to warrant a decision by this Court.

DATED at Toronto this 2nd day of August, 2011

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NOTICE TO THE RESPONDENT: A respondent may serve and file a memorandum in response to this application for leave to appeal within 30 days after service of the application. If no response is filed within that time, the Registrar will submit this application for leave to appeal to the Court for consideration pursuant to section 43 of the *Supreme Court Act*.

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APPLICANTS' MEMORANDUM OF ARGUMENT ON APPLICATION FOR LEAVE TO APPEAL

PART I—STATEMENT OF FACTS

1. This is a case that engages the all-important issue of the obligation to provide care having no medical benefit. It is an issue of unquestionable and pressing national importance on which there are conflicting Canadian decisions many of which are inconsistent with the line of authority found in other common-law jurisdictions.

2. Specifically, this case raises an important and unresolved question about consent to medical treatment – namely, whether consent is required to withdraw or withhold medical treatment that provides no medical benefit to a patient. The applicants' position is that consent in such circumstances is not required even if the patient will die when the treatment is withdrawn or withheld. The respondents, Hassan Rasouli through his wife and substitute decision maker (SDM), Parichehr Salasel, assert that consent is required, and she refuses to provide that consent. The Ontario Superior Court of Justice and Ontario Court of Appeal agreed with the respondents' position.

3. Hassan Rasouli is a patient in the Critical Care Unit of Sunnybrook Health Sciences Centre. He is currently alive only because he is receiving mechanical ventilation and artificial nutrition and hydration provided through a tube inserted into his stomach. The many doctors who have treated Mr. Rasouli have concluded that he is receiving no medical benefit from being kept on life support, and that it should be withdrawn. His wife and substitute decision maker, Parichehr Salasel, disagrees.[1]

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[1] Court of Appeal decision, Application Record, Tab 6, paragraphs 4-6.

4. Mr. Rasouli was diagnosed in October 2010 as being in a persistent vegetative state, a state of complete and irreversible unconsciousness. This arose from a post-operative infection, bacterial meningitis, which resulted in permanent, severe and diffuse brain damage.[2]

5. In the face of the impasse between Mr. Rasouli's doctors and his wife as to whether life support provided any medical benefit and should continue, the parties turned to the court for assistance. Ms Salasel applied to the Superior Court of Justice for various forms of relief, including:

(a) An order restraining the applicants from implementing the proposed changes to Mr. Rasouli's current treatment plan without first obtaining her consent; and

(b) An order requiring the applicants to refer their treatment proposal to the Consent and Capacity Board should they persist in challenging Ms. Salasel's authority to reject it on Mr. Rasouli's behalf as being contrary to his best interests.[3]

6. The applicants cross-applied to the court for various forms of relief, including:

(a) A declaration that Mr. Rasouli is in a persistent vegetative state;

(b) A declaration that they can lawfully withdraw and/or withhold the life-sustaining treatment that he is presently receiving and provide him instead with palliative care;

(c) A declaration that they do not need Ms. Salasel's consent, either at common law or under the *Health Care Consent Act*, *1996*, S.O. 1996, c.2, Sch. A, to proceed with the treatment plan they have proposed; and

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[2] Court of Appeal decision, Application Record, Tab 6, paragraphs 2-3.

[3] Court of Appeal decision, Application Record, Tab 6, paragraph 7.

(d) A declaration that the Consent and Capacity Board has no jurisdiction to decide whether they can proceed with their proposed treatment plan.[4]

7. The application judge, Himel, J., found that consent was required to withdraw life support, in this case, mechanical ventilation. Relying on the *Health Care Consent Act, 1996* (the "Act") she reasoned that the withdrawal of life support requires the consent of a patient or substitute decision-maker ("SDM") because life support is, by the medical definition, treatment; its withdrawal is therefore a withdrawal of treatment; the withdrawal of treatment is included within the definition of "plan of treatment" contained in the Act; "plan of treatment" is included in the statutory definition of "treatment"; and "treatment" requires consent under the Act.[5]

8. The applicants' appeal from the decision of Himel, J. was dismissed. The Court of Appeal held that the withdrawal of mechanical ventilation followed by the administration of palliative care would constitute "treatment" under the Act, for which the SDM's consent is required.[6]

9. While the Court of Appeal dismissed the appeal it did so for different reasons than Himel, J. The Court of Appeal accepted that neither the withholding of treatment nor the withdrawal of treatment, taken alone, requires consent. According to the Court of Appeal, only treatment that is offered by a doctor requires consent. However, it found that the withdrawal of life support leading imminently to death is active treatment when the attending doctors propose, along with the removal of life support, to provide palliative care to the patient pending death.

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[4] Court of Appeal decision, Application Record, Tab 6, paragraph 8.

[5] Court of Appeal decision, Application Record, Tab 6, paragraphs 9-10, 37-38.

[6] Court of Appeal decision, Application Record, Tab 6, paragraph 47.

10. The Court of Appeal correctly found that palliative care is "treatment" requiring consent. However, it went on to find that because the removal of the ventilator triggers the administration of palliative care in light of the patient's imminent death, the two are "integrally linked", and should be viewed for the purposes of the Act as a "treatment package". Since end of life palliative care includes the withdrawal of life support measures, which must be terminated before palliative care can begin and palliative care requires consent, the applicants are obliged to obtain the SDM's consent to the entire "treatment package" before withdrawing mechanical ventilation.[7]

11. The Court of Appeal left undecided the question of whether the continuation of life support is futile in Mr. Rasouli's case. It found that it did not have to decide that issue.[8]

12. The Court of Appeal suggested its approach addressed the applicants' criticism of Himel, J.'s interpretation of the Act. Broadly speaking, her interpretation would allow patients to pick and choose the treatment they are to receive regardless of medical indications because, by withholding consent, patients could prevent the withdrawal of treatment. And this problem would apply not just at the end of their lives but at any time.[9]

13. It was the applicants' position that Himel, J. erred because "treatment" under the Act does not include the withholding or withdrawal of treatment that has no medical value and which therefore a doctor is not prepared to offer to the patient. In particular, life support is not

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[7] Court of Appeal decision, Application Record, Tab 6, paragraphs 48, 50-51, 58.

[8] Court of Appeal decision, Application Record, Tab 6, paragraph 46.

[9] Court of Appeal decision, Application Record, Tab 6, paragraphs 11-16.

treatment when it is futile and when the doctors propose not to continue to provide it. Hence the patient's consent to its withdrawal is not required.[10]

14. As the Court of Appeal noted, it was not the applicants' position that doctors can withhold or withdraw treatment as they see fit, with no risk of legal consequences. On the contrary, doctors must act in accordance with the standard of care, and if it is found that their decision to withhold or withdraw treatment falls below the requisite standard of care, they can be held accountable.[11]

15. The Court of Appeal acknowledged the applicants' concerns, as just outlined, to be serious and warranting careful consideration. For the purposes of its decision, it was prepared to accept that the Act does not require consent to withhold or withdraw "treatment" that doctors view as medically ineffective. Had the legislature so intended, it said, the court would have expected to see clearer language to that effect. The court asserted that its own approach, by implicit contrast with that of the court below, addressed "head on" the concerns of the applicants, and that it "largely" avoided them. [12]

16. In an apparent response to the applicants' concerns, the court noted that its approach did not affect a doctor's discretion to <u>withhold</u> treatment altogether. It observed that when doctors <u>withhold</u> life support, because it is futile, and provide palliative care only, the two cannot be said to be integrally linked because there is "nothing to transfer from" before moving from one to the other.[13]

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[10] Court of Appeal decision, Application Record, Tab 6, paragraphs 14, 39, 40, 42.

[11] Court of Appeal decision, Application Record, Tab 6, paragraphs 12, 43.

[12] Court of Appeal decision, Application Record, Tab 6, paragraphs 16, 17, 41, 46, 54.

[13] Court of Appeal decision, Application Record, Tab 6, paragraphs 55-56.

17. The court also appears to have considered that its approach will not prevent doctors from <u>withdrawing</u> other forms of treatment apart from life support. It distinguished life support from other cases where active treatment is <u>withdrawn</u>, because futile, but death is not imminent. It instanced the discontinuation of chemotherapy where not benefiting the patient, saying this:

> Unlike the situation that exists when life support measures are withdrawn, there will generally be a gap between the withdrawal of chemotherapy and the end-of-life palliative care phase. Ending chemotherapy does not spell the patient's imminent death – and it does not trigger a requirement for a particular form of palliative care.[14]

18. In the result, the Ontario Court of Appeal concluded that consent is not required to the withholding of medical treatment that is considered not to offer any medical benefit. Further, it held that consent is not required to the withdrawal of medical treatment that is considered not to offer any medical benefit <u>**unless** death will result imminently from the withdrawal and another form of treatment requiring consent is instituted when the other medical treatment is withdrawn.</u>

PART II—QUESTIONS IN ISSUE

19. The proposed appeal raises the following questions of law, which are of public importance:

(a) Is there a special category of medical decisions taken at the end of a patient's life to which established medical standards of care do not apply?

(b) Is patient consent required under any circumstances to the withholding or withdrawal of treatment that the patient's doctor is not prepared to offer (or to continue to offer)?

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[14] Court of Appeal decision, Application Record, Tab 6, paragraph 53.

(c) Is a patient's right to personal autonomy engaged by a decision to withhold or withdraw life support or other measures required to sustain life when death is otherwise imminent?

(d) If life support or similar measures can legally be withheld or withdrawn, what process must first be followed by doctors and what redress is available to patients or SDMs in the event of a conflict?

PART III—ARGUMENT

20. In finding that, in certain circumstances, life support cannot be withdrawn without patient consent, the Court of Appeal misapplied the law of informed consent to confer upon patients a right to insist upon a particular treatment even though the medical standard of care would require it to be withdrawn.

