CITATION: Rasouli v. Sunnybrook Health Sciences Centre
and Cuthbertson, 2011 ONSC 1500
COURT FILE NOS.: CV-11-419084
CV-11-419611
DATE: 20110309

SUPERIOR COURT OF JUSTICE - ONTARIO

RE: Hassan Rasouli, by his Litigation Guardian and substitute decision-maker, Parichehr Salasel, Applicants

AND:

Sunnybrook Health Sciences Centre, Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld, Respondents (Court File No.: CV-11-419084)

AND:

Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld, Applicants

AND :

Hassan Rasouli, by his Litigation Guardian and substitute decision-maker, Parichehr Salasel, Respondents (Court File No.: CV-11-419611)

BEFORE: Himel J.

COUNSEL: J. Gardner Hodder and Guillermo Schible, for the Applicant Hassan Rasouli

Daphne Jarvis and Wendy Whelan, for the Respondent Sunnybrook Health Sciences Centre

Harry Underwood and Andrew McCutcheon, for the Respondents
Dr. Cuthbertson and Dr. Rubenfeld

HEARD: February 25, 28 and March 3, 2011

REASONS FOR DECISION

[1] Hassan Rasouli applies to the court through his litigation guardian for an order preventing two physicians and the Hospital from withdrawing life-sustaining treatment being administered to him. The physicians make a cross-application for declaratory relief concerning the proposed withdrawal of mechanical breathing apparatus from Mr. Rasouli. These applications raise the question of whether consent is required from a patient or his substitute decision-maker for the withdrawal of treatment in an end of life situation, the proper procedure for resolving these

matters and the relationship between the doctors, the hospital and the patient in these circumstances.

FACTUAL BACKGROUND:

[2] In October 2010, Hassan Rasouli ("Mr. Rasouli") underwent surgery at the Sunnybrook Health Sciences Centre (the "Hospital") to remove a benign tumour in his head. Following the procedure, Mr. Rasouli developed bacterial meningitis and ventriculitis. The infection caused severe and widespread brain injury as well as damage to the brainstem and the spinal cord. He has been in a coma since October 16, 2010 and is being kept alive in the Critical Care Unit by a mechanical ventilator and is being fed through a tube inserted into his stomach.

[3] Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld are the doctors responsible for Mr. Rasouli's treatment. Dr. Richard Swartz is a staff neurologist who has assessed Mr. Rasouli on five occasions. These physicians have formed the opinion that Mr. Rasouli is in a persistent vegetative state ("PVS"), that all appropriate treatments for Mr. Rasouli's condition have been exhausted, that there is no realistic hope of medical recovery and that ongoing mechanical intervention will provide no medical benefit to Mr. Rasouli and may cause harm. The doctors believe that if this current course of treatment continues, he will die slowly from one of the many complications detailed in the affidavit of Dr. Brian Cuthbertson related to being permanently confined to a hospital bed. The doctors also submit that any prospects for recovery decline markedly after three months and that Mr. Rasouli has been in a state of unconsciousness now since mid-October 2010.

[4] The physicians met with Parichehr Salasel who is Mr. Rasouli's wife, litigation guardian and substitute decision-maker under the *Health Care Consent Act, 1996,* S.O. 1996, c. 2 Sched. A (the *"HCCA").* Mr. Rasouli is a 59 year old retired mechanical engineer. Ms. Salasel was a physician in Iran until the family moved to Canada in April 2010. The family are members of the Muslim faith. The doctors informed Mr. Rasouli's wife of the diagnosis and that they intend to discontinue the mechanical intervention and provide palliative care only to Mr. Rasouli. They have sought Ms. Salasel's acquiescence to the proposed plan but she disagrees. There have been further meetings with members of Mr. Rasouli's family and the doctors from the Critical Care Unit, neurologists, a neurosurgeon, nurses, a social worker and an ethicist. During the months since Mr. Rasouli has been in a coma, there have been a number of examinations by the Critical Care physicians and by the neurologist and various diagnostic tests administered. All the results are consistent with the clinical diagnosis of PVS which involves an irreversible loss of consciousness.