21. The law of informed consent is irrelevant to the question of when doctors may withdraw life support or other treatment. The law of informed consent, whether statutory or common law, has as its sole purpose ensuring that active treatment is not administered without the patient's consent. It is a right to refuse treatment, not a right to require treatment. As was once succinctly observed by Lord Donaldson, M.R.:

> [C]onsent by itself creates no obligation to treat. It is merely a key which unlocks a door.[15]

22. Thus, in a case that applied the common law, the English Court of Appeal held that a patient's undoubted right of self-determination does not entitle him or her to insist on receiving a particular medical treatment of any type. The court endorsed the proposition that the doctor, exercising his or her professional clinical judgment, decides what treatment options are clinically

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[15] *Re R*, [1991] 4 All E.R. 177 at 184, Book of Authorities, Tab 1.

indicated, i.e., will provide a clinical benefit for the patient. The doctor offers those treatment options to the patient, and the patient decides whether or not to accept them. If the patient requests a form of treatment that the doctor concludes is not clinically indicated, the doctor has no legal obligation to provide it. Thus, treating a patient in a manner that the doctor considers to be medically appropriate may conflict with the patient's own wishes.[16]

23. Nothing in the Act suggests that it was intended to change the common law. Nor did the respondents show, in the courts below, that there is any apparent mischief that the Act was enacted to remedy. The Act simply codifies the common law as it relates to consent to treatment, and it also provides for a regime under which an SDM can provide consent on behalf of an incapable person.

24. Key provisions of the Act, such as s. 10 (the section that requires consent to "treatment"), as well as the definition of "treatment" itself, show that the obligation to obtain consent is predicated upon the offer of treatment by a doctor and a therapeutic purpose to the proposed treatment.[17] The Court of Appeal accepted that this was so (although its disposition incongruously ignores the fact).

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[16] *R. (on the Application of Burke) v. The General Medical Council,* [2005] E.W.C.A. Civ 1003, at paragraphs 31, 50, 55, Book of Authorities, Tab 2.

[17] Section 10(1) of the Act provides as follows:

> A health practitioner <u>who proposes a treatment</u> 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. [Emphasis added.]

"Treatment" is defined in s. 2(1) of the Act as follows:

> "Treatment" means <u>anything that is done for a</u> therapeutic, preventive, palliative, diagnostic, cosmetic or other <u>health-related purpose</u>, and includes a course of treatment, plan of treatment…. [Emphasis added.]

25. While it rejected Himel, J.'s approach to the interpretation of the Act, the Court of Appeal still purported to apply the Act in reaching its conclusion. The court, however, failed to explain how the provisions of the Act led it to its conclusion.

26. As previously noted, the court imposed a new duty on doctors to provide life support to patients on demand provided only that three conditions are met: the patient is already receiving life support; if it is discontinued, death will result imminently; and pending death palliative care will be provided instead. It follows from this duty that doctors are not permitted to refuse to continue life support regardless of the fact that it can do no benefit and will do harm.

27. There is no discernible principled basis for the adoption of the new duty. The duty does not arise from the provisions of the Act itself. Instead it follows from the court's adoption of the concept of a "treatment package". Nothing in the Act, as interpreted by the Court of Appeal, requires or even suggests this approach. To the contrary, it is one that is inconsistent both with the general purpose of the Act and with its specific provisions. The result achieved is pure judicial law-making.

28. Notably, the second condition (that death will result imminently) has been tacked on to avoid the absurdity which, the court recognized, would otherwise follow. The potential absurdity is the proposition, clearly unintended by the Act, that the patient has the right to treatment of his own choosing in any circumstance where the doctor purposes to discontinue one treatment and institute another. For example, if, after the failure of a trial of chemotherapy, the doctor were to propose radiation therapy instead, it would be unacceptable to say that the patient could require the doctor to continue to provide the chemotherapy by withholding consent to the institution of radiation. In order to cover off cases like this, the court adopted the rule that so long as there is a

"gap" in time between withdrawing treatment and death, consent to the withdrawal is not required.[18] It assumed, without the benefit of any evidence, that upon the discontinuation of chemotherapy death will not be imminent.

29. The Court of Appeal's decision is inconsistent with the Act for the following reasons:

(a) "Treatment" implies therapeutic value – life support has none for Mr. Rasouli, and a requirement for consent to its withdrawal therefore cannot have been intended under any circumstances.

(b) The Act treats withholding and withdrawal of treatment identically and does not permit a distinction to be drawn between them as the Court of Appeal and Himel, J. both did.[19]

(c) The Act does not distinguish between medical decisions made when a patient's death is imminent and those made at any other time of life. The stated policy of the Act is to provide rules that apply to all settings.[20]

(d) The Act does not state or contemplate that a withdrawal of treatment and the active treatment that replaces the treatment withdrawn are "integrally linked". This concept is not found in the Act.

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[18] Court of Appeal decision, Application Record, Tab 6 at paragraph 53.

[19] The two terms are referred to only in the definition of "plan of treatment" in s. 2(1) of the Act, which is as follows:

> "plan of treatment" means a plan that,
>
> (a) is developed by one or more health practitioners,
>
> (b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and
>
> (c) provides for the administration to the person of various treatments or courses of treatment <u>and may, in addition, provide for the withholding or withdrawal of treatment</u> in light of the person's current health condition. [Emphasis added.]

[20] Section 1(a) states, as being one of the purposes of the Act, "to provide rules with respect to consent to treatment that apply consistently in all settings".

30. The Court of Appeal should have held that if, on policy grounds, end of life decisions deserve special treatment, that requires an amendment of the Act or the formulation by the court of a distinct duty of care requiring doctors to provide life support to patients in a persistent vegetative state. Yet the court found that it was unnecessary for it to address the common law.[21] As a result, the court never turned its mind to the question whether it is a defensible proposition ever to require doctors to provide futile care.

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

32. In the leading case of *Airedale NHS Trust v. Bland*,[22] the House of Lords properly framed the question as being whether doctors have a legal duty to keep a patient alive in that condition. This required a consideration of duties arising under the criminal law and under the medical standard of care. In the result, it was held lawful for doctors to cease providing medical treatment to a PVS patient although it was known that shortly thereafter the patient would die.

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

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[21] Court of Appeal decision, Application Record, Tab 6, paragraph 36.

[22] [1993] A.C. 789 at 866, 868-869, Book of Authorities, Tab 3.

34. The approach adopted in this and many other English cases – that the decision is to turn on the benefit to the patient – is consistent with the decisions of courts in other countries, apart from Canada, which have similar legal systems.[23]

35. There are also Canadian cases that take the same approach, including the only other appellate decision on informed consent in the context of end of life decisions, *Child and Family Services of Central Manitoba v. L.(R.),* [1997] M.J. No. 568 (Man. C.A.).[24] In that case, the court considered whether a doctor required either consent or a court order to issue a non-resuscitation order where the infant patient was in a PVS. Twaddle, J.A. said, at para. 17:

> Whether or not such a direction should be issued is a judgment call for the doctor to make having regard to the patient's history and condition and the doctor's evaluation of hopelessness of the case. The wishes of the patient's family or guardian should be taken into account, but neither their consent nor the approval of a court is required.[25]

36. The medical standard of care in Ontario mirrors these common law principles. It is expressed in the relevant policy of the College of Physicians and Surgeons, which is entitled "Decision-Making for the End of Life". The policy sets out objective criteria for doctors to apply in determining whether to offer life support. It stipulates that doctors are not obliged to provide treatments that will almost certainly not be a benefit to the patient, either because the underlying illness or disease makes recovery or improvement virtually unprecedented, or

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[23] *Auckland Area Health Board v. Attorney General*, [1993] 1 NZLR 235 (High Court), Book of Authorities, Tab 4; *Clarke v. Hurst*, 1992 (4) SA 630, Book of Authorities, Tab 5; *Law Hospital NHS Trust v. Lord Advocate (No. 2)* 1996 S.L.T. 869 (Outer House), Book of Authorities, Tab 6; Thaddeus Mason Pope, "Involuntary Passive Euthanasia in U.S. Courts: Reassessing the Judicial Treatment of Medical Futility Cases", 2008 9 Marquette Elder's Advisor 229, Book of Authorities, Tab 7.

[24] Book of Authorities, Tab 8.

[25] See also: *Children's Aid Society of Ottawa–Carleton v. M.C.,* [2008] O.J. No. 3795 (S.C.J.) Book of Authorities, Tab 9; *Rotaru v. Vancouver General Hospital Intensive Care Unit,* [2008] B.C.J. No. 456 (B.C.S.C.), Book of Authorities, Tab 10; *Re L.I.C.,* 2006 ABQB 130, Book of Authorities, Tab 11; *Re I.H.V. Estate*, [2008] AJ No. 545 (Q.B.), Book of Authorities, Tab 12; Ellen Picard and Gerald Robertson, *Legal Liability of Doctors and, Hospitals in Canada* (4th ed. 2007), at 345-346, Book of Authorities, Tab 13.

because the patient will be unable to experience any permanent benefit. Both those conditions apply to Mr. Rasouli in his present and continuing circumstances.[26]

37. The Court of Appeal's decision is inconsistent with medical practice and mandates a breach of the standard of care as expressed in the CPSO policy in that:

(a) It requires that doctors obtain consent to the withdrawal of medically inappropriate treatment under certain circumstances and thus obliges them to provide such treatment if consent is withheld.

(b) It gives a different legal effect to a withholding of treatment (never requiring consent) than to a withdrawal of treatment (sometimes requiring consent).

(c) It creates, within the law of informed consent, a special category of medical decisions made in imminence of death.

(d) It creates, within the law of informed consent, the concept of "integrally linked" medical decisions to withdraw treatment and to provide some other form of treatment.

(e) It treats palliative care as provided only in substitution for active care.

(f) It misconceives the purpose of critical care medicine by failing to understand that critical care medicine is used as an adjunct in the treatment of <u>reversible</u> illness.

38. These propositions and those in the paragraphs that follow, are supported by and elaborated upon, *passim*, in the affidavits filed in support of this application from Dr. John Granton, current president of the Canadian Critical Care Society, Dr. Laura Hawryluck, a practising critical care physician and Arthur Schafer, a bioethicist.

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[26] CPSO Policy: Decision Making for the End of Life, Affidavit of Dr. Brian Cutbertson, Application Record Tab 12, Exhibit "B" at pp. 4-5.