[5] The Hospital also arranged for a second opinion with Dr. Jan Ween, a neurologist who had not been treating Mr. Rasouli. He concurred with the diagnosis and assessment done by the staff neurologist. He is of the view that Mr. Rasouli will never regain consciousness and that he runs a high risk of various complications if he is continued on life support intervention. The doctors say that they have invited the family to have an independent neurological examination conducted but have not been provided with any such assessment. Further, the Hospital contacted the Toronto Western Hospital to see whether Mr. Rasouli could be treated at another hospital but

that hospital was not prepared to admit Mr. Rasouli and offer active management of his condition.

[6] The physicians and the Hospital have agreed to postpone their plans to withdraw treatment until the family could bring an application to the court. The physicians' cross-application asks this court to give declaratory relief that the patient is in a persistent vegetative state and absolving the physicians of civil and criminal responsibility concerning the proposed withdrawal of treatment.

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POSITIONS OF THE PARTIES:

[7] Ms. Salasel takes the position on behalf of her husband that it is consistent with the religious beliefs of Mr. Rasouli and his family that life be continued. Ms. Salasel maintains that it is the view of Shia Muslims that access to health care is a fundamental right and that a person is entitled to remain alive until all signs of life are gone. In other words, preventable death must be prevented. She opposes the plan proposed by the doctors to withdraw the mechanical ventilation. There is no evidence of wishes expressed by Mr. Rasouli when mentally capable concerning treatment he would wish to receive in these circumstances.

[8] The family says that they have seen Mr. Rasouli make certain movements and believe that he is aware of his surroundings and may be improving. They point to situations where a person in a minimally conscious state has been misdiagnosed as being in a persistent vegetative state and later recovers from unconsciousness. Therefore, they oppose the withdrawal of mechanical ventilation. Ms. Salasel submits that the proposed withdrawal of treatment decision should be taken to the Consent and Capacity Board ("CCB") established under the *HCCA* to determine what is in the best interests of Mr. Rasouli. Ms. Salasel also argues that the Hospital is an agent of the state and may not breach Mr. Rasouli's rights protected under the *Canadian Charter of Rights and Freedoms,* Part 1, *The Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, of freedom of conscience and religion and the right to life, liberty and security of the person.

[9] The doctors take the position that they are not required to continue to provide treatment which is of no benefit to a patient and falls outside the standard of care. They say, in fact, that they are obliged to refrain from continuing such treatment even if the patient or his substitute decision-maker demands it where they deem the treatment to be inhumane.

[10] Counsel for the doctors submits that the physicians have applied recognized and authoritative clinical criteria to Mr. Rasouli's situation and have confirmed the diagnosis that he is in a persistent vegetative state. This means that there is an irreversible loss of consciousness caused by brain injury and that he will not improve. The physicians have notified the family of this diagnosis and prognosis and of the plan to discontinue artificial life support and to provide palliative care only. The doctors say they have attempted to take into account the family's cultural and religious values. The physicians argue that the behaviour of Mr. Rasouli which may include movements of limbs, tearing, raising an eye-brow, blinking and other responses which the family may believe is evidence that he is gaining consciousness are really examples of non-

volitional reflex responses which are consistent with the diagnosis of PVS. They see no indication that Mr. Rasouli has been misdiagnosed and say there are no symptoms which suggest that he is in a minimally conscious state.

[11] The neurologists who have examined and assessed Mr. Rasouli are of the view that there is no realistic hope of recovery and that ongoing mechanical intervention will provide no medical benefit to Mr. Rasouli and may cause harm. As a result, the course of treatment is outside the standard of care and mechanical intervention should be withdrawn and withheld and replaced with palliative care only. The doctors also submit that in reaching this position they have followed policies created by the College of Physicians and Surgeons of Ontario, the Hospital and the Canadian Medical Association concerning decisions about life support interventions.

[12] Counsel for the physicians takes the position that, in accordance with the common law, it is not necessary to take a doctor’s proposal to withdraw treatment to the Consent and Capacity Board as the physician is not obliged to offer treatment that will not be of benefit to a patient and where continuing the life-sustaining treatment falls outside the standard of care. The physicians apply for a declaration that the decision to withdraw life sustaining treatment from a patient in a persistent vegetative state is a medical decision and that the consent of the patient’s substitute decision-maker is not required either at common law or under the *HCCA*. They also seek a declaration that the *Charter* does not apply to a physician’s decision to withdraw life sustaining treatment. Finally, they seek a declaration absolving them of criminal and civil liability for their proposed acts.

[13] The Hospital takes the position that it is unnecessary and perhaps inappropriate for it to be a party to this application as it is not the Hospital making the diagnoses, proposing the treatment and obtaining the consent. The Hospital cannot be required to perform medical acts and cannot direct physicians to provide treatment that the doctors deem medically inappropriate. The Hospital is the setting in which the independent physicians practice medicine and use its resources.

[14] It is the Hospital policy that the attending Intensive Care Unit physician is responsible for determining whether life support interventions are anticipated to be medically beneficial and whether a treatment lies within the standard of medical care. The policy also outlines how information is to be shared with the family, how a second opinion is to be facilitated and how a patient transfer be considered if a physician is willing to accept care and provide the treatment. All these steps have been done in Mr. Rasouli’s case.

[15] Because the Hospital is already named as a respondent, the Hospital participates in this hearing and takes the position that this end of life decision ought to be consistent with the clinical judgment of the patient’s Critical Care physicians acting in accordance with the patient’s best interests, standards of care, hospital policy and medico-legal ethics. The Hospital argues that in circumstances where medical interventions do not provide any medical benefit, they do not have to be held out as treatment as they do not meet the standard of care and consent is not required to withdraw or withhold mechanical ventilation. The Hospital supports the physicians in asking that the applicant’s request for injunctive relief be dismissed.

ANALYSIS AND THE LAW:

1. Should the physicians have brought the proposed plan to withdraw treatment to the Consent and Capacity Board or is the Superior Court of Justice the appropriate forum to determine the case?

“Treatment” under the *Health Care Consent Act*, S.O. 1996, c. 2, (the “*HCCA*”) includes Withdrawing Life Support

[16] Under the *HCCA*, doctors must obtain consent before administering treatment (s. 10(1)). Treatment as defined in s. 2(1) of the Act includes “plan of treatment”. For the following reasons, I conclude that “treatment” includes the withdrawal of life sustaining intervention.

[17] Section 10(1) of the *HCCA* outlines when a health practitioner must obtain consent:

> **No treatment without consent**
>
> **10.** (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,
>
> (a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or
>
> (b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person’s substitute decision-maker has given consent on the person’s behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).

[18] Consent must be obtained when a health practitioner proposes to administer a “treatment”. Therefore, if the withdrawal or removal of life support services is considered to fall within treatment as defined by the *HCCA*, health practitioners are required to obtain consent from a patient or their substitute decision-maker before withdrawing or ending life support.

[19] The *HCCA* defines treatment as follows:

> **“treatment”** means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include,
>
> (a) the assessment for the purpose of this Act of a person’s capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the *Substitute Decisions Act, 1992* of a person’s capacity to manage property or a person’s capacity for personal care, or the assessment of a person’s capacity for any other purpose,
>
> (b) the assessment or examination of a person to determine the general nature of the person’s condition,
>
> (c) the taking of a person’s health history,

(d) the communication of an assessment or diagnosis,

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

(f) a personal assistance service,

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

(h) anything prescribed by the regulations as not constituting treatment.

[20] The *HCCA* defines treatment plan as follows:

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

[21] *Scardoni v. Hawryluck*, 5 E.T.R. (3d) 226, 12 Admin. L.R. (4th) 67, 69 O.R. (3d) 700, (Ont. Sup. Ct.) is an Ontario case that discusses whether the withdrawal of treatment, such as life support, is included within the *HCCA* definition of "treatment". In *Scardoni*, the court heard an appeal from a decision of the Consent and Capacity Board directing the substitute decision-maker to consent to the withholding of intensive care treatments that had been administered to the patient in the past. The treatment included the use of a ventilator and intropic support.

[22] In the case, Cullity J. discussed whether "treatment" as defined in the *HCCA* includes the withholding or withdrawal of treatment. He wrote as follows:

> [42] An alternative interpretation that Ms Chan supported is that all references to "treatment" in s.10(1) include a plan of treatment and that the obligation imposed by the subsection relates to the plan as whole, including the withholding or withdrawing of particular treatment. This interpretation, I believe, is more consistent with the definitions in s. 2 that are reproduced above. [...]