As to (a) – The Creation of an Obligation to Provide Treatment

39. Doctors have a professional duty to act in accordance with the standard of care which in turn is determined by whether a given treatment can benefit the patient medically. They apply that single criterion to every medical decision. That criterion determines whether any particular form of treatment is offered to a patient. No distinction is made between life support and other forms of treatment.

40. There are various other forms of active treatment apart from life support that are withheld or withdrawn when they cannot, or they can no longer, provide a benefit to the patient and death is imminent (with the result that palliative care is continued and potentially increased). If the Court of Appeal's decision stands, patients and their surrogates will be legally entitled to insist upon receiving an array of futile treatments.[27]

As to (b) – Inappropriate Distinction Between Withholding and Withdrawing Treatment

41. Doctors make no special distinction between withholding and withdrawing treatment, and the law should not either. In a doctor's mind, the potential for patient benefit is as critical to a decision to continue treatment (or not) as to a decision to offer it (or not) in the first place. All treatment is considered by doctors to be a "trial of treatment" requiring the continuing assessment of its efficacy and its withdrawal if found not to be providing a medical benefit.[28]

42. From a patient point-of-view, as well, a withdrawal and a withholding of treatment are, in practical terms, identical if they lead to the same result (e.g., death).[29]

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[27] Examples are given in the affidavit of Dr. John Granton affirmed August 2, 2011, Tab 10 of the Application Record at paragraphs 30-31.

[28] Affidavit of Dr. Laura Hawryluck, affirmed August 2, 2011, Tab 9 of the Application Record at paragraphs 8-11.

[29] This is true, for example, of cardio-pulmonary resuscitation as well as of life support. See also, the affidavit of Dr. Laura Hawryluck, Tab 9 of the Application Record at paragraph 20.

43. The Court of Appeal recognized this apparent anomaly and observed that the standard of care restrains doctors from acting arbitrarily in withholding care.[30] One could just as well observe that the standard of care equally restrains doctors from acting arbitrarily in withdrawing care. There is no justification for the law of informed consent to regard the decisions differently.

<u>As to (c) – Inappropriate Focus on Imminence of Death</u>

44. The potential for patient benefit is as critical to a decision to withhold or withdraw treatment <u>at the end of a patient's life</u> as at any other point. If the imminence of death is the test for requiring consent to the withdrawal of treatment, then the requirement for consent is made to turn upon the nature and severity of the patient's underlying disease, and not the offer of treatment – for which there can be no rationale whatever.[31]

45. Moreover, the Court of Appeal has created a test that is impossible to apply because there is no objective means to determine whether death will occur imminently if treatment is ended[32] (e.g., Mr. Rasouli could survive for days once taken off the ventilator).[33]

<u>As to (iv) and (v) – Misunderstanding of the Role of Palliative Care</u>

46. In medicine, a decision that treatment must be withdrawn and a decision to provide some other form in its place are separate decisions, each turning upon the separate medical indications that are implicated.[34]

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[30] Court of Appeal decision, Application Record, Tab 6, paragraph 57.

[31] Affidavit of Dr. Laura Hawryluck, Tab 8 of the Application Record at paragraph 18.

[32] Affidavit of Dr. John Granton, Tab 10 of the Application Record at paragraph 29.

[33] He has been previously weaned off the ventilator for days at a time. See the affidavit of Dr. Brian Cuthbertson affirmed February 14, 2011, Application Record, Tab 12 at paragraphs 21-23.

[34] Affidavit of Dr. John Granton, Tab 10 of the Application Record at paragraph 28.

47. The decision to provide palliative care is irrelevant to the decision that life support is futile. The two decisions are not "integrally linked". Each is made on its own merits based upon the presence or absence of medical indications.[35]

48. Moreover, the indications for palliative care do not result from the withdrawal of life support. The need for palliative care is the result of the patient's underlying incurable disease. Being on life support is itself an indication for palliative care.

As to (f) – Misunderstanding of the Role of Critical Care Medicine

49. The fundamental goals of critical care medicine are to resuscitate and support critically ill patients who can recover from acute reversible illnesses. Critical care medicine does not cure diseases but instead resuscitates patients and plays a supporting role in a broader treatment plan. The goal of critical care medicine is to provide sufficient support to a patient to survive an acute life-threatening illness. It is not the goal of critical care medicine to keep a patient breathing indefinitely where there is no hope for recovery from the underlying disease.[36]

NATIONAL IMPORTANCE

50. The matters in issue are of vital concern to the medical profession and to patients and their families. They also have importance to the public generally since they engage fundamental values. Moreover, there are implications for the public interest insofar as they bear upon the allocation of scarce medical resources in the Canadian medical system, for the cost associated

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[35] Affidavit of Dr. Laura Hawryluck, Tab 9 of the Application Record at paragraphs 26-27.

[36] Affidavit of John Granton, Tab 10 of the Application Record, paragraphs 9-11; affidavit of Dr. Laura Hawryluck, Tab 9 of the Application Record, paragraphs 16-17.

with providing treatment without medical indications risks depriving others who might benefit from medical intervention.[37]

51. The question of whether doctors should be ordered to provide, or to continue to provide, life support, cardio-pulmonary resuscitation, or other treatment to patients if death will otherwise ensue has been considered repeatedly by Canadian courts and can be expected, in an ageing population, to arise frequently in the future.

52. Canadian courts have had great difficulty expressing a principled basis for settling these disputes. The decisions are frequently internally inconsistent as well as inconsistent with one another. There is a great need for guidance from this Court.

53. The question has generally had to be determined on an injunction application, which is unsatisfactory for various reasons, including:

(i) Because there is a dearth of high Canadian authority on the issues, some courts have been led to conclude that the law is in an unsettled state, with the result that decisions are made *ad hoc*.

(ii) The supposition that the law is in an unsettled state may itself provide a reason for the court to grant an injunction even though the result may be that the patient receives medically-inappropriate treatment.

(iii) Although interlocutory, the orders granted serve as final dispositions since they result in the treatment being given or being withheld, and in either event the patient dies before there can be any hearing on the merits.

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[37] Affidavit of Arthur Schafer, Tab 11 of the Application Record at paragraph 19.

54. The cases cited above at para.35, in which it was held that patients have no right to compel doctors to provide futile treatment, may be contrasted with others in which an interim injunction was granted either to restrain a non-resuscitation order[38] or to restrain the removal of mechanical ventilation.[39] The two sets of cases are irreconcilable.

55. Every province except New Brunswick has legislation that either explicitly requires consent to treatment or health care[40] or requires doctors to comply with patients' advance directives or the decisions of their SDMs respecting health care.[41]

56. Many of these statutes contain definitions of "treatment" or "health care" that share one or more of the following characteristics with the definition of "treatment" as that term is defined in the Ontario Act:

(a) They expressly include palliative care or anything done for a palliative purpose;[42]

(b) They expressly include a course of treatment, series of related treatments or a plan of treatment;[43]

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[38] *Sawatzky v. Riverview Health Centre Inc.,* [1998] M.J. No. 506, Book of Authorities, Tab 14.

[39] *Golubchuk v. Salvation Army Grace General Hospital*, 2008 MBQB 49; Book of Authorities, Tab 15; *Sweiss v. Alberta Health Services*, 2009 ABQB 691, Book of Authorities, Tab 16.

[40] Provinces that impose a statutory duty on doctors to obtain consent prior to treating a patient include:
British Columbia - *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181, ss. 4-5 [*BC Act*]; **Yukon** - *Care and Consent Act*, SY 2003, c 21, Sch B, ss. 3-4 [*YK Act*]; **Ontario** - *Health Care Consent Act, 1996,* SO 1996, c 2, Sch A, s.10; **Québec** – Civil Code of Québec, LRQ, C. C-1991, ss.10-11 [*CCQ*];
Prince Edward Island - *Consent to Treatment and Health Care Directives Act*, RSPEI 1988, c C-17.2 ss. 4-5 [*PEI Act*]

[41] **Alberta** - *Adult Guardianship and Trusteeship Act*, SA 2008, c A-4.2; [*AB Act*]; **Saskatchewan** - *Health Care Directives and Substitute Health Care Decision Makers Act*, SS 1997, c H-0.001 [*SK Act*];
Manitoba - *The Health Care Directives Act*, CCSM c H27; [*MB Act*]; **Nova Scotia** - *Personal Directives Act*, SNS 2008, c 8 [*NS Act*] and *Personal Directives Regulations*, NS Reg 31/2010 [*NS Regulations*]; **Newfoundland and Labrador** - *Advance Health Care Directives Act*, SNL 1995, c A-4.1 [*NL Act*]; **Northwest Territories and Nunavut** - *Personal Directives Act*, SNWT 2005, c 16, *Guardianship And Trusteeship Act*, SNWT 1994, c 29 *Nunavut Act*, SC 1993, c 28, s.29(1) [*NT and NU Acts*]

[42] *BC Act*, s.1, "health care"; *AB Act,* s.1, "health care"; *SK Act,* s.1, "treatment"; *MB Act,* s.1, "treatment"; *NS Regulations,* "health care"; *PEI Act*, s.1, "treatment"; *YK Act*, "health care"; *NT and NU Acts*, s.1, "health care"

[43] *BC Act*, s.1, "health care" – a plan for minor health care; *AB Act,* s.1, "treatment plan"; *MB Act,* s.1, "treatment"; *NS Regulations,* "health care"; *PEI Act*, s.1, "treatment"; *YK Act*, "care plan"

(c) They expressly include the withdrawal or withholding of treatment in the definition of "treatment" or a "plan of treatment";[44]

57. The Court of Appeal's interpretation of the Act is potentially applicable to each of these statutes because, under any of these statutes, a question may arise whether a withdrawal of treatment is, in certain circumstances, to be considered "treatment "or "health care" such that the consent of the patient or the patient's substitute decision-maker is required. Moreover, the same question can arise under the common law as it relates to consent to treatment.

PART V—THE ORDER SOUGHT

58. The applicants seek an order granting leave to appeal. They do not seek costs.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

Dated at Toronto, this 3rd day of August.