[23] Cullity J.'s comments in *Scardoni* were *obiter,* as he found that regardless of the definition of treatment under the *HCCA*, the Board had jurisdiction to hear the application as the consent of the substitute decision-maker was requested by the health practitioner in this case.

[24] In my view, the interpretation of treatment as including withholding and withdrawing treatment accepted by Cullity J. is consistent with the definition of "treatment" under the Act.

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[25] The proper approach to the interpretation of legislative language is the modern or purposive approach outlined by the Supreme Court of Canada in *Bell ExpressVu Ltd. Partnership v. Rex*, 2002 SCC 42, [2002] B.C.W.L.D. 366 at para. 26:

> There is only one principle or approach, namely, the words of an Act are to be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament.

[26] The Ontario Court of Appeal stated in *F. (M.) v. S. (N.)*, 134 O.A.C. 117, 49 O.R. (3d) 414, 44 C.P.C. (4th) 193; leave to appeal refused by [2000] S.C.C.A. No. 531:

> [28] A basic principle of statutory interpretation is that the court should adopt the ordinary meaning of a legislative provision absent a good reason to reject it. The ordinary meaning is presumed to be the intended or most appropriate meaning unless the context, or the purpose and scheme of the legislation, or the consequences of adopting the ordinary meaning suggest otherwise. Professor Ruth Sullivan, who edited the third edition of *Driedger on the Construction of Statutes*, sets out the presumption in favour of the ordinary meaning:
>
>> (1) It is presumed that the ordinary meaning of a legislative text is the intended or most appropriate meaning. In the absence of a reason to reject it, the ordinary meaning prevails.
>>
>> (2) Even where the ordinary meaning of a legislative text appears to be clear, the courts must consider the purpose and scheme of the legislation, and the consequences of adopting this meaning. They must take into account all relevant indicators of legislative meaning.
>>
>> (3) In light of these additional considerations, the court may adopt an interpretation in which the ordinary meaning is modified or rejected. That interpretation, however, must be plausible; that is, it must be one the words are reasonably capable of bearing.

[27] In applying the approach outlined in *F. (M.)* to the statutory interpretation of the term “treatment”, the court must consider the ordinary meaning of the text, the purpose and scheme of the legislation, the consequences of adopting this meaning and, if a modified meaning is adopted, the plausibility of that modified meaning.

[28] The definition of “treatment” under the *HCCA* includes “plan of treatment”. Plan of treatment is defined in s. 2(1) and is outlined above. On a plain reading of this text the ordinary meaning is that withholding or withdrawing treatment in accordance with a patient’s health condition is included in a plan of treatment.

[29] This definition is circular in that the word “treatment” must be defined in and of itself in order to determine what “withholding or withdrawal of treatment” means. The *HCCA* definition of treatment includes anything done for “therapeutic” or “preventive” purposes.

[30] *Stedman's Medical Dictionary*, 27th ed., defines "preventive" as "to come before, prevent." "Therapeutic" is defined as "relating to therapeutics or to the treatment, remediating, or curing of a disorder or disease."

[31] The provision of life support, such as mechanical ventilation, falls within these definitions. According to the Hospital Policy on Appropriate Use of Life-sustaining Treatment produced by the University of Toronto Joint Centre for Bioethics/Critical Care Program Task Force, "the goal of intensive care is to prevent unnecessary suffering and premature death by treating *reversible* illnesses for an appropriate period of time."[1] Life support is included in the life sustaining treatment offered in intensive care. When viewed in this light, the goal of life support is to "prevent suffering and premature death" and treat "reversible illness".

[32] At issue in this application is whether the life sustaining treatment being offered to the applicant is fulfilling the goal outlined above. When interpreting the *HCCA*, the characterization of the type of care offered by life support should be determined based on its intended purpose. This purpose falls within "preventive" and "therapeutic" treatment.

[33] Therefore, on the ordinary meaning of the text, life support falls within the definition of treatment under the *HCCA*. Thus, according to the definition of plan of treatment, the withholding or withdrawing of life support also falls within the definition of "treatment".