Harry Underwood
Erica J. Baron
Andrew McCutcheon

Counsel for the Applicants

10589470

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[44] *AB Act,* s.1, "treatment plan"; YK *Act*, s.1, "care plan";

PART VI—TABLE OF AUTHORITIES

Authority	**Paragraphs Where Cited**
Re R, [1991] 4 All E.R. 177	21
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Airedale NHS Trust v. Bland [1993] A.C. 789	32
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Clarke v. Hurst, 1992 (4) SA 630	34
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Thaddeus Mason Pope, “Involuntary Passive Euthanasia in U.S. Courts: Reassessing the Judicial Treatment of Medical Futility Cases”, 2008 9 Marquette Elder’s Advisor 229	34
Child and Family Services of Central Manitoba v. L.(R.), [1997] M.J. No. 568 (Man. C.A.)	35
Children’s Aid Society of Ottawa–Carleton v. M.C., [2008] O.J. No. 3795 (S.C.J)	35
Rotaru v. Vancouver General Hospital Intensive Care Unit, [2008] B.C.J. No. 456 (B.C.S.C.)	35
Re L.I.C., 2006 ABQB 130	35
Re I.H.V. Estate, [2008] AJ No. 545 (Q.B.)	35
Ellen Picard and Gerald Robertson, *Legal Liability of Doctors and, Hospitals in Canada* (4th ed. 2007), at 345-346	35
Sawatzky v. Riverview Health Centre Inc., [1998] M.J. No. 506	54
Golubchuk v. Salvation Army Grace General Hospital, 2008 MBQB 49	54
Sweiss v. Alberta Health Services, 2009 ABQB 691	54

PART VI—STATUTES

S.C.C. No.

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

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)

- and -

THE CONSENT AND CAPACITY BOARD

Intervener

AFFIDAVIT OF JOHN GRANTON
IN SUPPORT OF THE APPLICATION FOR LEAVE TO APPEAL

(Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld, Applicants)
(Pursuant to Rule 25 of the *Rules of the Supreme Court of Canada*)

I, JOHN GRANTON, of the Village of King City, Township of King, in the Province of Ontario, **AFFIRM:**

1. I am a medical doctor with specialties in Respirology and Critical Care Medicine. I am the Chief, Division of Respirology at University Health Network in Toronto.

2. I am the current president of the Canadian Critical Care Society (the “Society”). The Society represents adult and paediatric critical care medicine physicians in Canada.

3. I have knowledge of the matters to which I hereinafter depose.

4. The Society is committed to fostering the provision of the highest quality of care to critically ill patients and to the promotion of patient safety, education, research, and professional development in Canada and around the globe. The Society is involved in critical care medicine education in association with the Royal College of Physicians and Surgeons of Canada and in critical care medicine research with the internationally renowned Canadian Critical Care Trials Group.

5. I believe the approach to critical care medicine does not vary in any significant way across Canada.

The Multidisciplinary Approach to Critical Care Medicine

6. Assessments of medical benefit in the ICU are multiprofessional in nature and, for a given patient, may involve the input and opinion of many medical and surgical personnel involved in that patient's care. ICU teams work as a collaborative unit of care and involve highly trained specialized physicians from a variety of specialties (internal medicine, respirology, anesthesia, surgery, emergency medicine) who have done subsequent training in critical care medicine; critical care nurses (nurses who have undergone specialty training in critical care); respiratory therapists, nurses and physiotherapists. In addition, bioethicists, social workers and spiritual care workers are frequently involved with patients in the ICU. All of these individuals, together with family members, provide invaluable perspectives and input into the care of a critically ill patient.

7. Critical care physicians rotate in providing care for patients in the ICU, offering repeated opportunities for new perspectives and second opinions regarding response to treatments, whether such treatments, or other treatments not yet initiated, may offer potential benefit, and the review and revision of goals with patients and substitute decision-makers.

8. There is thus considerable oversight over all decision-making in clinical practice within critical care medicine.

The Fundamental Goals of Critical Care Medicine

9. Critical care medicine's fundamental goals are to resuscitate and support critically ill patients physiologically and hemodynamically while they recover from an acute reversible illness. Critical care treatments include: life-sustaining treatments such as artificial ventilation (non-invasive or invasive); inotropic and vasopressor support (drugs given to support heart function and blood pressure such as adrenaline, administered intravenously); dialysis (in particular continuous modes of dialysis which can only be provided in an ICU); and extracorporeal life support (invasive artificial heart lung machine).

10. Such treatments are indicated when patients suffer from an acute life-threatening illness and need very intensive and aggressive interventions, resuscitation and stabilization if they are to survive the illness. These patients are the sickest patients in any hospital setting and can only be cared for in an ICU. Common reasons to institute ICU treatments include: septic shock from severe infections, severe multi-system organ failure, systemic inflammatory response syndromes, cardiogenic shock, neurogenic shock (e.g., head trauma, severe subarachnoid hemorrhages,

spinal cord trauma), massive traumas, massive hemorrhages, organ transplantation, and peri-operative support for major surgical interventions.

11. Life support treatments do not in themselves cure diseases, but rather they play a major role in resuscitating patients in shock and a supporting role in a broader treatment plan, when appropriate, as patients contend with critical illness and which is directed towards improving the patient's clinical condition and underlying illness.

The Concept of Trial of Therapy

12. Medical care provides a benefit when it offers the chance of a cure or the potential to slow the rate and decrease the extent of disease progression, when its risks do not outweigh its benefits, and when it is the least intrusive treatment possible to achieve such results.

13. Life-sustaining treatments, as in case of many other medical treatments or treatment plans, are always undertaken as a trial of therapy—one that carries with it the implicit acknowledgement that it may fail despite the best efforts of the health-care team. When life-sustaining treatments do not offer, or they no longer offer, any hope of recovery from the underlying illness, the standard of care is not to offer, or to discontinue, such treatments. This standard of care is grounded in the most fundamental principle of medicine, which is "First, do no harm".

14. Seventy to ninety percent of deaths in ICUs are the result of withholding or withdrawing such treatments once no longer effective or when such treatments are no longer felt to lead to a state or condition that would be congruent with patients' values and wishes.

15. All decisions to withhold or withdraw treatments in medical practice including critical care medicine are based on whether the treatments will help in alleviating pain and suffering, in which case they will be continued or will serve only to increase pain and suffering and prolong death, in which case they will be discontinued.

The Potential Harm Resulting from Life-Sustaining Treatment

16. ICU treatments are never neutral in their effects on a given patient's physical condition, cognitive function, or overall well-being. Prolonged ICU stays or recurrent need for critical care treatments, even when appropriate in an attempt to support a patient through acute reversible illnesses, will result in progressive deterioration in the patient's state of health, overall physical condition, well-being, and ability to survive another episode of life-threatening illness.

17. The most common risks of prolonged ICU treatments are:

(a) infections, including secondary infections (such as ventilator-associated pneumonias and central line infections);

(b) persistent and permanent cognitive deterioration;

(c) delirium with a high risk of residual brain impairment after discharge from hospital

(d) deep venous thrombosis and pulmonary embolism;

(e) skin breakdown (such as bed sores over pressure points such as back of skull, hips, sacrum, and heels, causing significant pain and morbidity and potentially leading to osteomyelitis and septic shock);

(f) generalized bone degeneration and heterotopic ossification (joints turn into bone);

(g) osteoporosis and bone fractures

(h) stress ulcers, i.e. gastrointestinal ulceration and hemorrhages;

(i) critical illness polyneuropathies and myopathies resulting in severe generalized weakness and muscle wasting; and

(j) damage to the vocal cords and ability to swallow.

18. When patients have an untreatable underlying severe, life threatening illness or an illness where treatment will lead to a state or degree of disability that the patient would not desire, critical care treatments should not be offered or continued because their harms and risks, resulting in increased morbidities (outlined above) and mortality, are the only possible effects that patients will experience. Providing critical care treatments in these situations will serve only to increase the patient's suffering and delay an inevitable death.

Palliative Care in the ICU

19. Palliative care treatments focus on alleviating pain and suffering, optimizing quality of life and helping patients <u>live</u> with life-threatening illness. Their goal is to improve the patient's well-being and enhance their quality of life for as long as possible. When the end of life approaches, palliative care also plays a key role in alleviating pain and suffering in a patient's last weeks, days and hours of life

20. The current standard of care is that palliative care medicine is provided for a range of indications in the treatment of **all** patients in the ICU and not just those whose death is imminent.

In patients whose treatment goals are curative or potentially curative, palliative care treatments are those treatments that focus on alleviating the pain and the distress to which critical care treatments often contribute and are used to improve the quality of life in patients in the ICU. If a trial of therapy is not working, palliative care continues but plays a more central role in alleviating pain and suffering and easing the dying process when treatments are withheld or withdrawn.

Consultations with Patients and Substitute Decision-Makers

21. In most cases where critical care treatments are under consideration, patients are not capable and a decision must be made by a substitute decision-maker (SDM). Both patients and SDMs frequently lack understanding of what such treatments entail, the side effects of the treatments, and what the treatments may and may not be able to achieve as well as the long term effects of critical illness and ICU treatments. Education is often needed as to what can reasonably be expected to be achieved in the context of the patient's current severe illness, overall state of health, and co-morbidities.

22. Open, transparent and consistent discussions of the patient's values, wishes, with frequent review and revision of goals of treatments, and the potential risks and benefits of treatment with patients and their SDMs are crucial as patients contend with life-threatening illness. The highest quality of decision-making involves a collaborative process which encompasses consideration of each of the patient's values and the prospect for benefit and harm of a proposed course of treatment. Physicians are expected to make recommendations among available treatment options and explain the rationale behind such recommendations. When critical care treatments cannot offer any benefit this should be acknowledged openly and honestly. In these situations, these

treatments are considered not to be a treatment option and that too should be openly and empathetically discussed and explained and a second opinion sought if requested by the family. All hospitals recognize the obligation to facilitate second opinions in cases of conflict or doubt regarding potential for critical care treatments to offer medical benefit.

23. In the event of conflicts with SDMs regarding treatment goals, the critical care team will first seek to resolve such disputes by trying to understand the underlying reasons for the disagreement. This process may reveal a lack of understanding of what treatments can achieve, a difference of opinion regarding goals of treatments, a lack of understanding of the role of SDM as provided for in Ontario in the *Health Care Consent Act*, or they may simply reflect grief and emotional distress over the anticipated loss of a loved one.