[34] Next the purpose and scheme of the legislation must be considered. Section 1 of the *HCCA* outlines the purposes of the Act:

> 1. The purposes of this Act are,
>
> (a) to provide rules with respect to consent to treatment that apply consistently in all settings;
>
> (b) to facilitate treatment, admission to care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters;
>
> (c) to enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed and persons who are to receive personal assistance services by,
>
> (i) allowing those who have been found to be incapable to apply to a tribunal for a review of the finding,
>
> (ii) allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on their behalf

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[1] Hospital Policy on Appropriate Use of Life-Sustaining Treatment, Crit Care Med 2001 Vol. 29, No. 1.

concerning treatment, admission to a care facility or personal assistance services, and

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

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

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

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

[35] When considering the issue of consent on behalf of incapable patients, the purposes stated in sections 1(a), 1(b) and 1(e) are notably relevant.

[36] During the hearing of these applications, counsel for the doctors and the Hospital were asked to comment on various cases where decisions concerning the withdrawal of treatment had been taken before the CCB. The respondents contend that doctors have the ability to choose whether or not a decision to withdraw life support will be referred to the CCB. They submit that while doctors are able to make the decision to end life support unilaterally, it is within their discretion to ask substitute decision-makers for consent, and refer the decision to the CCB if consent is not granted. Counsel for the Hospital cited circumstances where doctors may choose to bring the proposed plan to withdraw treatment to the Board. According to the respondents' submissions, applying the *HCCA* consent process in regard to end of life decisions is completely optional.

[37] In my view, this position is not consistent with s. 1(a) of the *HCCA*: to provide rules with respect to consent to treatment that apply consistently in all settings. If the respondents' interpretation of the *HCCA* is accepted, no consistent rules regarding the withdrawal of life support in Ontario would exist. Whether or not substitute decision-makers would be given an opportunity to consent would depend on the doctor in question, with recourse only being had to the CCB at the doctor's discretion.

[38] The interpretation of "treatment" as including the withdrawal of life support is, however, consistent with s. 1(a) of the *HCCA*. Treatment decisions subject to the consent provisions of the *HCCA* must follow the established statutory scheme, which provides for situations in which consent is needed, who the substitute decision-maker shall be, what considerations must be taken into account when the decision is made and how disputes regarding the decision shall be determined. The definition of "treatment" as encompassing the withdrawal of life support gives patients and their substitute decision-makers the assurance and benefit of knowing exactly what process a decision ending life support must follow. Such consistency province-wide is in accordance with the purposes of the *HCCA*.

[39] The purpose of facilitating treatment stated in s. 1(b) for persons lacking capacity is arguably achieved whether the end of life decision lies with the doctor or with the substitute decision-maker. In either case, someone has the legal authority to make the decision as to whether life support should be continued or stopped on behalf of the incapable person. However, the scheme of the *HCCA* facilitates treatment on behalf of incapable individuals through the requirements of consent under s. 10(1) and the appointment of substitute decision-makers under s. 20(1). The legislature has created a process that facilitates treatment through the delegation of decisions to specific individuals: those eligible to be substitute decision-makers, or, in the event no person listed under s. 20(1) is available, the Public Guardian and Trustee (see: s. 20(5).) Facilitating the treatment, including the withdrawal of life support, of incapable persons by applying this established statutory process is consistent with the scheme of the *HCCA*.

[40] Section 1(e) of the *HCCA* provides that a purpose of the Act is to ensure a significant role for supportive family members when a person lacks capacity. The provision for the automatic appointment of substitute decision-makers under s. 20 and the requirement that doctors obtain consent from substitute decision-makers pursuant s. 10(1) ensures this significant role. If no consent is needed for end of life decisions family members are not provided with the same role in regard to such decisions as that afforded to them in the making of other treatment decisions on behalf of an incapable person. The role of substitute decision-makers would depend on the doctor in question and would vary with hospital policies.

[41] Including the withdrawal of life support in the definition of treatment ensures that family members, specifically substitute decision-makers, play a significant and important role in end of life decisions. This is consistent with the purpose established in s. 1(e) of the *HCCA*.