24. Clarifications of any misunderstandings and an explanation of the SDMs role may help in many situations. Time, empathy, and emotional and psychological support are provided by all members of the team. Help may be sought from social workers, spiritual caregivers, bioethicists, and staff from Hospital Patient Relations. Many hospitals have conflict resolution policies to provide guidance in such situations. Only when all efforts fail do critical care physicians look to the legal system for help.

25. When treatments cannot offer any benefits, but are nonetheless required to be provided because mandated by the courts arising from SDM demands, the results lead to caregiver stress,

burn-out and attrition of ICU team members resulting, on occasion, in the loss of highly skilled professionals.[1] As a result the overall quality of critical care medicine suffers.

Implications of the Court of Appeal's Decision

26. I have reviewed the decision of the Court of Appeal herein. The Court effectively imposes a new duty on doctors to provide life support on demand regardless of its efficacy provided only that three conditions are met: i) the patient is already receiving life support; ii) if it is terminated, death will result imminently; and iii) pending death, palliative care will be provided instead.

27. The Court appears to have failed to appreciate that treatment that is medically indicated at a given time may no longer be medically indicated at a later time; that all forms of treatment are undertaken as a trial of treatment that may or may not work; and that the standard of care requires doctors to discontinue any form of treatment when it no longer provides benefits to the patient, just as they are obliged to withhold treatment in the same circumstances (which the Court appears to accept).

28. The Court propounds the concept of a withdrawal of care that is "integrally linked" to active treatment so as to require consent to both. This concept is unknown to medicine and is contrary to good medical practice as explained above. Any form of treatment may have to be withdrawn regardless of whether there is another form of treatment that can appropriately be

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[1] Attached hereto and marked as Exhibit "**A**" is a copy of an article published in Intensive Care Medicine in 2009 entitled "Conflicts in the ICU: perspectives of administrators and clinicians" detailing implications of conflicts, including staff burn out.

provided in its place. They are separate considerations because the medical indications for a withdrawal of given treatment will differ from the indications for the institution of another form of treatment.

29. In its holding, the Court draws an unsustainable distinction between life support and any other forms of medical treatment on the basis that, in the case of the latter, death is not imminent. This seems to imply that it is the withdrawal of the treatment that causes the patient's death. In fact, it is the severity of the underlying illness that determines whether death is more or less imminent. The concept of continuing treatment because without it death would be imminent is unknown to medicine and would promote poor quality medical care across Canada. While imminence of death or the severity of the underlying illness does play a role in decision-making in respect of treatments, these factors are only relevant because they may bear on whether a treatment can offer any medical benefit. Moreover, it is unclear precisely what imminence of death means – whether hours, days or weeks.

30. It is an apparent unstated assumption in the Court's decision that life support stands alone as a form of active treatment that, once withdrawn, leads imminently to death and, pending death, to a requirement for palliative care. The Court distinguishes a withdrawal of life support from a withdrawal of other treatments such as chemotherapy on the basis that there will normally be a gap in time between the latter and death. The Court cites no support for its assumption. The assumption is, in fact, incorrect. Chemotherapy is regularly given to patients with cancer in advanced stages (e.g., respiratory distress from tumor metastasis, malignant pleural effusions, widespread metastasis to liver, bone, abdominal and pelvic cavities), and sometimes also with

concurrent illnesses (e.g., underlying lung disease, cardiac disease, progressive kidney dysfunction). Treatment may be withdrawn only when death is imminent.

31. Instances of similar cases in clinical practice could be multiplied. The following are a just few examples of active treatments which are withdrawn in patients who are not candidates for life support, when it is known that death will ensue in the short term, and when palliative care is appropriately continued and often escalated:

(a) end-stage lung disease, with concurrent pneumonia not responding to treatment;

(b) endstage lung disease with irreversible disease progression;

(c) cirrhosis of the liver as a cause of kidney failure for which dialysis is not a treatment option as it cannot benefit;

(d) hepatobiliary surgery patients with recurrent biliary sepsis for whom treatment options are exhausted;

(e) patients with organ graft failure post transplantation for whom repeat transplant is not an option;

(f) patients with leukemias and lymphomas who have exhausted all curative treatment options and are in endstages of disease progression;

(g) end-stage heart disease of any etiology, with congestive heart failure not responding to treatment who are not transplant candidates; and

(h) All those patients with end-stage cancer receiving palliative chemotherapy or radiation therapy who develop respiratory failure from disease progression.

32. The Court’s decision also displays a profound lack of understanding of current medical practice as to the role of palliative care medicine in patient care. The reasons reflect misapprehensions that those in the palliative care field have worked hard to overcome over the past twenty years. Notably, it is a key principle of palliative care medicine to ensure pain and suffering are alleviated or minimized to ensure quality of life is optimized during a patient’s severe or critical illness. The misapprehension shown by the Court – that patients have to be actively dying before palliative care can or should become part of their treatment plan – has historically been one of the main reasons for delays in timely referrals, unnecessary compromises in patients’ quality of life and the failure to involve palliative care physicians in the care of patients across Canada. Palliative care is a continuum of care, with intensification over time as indicated by the patients’ condition and symptoms. Similarly the intensity of palliative care could be reduced or discontinued if indicated if the patient’s condition improves.

33. Finally, the Court’s decision may cause doctors not to institute life support at all, as a trial of treatment in borderline cases, if such treatment cannot be withdrawn except with consent when proven to be medically ineffective. Doctors may withhold treatments in borderline cases out of a legitimate concern that they may find themselves required to go on to provide treatments that will have no effect except to increase the rate and extent of deterioration of patients, and thus their pain and suffering. If such circumstances are deemed likely, many may feel it would be better not to initiate treatment at all. The concern we as critical care physicians would have is

the risk of failing to err on the side of providing ICU treatments when our ability to help is unclear.

AFFIRMED BEFORE ME at the City of Toronto, on August 2, 2011.	
Commissioner for Taking Affidavits	John Granton

S.C.C. No.

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

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)

- and -

THE CONSENT AND CAPACITY BOARD

Intervener

AFFIDAVIT OF LAURA HAWRYLUCK
IN SUPPORT OF THE APPLICATION FOR LEAVE TO APPEAL
(Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld, Applicants)
(Pursuant to Rule 25 of the *Rules of the Supreme Court of Canada*)

I, LAURA HAWRYLUCK, of the City of Burlington, in the Province of Ontario,

AFFIRM:

1. I am a critical care physician with privileges at University Health Network. I also have a Masters of Science in Bioethics from the Joint Centre for Bioethics and the Institute of Medical Science at the University of Toronto. From 2006 to 2009, I was the Physician Lead for the Critical Care Secretariat, Ontario Ministry of Health and Long Term Care Ethical Issues of Access section. From 2006-2007, in its inaugural year, I was Physician Lead of the End of Life

Care Performance Improvement Team, Critical Care Secretariat, Ministry of Health and Long Term Care. In this same time frame, I led the development of an innovative multiprofessional continuing education program in ethics, law and communication skills in critical care medicine for the Canadian Resuscitation Institute (CRI), which has now been integrated into the program of the Royal College of Physicians and Surgeons of Canada. From 2001 to 2009, I was the Physician Leader of the National Ian Anderson Continuing Education Program in End-of-Life Care at the University of Toronto, the goal of which was to improve the knowledge and skills of physicians and multiprofessional teams across Canada in caring for dying patients. In 2002, I was awarded the Queen's Golden Jubilee Medal for contributions to Canada in end of life care. In 2011 I was awarded the Associated Medical Services (AMS) award for excellence in end of life care. I am currently a Member Joint Centre for Bioethics Affiliates and Advisory Board, University of Toronto. In addition, I am Associate Professor at the University of Toronto medical school and am involved in training medical students, residents in various subspecialty programs, and residents in critical care medicine. I have designed web-based programs in end of life care for postgraduate residency trainees at the University of Toronto with a particular focus on ethical decision-making, professionalism and standards of practice. These programs are considered cutting edge in medical education across Canada. I teach both clinical practice as well as the ethical issues engaged by the practice of critical care medicine. Finally, I have devoted a significant part of my professional career to the consideration of ethical issues in the administration of critical care medicine, including speaking and publishing extensively in the area. A copy of my curriculum vitae is attached hereto and marked as Exhibit "**A**".

2. I have knowledge of the matters to which I depose.

3. The purpose of this affidavit is to address the impact of ethical concepts in the context of delivering critical care medicine. The concepts set out in this affidavit reflect the standard of care applicable to the delivery of critical care medicine.

4. I believe the ethical principles of critical care medicine do not vary in any significant way across Canada

5. Many different ethical theories exist to help guide decision-making challenges in medicine including critical care medicine. The four principles of patient autonomy, beneficence, non-maleficence and justice as are often used to define the common ground among ethical theories. These principles are thus commonly used to explore ethical issues in clinical practice and to help resolve ethical dilemmas and are addressed in greater detail below.

Patient Autonomy

6. In medicine, the ethical principle of patient autonomy is sacrosanct. Patient autonomy refers to a patient’s right to make healthcare decisions that reflect that patient’s values, beliefs and wishes. Quality healthcare is patient-centered and recognizes that different people will choose differently among potential treatment options according to what gives their life meaning, what is important to them, and what views they have on quality of life. This right of capable patients to choose among treatment options is given great weight in clinical decision-making in all fields of medicine and medical teaching reinforces the fact that capable people – those who understand the treatment options and appreciate the consequences of their choices in context of their state of health, values and treatment goals – are allowed to disagree with their

healthcare team's recommendations and to make what the team may consider to be unwise decisions. This is true in every field of medicine including critical care.

7. The right to self-determination is reflected in the decision-making substitute decision makers (SDMs) assume when a treatment patient is incapable. The SDM is required to respect the patient's expressed views and values and beliefs in any decisions taken with the health care team. In critical care medicine most patients are incapable and the critical care team therefore engages with their SDMs.

Beneficence and Non-Maleficence

8. In every field of medicine the principles of beneficence and non-maleficence are relevant to the consideration of whether a treatment option is medically appropriate for a given patient. A treatment must have some potential to benefit and, while any treatment has risks and side effects, it must not exclusively cause harm. In other words, a treatment will only be offered if its risks and side effects do not outweigh its benefits. If harms outweigh benefits in the context of a patient's state of health, such a treatment would fall outside of the standard of care and it is not an appropriate treatment option to be offered to patients or their SDMs.

9. When applied to critical care, beneficence and non-maleficence mean that life support is a treatment option only when it can potentially benefit a given patient. It ceases to be a treatment option when its harms outweigh its benefits.

10. All treatments are trials of treatment. No treatment ever comes with a guarantee of benefit and every treatment, including life-sustaining ones, must be continually re-evaluated once initiated to assess its potential benefit as compared to its potential to harm.

11. This is particularly true in the context of critical care medicine. Critically ill patients are the most seriously ill patients that exist. If they cannot be resuscitated and stabilized, they will die. ICU teams are the most highly trained multiprofessional teams in any hospital and work around the clock in an attempt to reverse the devastating effects of critical illness even when the odds are very much against survival. For example, the most common reasons patients require life support is to treat septic shock which has, at best, a 50% survival rate in patients without other underlying illnesses. If the patient has underlying illnesses, survival rates are even lower. Other critical illnesses have a 90% mortality rate or more yet ICU teams nonetheless attempt save such patients. That said, such attempts to achieve benefit carry with them tremendous responsibility to:

(a) minimize harm which includes attending to comfort and palliation simultaneously with aggressive life sustaining treatment; and

(b) recognize when there is no potential for medical benefit, or when risks and harms outweigh any medical benefits, at which time potential life sustaining treatments should either not be initiated or should be discontinued.

12. In clinical practice, all multiprofessional ICU team members and all consulting teams (of which there are usually many, for instance, infectious diseases, other medical subspecialties and surgical subspecialties) will be involved in caring for critically ill patients and will participate in assessing benefit to ensure a comprehensive evaluation of any given patient. While professional standards and policies regarding decision-making have been made by

regulating bodies and institutions, in daily practice, the implementation of decisions affecting critically ill patients and their SDMs is also subject to significant oversight and second opinions.

13. Moreover, in clinical practice the ICU physician meets regularly with the patient and/or SDM, along with other multiprofessional members of the ICU team (e.g. bedside RN, social worker, spiritual care giver) and other consulting team members to discuss responses to treatment, prognosis, what—if any—treatments may help in the patient's ongoing journey with critical illness, how treatment goals need to be revised and when the situation and treatment plans should be reviewed in the future. Such discussions are done honestly, transparently and with empathy and compassion. In situations where ICU treatments can no longer benefit, the physician will recommend revision of treatment goals and will recommend withholding of any escalation of treatments and/or withdrawal of all treatments (including life support) not directed towards palliation and alleviating pain and suffering. Ethical practice mandates such a recommendation even if withdrawal of life support is anticipated to result in more imminent death since in these situations life support is only causing harm, increasing suffering and prolonging death.

14. In most cases, patients and SDMs agree with these recommendations. In the rare cases when they do not, the impact and implications are significant (as discussed further below).

15. While life sustaining treatments can cease to benefit patients, they never cease to harm. Most of these treatments are uncomfortable to begin and many patients find them difficult to endure. Secondary complications of life sustaining treatments include ventilator-associated pneumonia, central line infections, deep venous thrombosis, stress ulcers, generalized muscle weakness and deconditioning, skin breakdown and cognitive impairment. These secondary

complications increase in number and severity over time in critically ill patients, whether or not there is continuing medical benefit of ICU treatments to the patient.

16. In critical care medicine, decisions regarding whether life support is a treatment option for a given patient, whether such treatments should be initiated, continued, withheld or withdrawn, are based on whether such treatments have the potential to benefit or whether they can only serve to add to the patient's pain and suffering and prolong their dying. If a patient cannot benefit from life support it is not an appropriate treatment option even if it is anticipated that a patient's death may be more imminent without it. It is the underlying nature of the patient's severe illness that determines the immediacy of death not the withdrawal of treatments that are no longer offering any benefit. In medical practice, no distinction to initiate, continue, withhold or withdraw treatment is or can be made based solely on the types/nature of medical treatment being considered (e.g., life support as compared to chemotherapy), rather such decisions must be made based on consideration of potential benefits and harms for individual patients.

17. In the practice of critical care medicine, benefit exists when there the patient's illness is one that can be completely reversed, whose rate of deterioration can be slowed or whose extent of deterioration diminished. Since life-sustaining interventions are never neutral (as described above), decisions to include such treatments in options provided to patients and SDMs are never undertaken lightly and require as a prerequisite the possibility of some reversibility and recovery from an underlying illness. Further, medical practice mandates that even if treatment is instituted its continuation should be carefully and regularly reviewed to assess whether the patient is responding and still receiving a benefit.

18. In *Rasouli*, the Court of Appeal creates a new, previously unknown standard of medical care regarding whether a treatment should be provided, not based on considerations of benefit and harm, but based on immediacy of death where there is substitution of palliative care for active treatment (specifically life support). This approach is untenable both in medical ethics and clinical medical practice.

19. The Court of Appeal's decision also fails to appreciate that treatment, including life-sustaining treatment, that may offer a benefit at a given point in time may cease to offer any benefit if there is a significant change in prognosis for recovery with the passage of time and change in clinical condition. Ethical medical practice mandates that such considerations be regularly reviewed and that treatment options be revised as the situation evolves.

20. Finally, there is no ethical or medical distinction regarding considerations of benefit depending upon whether treatment is to be initiated, continued, withheld or withdrawn. In *Rasouli*, the Court of Appeal has drawn a distinction by requiring consent to withdrawal when other treatment is offered after withdrawal of ICU treatments but not requiring consent to withholding treatment including ICU treatments. This may result in physicians not initiating trials of treatment when benefit is uncertain. In *Rasouli* the Court denies physicians the ability to cease treatments that no longer benefit, those whose risks and harms outweigh benefits and also effectively denies them the ability to shift greater focus to treatments that would offer significant benefit such as palliative care. As a result, physicians will fear falling into the terrible situation where the care they are mandated to provide to patients violates their professional oath to "First do no harm"

21. When life support can potentially benefit, healthcare teams educate patients and SDMs what such treatment entails, their material risks, likelihood of benefit and need to review and revise treatment goals according to response to treatment. Patients or their SDMs may choose such treatments as part of a treatment plan according to their unique values, beliefs, wishes regarding short and long term treatment goals. Similarly they may choose not to proceed with it. If an informed capable patient elects not to proceed with the treatment, the patient will not receive it in accordance with respect for patient autonomy described above.

22. It is more complicated for incapable patients. Advance care planning regarding critical care treatments remain problematic across Canada as few Canadians understand what life support entails, what it may practically achieve, and its risks and potential benefits. Therefore even on rare occasions when a patient has expressed wishes about such care prior to incapacity, these wishes are often not medically well informed and pose ethical challenges for healthcare teams and SDMs. In clinical practice ICU teams invariably need to educate both patients and their SDMs before engaging in any decision-making to ensure informed consent.

23. Typically, decision-making in clinical practice is approached collaboratively. Patients and SDMs share values, beliefs and wishes for short and longer term treatment goals and healthcare teams discuss whether such goals may be achieved, what would be entailed, what the risks are, what timeframe is expected and what likelihood of success can be anticipated. Then the healthcare team makes a recommendation for a treatment plan. Frequently, patients and SDMs accept these recommendations including recommendations to withhold or withdraw critical care treatments. Recommendations from the healthcare team are essential, especially when patients

are critically ill to reduce the burden and stress on SDMs, families and friends struggling to cope with and make the right decisions on behalf of someone they love.

24. If critical care treatments are considered appropriate treatment options for a given patient, these treatments are best viewed as a plan of treatment where consent is implied for whatever treatments (but only those treatments) that will get a critically ill patient through a life-threatening illness. Explicit consent is typically not sought for individual treatments associated with ICU admission such as the insertion of central lines needed to administer life supporting medications such as inotropes and vasopressors, for antibiotics and prophylactic medications to prevent deep venous thrombosis and stress ulcers, for medications for pain and symptom management, and those for sedation to ensure ventilator support is more bearable for the patient, for hemodialysis and bronchoscopy. These are considered a routine part of life supporting care and implicitly fall under the umbrella of consent for critical care treatments.

25. When ICU treatments are initiated, it is never clear if they will succeed and hence the possibility of patient death is always present despite the best efforts of the ICU team. Implied consent is also considered to include consent to palliative care should life supporting treatments no longer provide medical benefit. Key palliative care principles— to alleviate pain and suffering and enhance patients' well-being and quality of life when they suffer from life-threatening illnesses—are crucial to the practice of critical care medicine. When life supporting treatments are being withdrawn, palliation of pain and suffering in the patients' last days and hours is a major concern for patients (if capable) and their SDMs. Questions regarding how pain and suffering will be alleviated are usually the first broached in family meetings, which reflects the anxiety, fears and concerns this issue presents. Ethical critical care practice mandates that how

life supporting treatments will be withdrawn and how palliation will be achieved are carefully and empathically explained in detail by the critical care team. In clinical critical care practice, palliation of pain and suffering is considered as important as getting a patient through a life-threatening illness. Furthermore in these circumstances palliative care can also be viewed as being similar to emergency treatments where no consent is required.

26. In *Rasouli*, the Court of Appeal misapprehends the role of palliative care in the care of patients with life-threatening illnesses whether they be in an ICU or in another healthcare setting. The Court draws an artificial separation between acute treatments aimed at cure and palliative care to ease patients' dying. This distinction simply does not exist in ethical medical practice—rather care is viewed as a continuum wherein palliative treatments are provided alongside potentially curative treatments and the main goal of treatment plans may shift depending on patients' responses to treatment. If patients fail to respond to treatment and treatments cease to benefit, palliative treatments assume a greater role in their treatment plan. In *Rasouli*, the Court draws an unfeasible distinction between withdrawing life support and discontinuing chemotherapy on the basis that consent to palliative care will immediately be required after withdrawal of life support but not after the withdrawal of chemotherapy. In the care of many Oncology patients, chemotherapy is stopped and palliative care must be escalated.

27. The Court of Appeal's decision however, creates a unsustainable link between a requirement for consent to active treatment (palliative care) and withdrawal of treatment (life support), requiring consent for both even when life support is deemed medically ineffective. This is an unsound association that is untenable in high quality professional medical practice.

28. While autonomy allows a capable patient to refuse treatment, it does not follow that it empowers patients or SDMs to insist on medical treatments that are considered medically ineffective. Such treatments are not offered in accordance with the standard of care. If autonomy were allowed to be divorced from beneficence and non-maleficence as the Court of Appeal effectively does in its decision in *Rasouli*, it would create a situation where medically uneducated and uninformed patients and SDMs could demand treatments not in accordance with standards of medical care. In other words patients and families would be sole determinants of professional medical standards of care. Indeed, physicians currently across Canada sometimes fail to make treatment recommendations based on the standard of care and instead acquiesce to patient or SDM demands even when treatments cannot benefit as a consequence of misapprehensions of the role of autonomy in decision-making. Such an approach is not only ethically very problematic, but also ultimately unsustainable in the context of the fundamental principle of our healthcare system of equitable access for all Canadians in need to medical resources. The Court of Appeal had the power to outline best practices in medical decision-making and promote considerations of both autonomy, and beneficence/non-maleficence. However in its decision in *Rasouli*, by disregarding any consideration of benefit in determining whether ICU treatments are an appropriate treatment option, the Court imposed its own standard of care which fails to give any deference to medical expertise. It will serve only to ultimately erode medical professionalism and worsen the quality of ethical decision making with individual patients across Canada and increasingly limit our ability to respond to those in need by exhausting our finite healthcare resources.

Justice

29. The ethical principle of justice also has implications in the context of the administration of critical care medicine. All people in need should have fair access to and use of medical services including critical care. The most ethically robust theory for justice in medicine and fair access to medical services is known as accountability for reasonableness. According to accountability for reasonableness, medical treatments should be allocated based on clearly defined criteria that fair-minded people can agree with, such criteria should be made public, should be consistently applied and there should be a process to review decision-making and alter it when appropriate.

30. The considerations that define medical benefit, as outlined above, determine if a given treatment or plan of treatment is an appropriate option to discuss with patients and SDMs. This reflects the values of a just society by balancing respect for individual autonomy and multicultural and religious diversity with the equally vital need to ensure appropriate use and fair access to healthcare resources for all patients in need.

31. In practice, limited health care resources are an irrelevant consideration where a potential treatment has the prospect of allowing a patient to recover from a reversible acute illness. However, where a treatment can offer no medical benefit to a patient the use of limited health care resources to provide that treatment is not an irrelevant consideration since the administration of that treatment decreases availability of resources for patients who would benefit from such medical treatment.

32. In clinical critical care practice, conflicts regarding treatment goals are common and most are due to misinformation and misunderstanding of what can practically be achieved. Many of these resolve with ongoing discussion and further trials of treatment with clear preset

treatment goals and plans to review responses to treatment after appropriate intervals. Most hospitals have policies that outline conflict resolution plans and include second opinions, Bioethics, Patient Relations consults, attempts to facilitate transfer of patient care to another hospital willing to provide ongoing care.

The Role of the Consent and Capacity Board

33. In *Rasouli*, the Court considered the Consent and Capacity Board (the "CCB") of Ontario as an appropriate legal recourse to review decision-making regarding ICU care as part of treatment plan for a given patient in cases of intractable conflict. The CCB panel is composed of a lawyer, a psychiatrist and a member of the public. The psychiatrist member is often considered to be the medical expert of the panel. Psychiatrists, however, have minimal if any knowledge of ICU treatments. Because the CCB has no critical care physician members the only medical knowledge for such crucial and complex decisions with significant consequences for individual patients typically comes from the applicant physician, one of the parties to the proceeding.

34. In *Rasouli*, the Court gives deference to its perception of the expertise of the Board. Yet the Court's deference is unwarranted as the Board has no independent medical expert to assist in:

(a) the evaluation of whether a previously expressed wish applicable to the circumstances is possible in view of the patient's current medical realities

(b) the evaluation of a patient's best interests through a comprehensive review and understanding of the treatment options and recommended treatment plans, their ability to benefit and harm.

35. The fairness of the CCB process to all parties in critical care cases is problematic. If the importance of having a psychiatrist on the Board for review of cases under the *Mental Health Act* is unquestionable to ensure just hearings into the finding of patient incapacity and into the review intrusiveness of mental illness treatment plans, than surely the presence of a critical care physician on the Board is required to ensure clear understanding and fair process in critical care cases where the complexity and consequences of the Board's decisions are even greater. The Board does not select among its potential panel members to ensure the panel has previous experience, knowledge and understanding when hearing and adjudicating critical care cases. The fact that critical care cases have been brought to the Board in the past reflects critical care physicians' attempts to resolve conflicts by turning to an available legal recourse among others. The fact that the Board has heard such cases in the past, does not mean the Board has any particular knowledge or skill in these matters

36. The Court of Appeal further suggested that reviews by the CCB are timely. They are not always so. The process may be interrupted and delayed to allow counsel to be retained for either physicians, patients (usually through the Office of the Public Guardian and Trustee) or SDMs. Further, the hearing is often re-scheduled to accommodate the schedule of Board members, counsel and the parties. For the applicant physician, ICU team and consulting physicians trying to care for the sickest patients in hospital, the process takes them away from the bedside and makes fulfilling their professional duty to care for their other critically ill patients difficult if not impossible. This is particularly true in situations where another patient, is acutely ill and rapidly deteriorating requiring a physician at bedside to stabilize the patient and the physician has to remain at the CCB hearing. I have personally participated in CCB hearings and have found them

cumbersome, lengthy and inordinately time consuming. In view of my academic interests and activities I am frequently contacted by other physicians attempting to resolve conflicts and seeking to engage the legal system through a Board hearing. Commonly, their experiences and concerns regarding the fairness of the process reflect my own. Even when I have participated as the physician who provided a second opinion I was kept waiting to testify at another hospital for a number of days during which time the CCB could not provide any timeframe for my being called and I was unable to perform my clinical duties.

37. In my experiences before the Board, lawyers are often inexperienced in and uninformed about the Board's processes, and as a result further delays ensue. The questions asked of the critical care team by lawyers for other parties and by Board members themselves reveal a lack of knowledge of ICU treatments that can potentially compromise the fairness of the proceedings.

38. The Board's decisions are not final in that they may be appealed to the Superior Court and, even when expedited, the appeals may not be heard until months later. Superior Court decisions can be appealed to the Court of Appeal, which again may result in months of delay. An appeal to the Superior Court occurred in both cases I was involved with. The average length of stay in ICU of a critically ill patient is a week. Months are an unacceptably long period of time

for such decisions to be delayed as the harm of ongoing critical care treatments continues to escalate as does the stress and burnout of families and healthcare teams.

AFFIRMED BEFORE ME at the City of Toronto, on August 2, 2011.	
Commissioner for Taking Affidavits	Laura Hawryluck

S.C.C. No.

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

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)

- and -

THE CONSENT AND CAPACITY BOARD

Intervener

AFFIDAVIT OF ARTHUR SCHAFER IN SUPPORT OF THE APPLICATION FOR LEAVE TO APPEAL

(Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld, Applicants)
(Pursuant to Rule 25 of the *Rules of the Supreme Court of Canada*)

I, ARTHUR SCHAFER, of the City of Winnipeg, in the Province of Manitoba, **MAKE OATH AND SAY:**

1. I am the Director of the Centre for Professional and Applied Ethics and a Full Professor in the Department of Philosophy at the University of Manitoba. Previously, I was the Head of the Bio-Medical Ethics Section in the Faculty of Medicine at the University of Manitoba. I also act as an Ethics Consultant for the Department of Child Health for the Winnipeg Regional Health

Authority in Winnipeg. Attached hereto and marked as Exhibit "A" is a copy of a short version of my curriculum vitae.

2. I have knowledge of the matters to which I hereinafter depose.

3. I have reviewed the Court of Appeal decision in the case herein. Its formulation of the circumstances in which doctors require consent to the withdrawal of medical treatments raises ethical, professional and practical concerns which are likely to result in outcomes which are morally indefensible. This affidavit will explore some of those concerns arising from the decision.

4. The issue of when consent is necessary to medical treatment has developed in Canada over the last two decades. While much in the area of consent is already clear and consistently applied throughout Canada, consent in some aspects of end-of-life care remains unclear and an area of dispute and controversy. The Court of Appeal in *Rasouli* has not helped to clarify an ethically defensible consent policy in this area; if anything, it has worsened the current disorder of decision-making and has furthermore raised the prospect for confusion in other areas of medicine.

5. It is clear in law (and ethics) that if a capable patient refuses to provide consent to medical treatment, doctors are not permitted to administer that treatment even if a doctor believes it should be administered. In other words, a competent adult patient has a well-established legal and moral right to refuse consent for anyone to interfere with her/his body even when that decision may seem wrong-headed to others and even when it is believed that this treatment refusal will lead to premature death. Similarly, if an incapable patient's substitute decision maker ("SDM") refuses to provide consent to medical treatment, doctors are forbidden

to administer treatment, including life-saving treatment, absent a legal determination that the SDM's decision is improper.

6. It does not follow, however, that the right to refuse the administration of medical treatment means that patients or their SDMs have a corollary right to require medical treatment to be instituted or continued. To the contrary, it seems clear that patients are not entitled to receive and have no right to demand medical "treatments", e.g., medications, medical imaging or surgical interventions, when competent medical professionals judge that such treatments are not medically indicated.

7. Unhappily, however, with respect to life sustaining treatment such as artificial ventilation, CPR or dialysis, there appears to be a patchwork, inconsistent approach by courts across Canada. As a result, physicians and health care team members are at present left without clear guidance as to their legal obligations in circumstances where there is a dispute concerning whether or not a treatment should be offered to a patient or, having been offered should now be withdrawn. Similarly, patients and their family members do not know the extent of their legal right, if any, to insist upon medical treatment and to compel health care professionals to provide that treatment in circumstances where the health care professionals believe that the treatment is not indicated because it will be futile or counter-productive, i.e., will produce more harm to the patient than benefit . In the absence of such clarity, litigation is the inevitable result.

8. This issue has arisen on a number of occasions in Manitoba. In 1998 the Manitoba courts considered whether life sustaining treatment should be administered to Andrew Sawatasky who suffered from advanced Parkinson's Disease with dementia. His wife wished that all life support measures be provided to her husband. The medical team believed a Do Not Resuscitate order

was appropriate. They argued that to perform CPR on Mr. Sawatsky would be to commit a violent assault against a frail elderly man with serious harm to him and no possible benefit. The Manitoba courts granted a temporary injunction requiring CPR to be administered to Mr. Sawatsky in the event that his heart stopped before a second opinion could be obtained and the matter adjudicated on a final basis. The matter was never determined on a full record as Mr. Sawatsky died before the case could be heard.

9. More recently, in 2008, the Manitoba courts again considered this issue in the case of Samuel Golobchuk who suffered from a serious brain injury which left him in a near-vegetative condition and who subsequently developed pneumonia which required an ICU admission if he were to be kept alive. Again, the Manitoba courts granted a temporary injunction requiring the continuation of life prolonging treatment pending determination of the case on a final basis. Again, the patient died before the case could be heard on its merits. In the interim, two of the ICU physicians resigned rather than being forced to continue the treatments they believed were inconsistent with their professional integrity because it violated their fundamental obligation not to cause harm to their patients unless the patients stood to obtain a greater benefit from the procedures being imposed upon them. One of the physicians described the treatments necessary to keep Mr. Golobchuk alive in a near-vegetative condition as causing him pain and distress akin to “torture”.

10. Because these cases were decided on an interim basis, there is limited legal guidance as to doctors’ obligations and patient’s rights when the family of an incompetent patient demands “treatment” which the physicians believe is futile because it will bring no benefit to the patient or will cause significantly more harm than good for the patient.

11. In 2003, the Manitoba Law Reform Commission considered this sort of issue and issued a report which concluded that where dispute arises between physicians and family members clear communications and attempts at a resolution should be attempted but ultimately "where all preceding measures have failed to produce an agreement the physician may, after an appropriate notice period, withhold or withdraw life sustaining medical treatment where such treatment would be medically inappropriate or professionally unethical."

12. In 2008, the Manitoba College of Physicians and Surgeons established a policy related to withholding and withdrawing of life sustaining treatment a copy of which is attached hereto and marked as Exhibit "**B**" and provides that physicians are not obliged to provide treatment to a patient when the physician does not believe that the treatment provides a medical benefit. I understand Ontario has a similar policy.

13. Similarly, the Canadian Medical Association has issued a Joint Statement on the Institution of Resuscitative Measures which provides that "there is no obligation to offer a person futile or non-beneficial treatment." Attached hereto and marked as Exhibit "**C**" is a copy of the CMA Joint Statement.

14. While these reports, policies and statements are of some assistance to doctors as they attempt to ascertain their professional obligations in a context of disagreement with the families of incompetent patients, because there are conflicting court cases in jurisdictions across Canada, health care teams often remain unclear at present as to their legal responsibilities.

15. All of the Manitoba College policy, the Law Reform report and the CMA Joint Statement emphasize the importance of process but ultimately conclude that a doctor should not obliged to

provide treatment that the doctor considers to be without medical benefit to the patient, even if the patient or SDMs demand it.

16. Any ethically consistent and medically sound approach would be the following:

(a) If a treatment can offer a medical benefit (that is, more benefit than harm) and a patient or SDM consents to that treatment then it should be instituted or continued; and

(b) If a treatment cannot offer a medical benefit, even if the patient (or the patient's SDM) wishes to have it, it should be not be instituted or should be discontinued.

17. To illustrate: a patient should not be administered antibiotics for an infection believed to be viral; a patient should not be given an organ transplant if there is no significant chance that it will succeed and a good chance that it will cause harm to the patient; patients should not be admitted to an ICU unless there is some non-negligible chance that they will benefit and recover sufficiently to be discharged.

18. If treatment can offer benefit, whether or not consent is granted should be a personal decision for the patient herself/himself to make, informed as to the possible benefits, risks of harm. The values and beliefs of the patient, including his or her religious beliefs, will obviously be relevant for the competent patient or for the SDM of the incompetent patient to consider in making those decisions.

19. The question of whether a treatment offers a medical benefit is, obviously, at least in the first instance, a medical question. Therefore, no matter how strongly held a patient's views are, if the health care team judges that there is no reasonable likelihood of medical benefit, and especially if there is a reasonable likelihood of significant harm, then the treatment should not be

offered. In the Canadian medical system, this is justified partly because the cost in time and resources associated with providing treatment without medical benefit constitutes a deprivation to others who might otherwise have benefited from medical intervention whether in the ICU, or more broadly in the medical system. One person's provision is often another person's deprivation; so the decision to offer a non-beneficial treatment raises the ethical issue of how to allocate scarce medical resources.

20. To allow a patient or SDM to dictate the nature of medical treatment to be offered is to convert health care team members from professionals with professional obligations (including the obligation to do no harm) into mere technicians, little different from the machines that prolong a patient's dying . Just as a capable patient cannot justifiably be forced to accept a medical treatment, so a physician with professional integrity cannot be justifiably forced to provide pseudo-treatment that is not genuine treatment because it offers no medical benefit. Except in emergencies, provision of medical treatment can only occur with two willing participants.

21. The exception to these well-established principles created by the Court of Appeal is not only impractical, for reasons I will explore below, but also creates a distinction for which no ethical basis can be provided. The Court of Appeal draws a sharp ethical distinction between the withholding of life-prolonging treatment, which it judges to fall legitimately within the discretion of physicians and the withdrawal of life-prolonging treatment, which it judges to fall outside the discretion of the physician unless the patient or the patient's SDM consents. But, from an ethical point of view, the distinction between the withholding of life prolonging treatment, on the one hand, and its withdrawal, on the other, is a distinction without an ethical difference.

22. Either withholding or withdrawing life support will be justifiable when the life support technologies are incapable of providing more benefit than harm to the patient; and neither withholding nor withdrawal of life support will be justifiable when the life support technologies are likely to produce more benefit than harm (and their use is consented to by a competent adult patient or by the SDM of an incompetent patient). In short, whether dealing with a decision not to admit a patient to the ICU because the patient will not benefit from intensive care or a decision to withdraw a patient from the ICU because it has been discovered, subsequent to admission that the patient is not benefiting from ICU treatment is the same, from the ethical point of view. The same circumstances that make it ethical to withhold futile treatment make it ethical to withdraw futile treatment. Ethical obligations in medicine depend upon the health and well being of patients who are being treated or for whom treatment options are being considered. Therefore the implications for the patient of withholding and withdrawing care are precisely the same and the same criteria should apply to the decision to withdraw as apply to the decision to withhold.

23. While death may occur shortly after the withholding or the withdrawing of treatment, if that course of action is proper, the death must be considered to have been caused by the underlying illness and not the act or omission of withdrawing (or withholding) care which would be of no benefit.

24. The Court of Appeal's approach is impractical as it fails to provide any clear guidance to physicians, the health care team or patients and their SDMs. A patient with a life threatening illness may require admission to hospital or life support at different times during that illness but the primary justification for medical treatment should always be the reasonable likelihood that the patient might benefit. In situations of predicted good outcomes when treating a completely or partially reversible illness, the patient may experience sufficient recovery no longer to require

that treatment, in which case it may be discontinued without consent. The patient may then deteriorate again. When that deterioration occurs in the future, a new assessment is required as to whether or not the reinstitution of the treatment will provide medical benefit given the patient's state of health and likelihood of benefiting at that time. On the Court of Appeal's analysis, it is not clear whether a decision to not provide the treatment because of a lack of medical benefit would be treated as a withholding of treatment (to which no consent of the patient or SDM is required) or a withdrawal of a previously instituted treatment (in which case consent would be required from the patient or the SDM).

25. A further practical and ethical difficulty with the decision is that in the circumstances of a withholding of treatment, for which no consent is required, the Court of Appeal has set no guidelines as to a process to be followed to communicate this decision to the patient or SDMs, or guidelines as to the right of the patient or SDM to obtain second opinions or court guidance should the family choose to proceed in this fashion. Worryingly, the Court of Appeal provides little guidance to physicians for future cases and little protection to patients and families where legitimate medical disputes may exist.

26. Ethical obligations dictate that when a physician decides that a treatment offers no reasonable prospect of medical benefit that the following take place:

(a) Genuine dialogue and respectful discussion take place between the health care team (including not only physicians and nurses but also the hospital social worker, pastoral care provider, and ethicist) and the patient, where competent, or the family and SDM. Where consensus between the medical team and the family cannot be reached, the decision of the health care providers should be communicated to the family in a clear, honest and open fashion;

(b) The family should be provided with a reasonable opportunity to obtain a second medical opinion if desired;

(c) The family should be provided with a reasonable opportunity to seek legal advice and direction from the Court if it believes that the physician's decision is not in accordance with the standard of care; and

(d) Following any court determination of the issue, the physicians comply with the legal determination on standard of care.

27. The Court of Appeal in *Rasouli* provides no framework to ensure such a process is followed in cases where there is a dispute between physicians and family members about appropriate treatment. Instead, it insists on consent in a narrow set of circumstances and provides no framework with respect to all other circumstances.

28. Finally, the Court of Appeal's decision, by drawing an ethically indefensible distinction between withholding and withdrawing care, may indirectly encourage physicians to withhold care at the outset where its potential for benefit is small rather than risk the possibility of being unable to withdraw the care in the future when the lack of medical benefit is clear.

29. This decision will no doubt be used in future cases across the country where disputes arise; however, without further guidance applicable to all circumstances where these disputes arise costly and timely litigation will continue.

SWORN BEFORE ME at the City of Winnipeg, on July 29, 2011.	
Commissioner for Taking Affidavits	Arthur Schafer