[42] While the inclusion of withdrawing life support in the definition of treatment appears to be consistent with the purpose and scheme of the *HCCA*, it is also important to consider the consequences of this interpretation. The respondents submit that adopting this interpretation will result in patients being able to pick and choose their own treatment. If consent is required to withhold or withdraw treatment, doctors will have a duty to provide and a duty to continue to provide whatever treatment is demanded by patients.

[43] In *Scardoni*, Cullity J. stated that as a general proposition he accepted that the definition of “treatment” should not be construed as to permit a patient or their substitute decision-maker to choose the health treatment to be administered. However, he found that:

> [40][...] It does not, however, follow that there is no room for a distinction between treatments that should be considered to be withdrawn, or withheld, for the purposes of the statutory definition of a plan of treatment and other treatments that health practitioners would considered to be inappropriate for a patient’s medical condition. If consent is required for the former, the statute does confer an element of choice on a capable patient and requires a consideration of the factors in s. 21 when the patient is incapable.
>
> [...]

> [42][...] The distinction between treatment that is rejected by heath practitioners as appropriate on health grounds and treatment that [a]s part of a plan of treatment is withheld may be difficult- and even very difficult- to apply in some cases, but not, I think, here where the application of the treatment in intensive care for specific problems [...] has been found by her physicians in the past to be medically appropriate and would be administered in the future but for their views of her best interests within the meaning of s. 21 of the Act [...]

[44] Cullity J.'s comments indicate that a distinction can be made between treatment that has been withdrawn as a part of a plan of treatment and treatments that cannot be considered part of a plan of treatment because they were rejected from the onset as being medically inappropriate. While this distinction may be difficult to apply, the wording of the *HCCA* forecloses the possibility of patients picking and choosing their own treatment on the basis of this distinction.

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

[46] The respondent Hospital further contends that a consequence of adopting the withdrawal of life support into the definition of treatment under the *HCCA* may be that the limited resource of intensive care will be overwhelmed with individuals with no hope of recovery remaining on life support for extended periods of time. However, the *HCCA* provides recourse to doctors in the event that they believe someone is being kept on life support when it is not beneficial to them and not medically indicated.

[47] Under s. 37 of the *HCCA*, doctors can apply to the CCB for a determination as to whether a substitute decision-maker's decision to maintain life support is in the best interests of the patient in accordance with s. 21 of the *HCCA*. If the CCB so determines that it is not in the patient's best interests to continue receiving life support, the decision of the CCB will be substituted for that of the substitute decision-maker: see s. 37(3). Sections 37(1) and 21 read as follows:

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

> **Principles for giving or refusing consent**
>
> **21.** (1) A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles:
>
> 1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.
> 2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.
>
> **Best interests**
>
> (2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,
>
> (a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;
>
> (b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and
>
> (c) the following factors:
>
> 1. Whether the treatment is likely to,
>   - i. improve the incapable person's condition or well-being,
>   - ii. prevent the incapable person's condition or well-being from deteriorating, or
>   - iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
> 2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
> 3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
> 4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

[48] Once the CCB receives an application under s. 37(1), the Board is required to promptly fix a time and place for a hearing: see s. 75(1). The hearing shall begin within seven days after the day the Board receives the application, unless the parties agree to a postponement: see s. 75(2). The Board must release its decision within one day after the day the hearing ends: see s. 75(3). Pursuant to s. 71(3) the Chair of the Board specifies qualifications that must be met by members of the Board before they are assigned to deal with certain applications. According to the Consent and Capacity Board's *2009-2010 Annual Report*, as of March 31, 2010, the CCB

members included: 46 lawyers, 47 psychiatrists and 41 public members. In many cases, the panel will include all three of these persons: see *Re EJG*, 2007 CanLII 44704 (ON C.C.B.); *Re N*, 2009 CanLII 42576 (ON C.C.B.); *Re G*, 2009 CanLII 25289 (ON C.C.B.); *Re B*, 2009 CanLII 50838 (ON C.C.B.). However, s. 73(2) of the *HCCA* stipulates that a member of the Board may be assigned to sit alone to deal with an application if they have certain qualifications. Section 73(2) reads as follows:

> **Qualifications of member sitting alone**
>
> (2) A member of the Board may be assigned to sit alone to deal with an application only if,
>
> (a) throughout the two-year period immediately preceding the assignment, he or she has been a member of the Board or of the review board established by section 37 of the *Mental Health Act*, as it read before the day subsection 20 (23) of the *Consent and Capacity Statute Law Amendment Act, 1992* came into force;
>
> (b) he or she is a person licensed under the *Law Society Act* to practise law in Ontario as a barrister and solicitor and, throughout the 10-year period immediately preceding the assignment, he or she has been,
>
> (i) a person licensed under the *Law Society Act* to practise law in Ontario as a barrister and solicitor, or
>
> (ii) a member of the Law Society of Upper Canada and, subsequently, a person licensed under the *Law Society Act* to practise law in Ontario as a barrister and solicitor;
>
> (c) in the case of an application for a review of a finding of incapacity, he or she has experience that, in the opinion of the chair, is relevant to adjudicating capacity; and
>
> (d) he or she meets all of the other qualifications specified by the chair under subsection 71 (3).

[49] The timelines for CCB applications and the qualifications required of Board members ensure that disputes regarding consent to the withdrawal of life support will be handled expeditiously and by a tribunal with expertise in the area. The process under s. 37(1) helps to prevent hospital intensive care units from becoming overwhelmed with incapable persons receiving life support when it is not in their best interests.

[50] It is noteworthy that the current practice of many doctors is to seek consent for end of life decisions, and if they disagree with the decision of a substitute decision-maker refer the decision to the CCB. *Maraachli and Nader v. Dr. Fraser*, 2011 ONSC 124, *P. (D.), Re,* 2010 CarswellOnt 7848 (C.C.B.), *Grover v. Grover*, 2009 CarswellOnt 1944 (Ont. Sup. Ct.), *E.J.G. (Re)*, 2007 CanLII 44704 (C.C.B.), *G (Re)*, 2009 CanLII 25289 and *N.,(Re)*, 2009 CarswellOnt 4748, are all examples of cases where health practitioners requested consent from substitute decision-makers to stop life support treatments. In all of the cases, the substitute decision-makers refused, and the health practitioners applied to the Board to challenge the refusal pursuant to s. 37(1) of the *HCCA*. These decisions demonstrate that many health practitioners in Ontario regard

the process under the *HCCA* as the appropriate recourse when consent to the withdrawal of life support is refused.

[51] Seeking consent from an incapable person's substitute decision-maker is also consistent with the College of Physicians and Surgeons of Ontario policy statement, *Decision-making for the End of Life*. Under the title "Capacity and Informed Consent", the policy states at p. 3:

> The requirements of informed consent at the end of life are the same as the requirements in other situations (see the Consent to Medical Treatment policy).
>
> When the patient is mentally capable, he or she makes treatment decisions and must provide consent for the many decision involved in his or her care, including the participation of family members. When the patient is not capable, a substitute decision-maker makes these decisions for the patient.
>
> Informed decision-making requires that the patient or substitute decision-maker be given the information and support necessary for assessing the available options for care. In the context of decision-making for the end of life, this includes information about the potential benefits, risks and consequences of the proposed courses of action, including palliative care.

[52] On a reading of the definition of "treatment" in the *HCCA* in its entire context and in its grammatical and ordinary sense harmoniously with the scheme and object of the Act, I conclude that treatment includes the withdrawal of life support treatment and that the provisions of the *HCCA* apply in this case.

The Common Law Position on Obtaining Consent to Withdraw Life Support is Unclear in Canada

[53] If the withdrawal of life support is found not to fall within the definition of "treatment" as defined by the *HCCA*, the common law applies: "The common law continues to apply to any matters that fall outside the purview of the *HCCA* and the *SDA*."[2]

[54] The respondents submit that according to the common law, doctors do not require consent to withhold or withdraw treatment. The applicant submits the contrary, stating that in Canada, courts have found doctors do require consent before withdrawing life support.

[55] I have determined that the statutory scheme for consent under the *HCCA* applies to the withdrawal of life support. The common law in Canada on this issue is unclear in my view. It is

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[2] Dr. Hy Bloom and Michael Bay, "A Practical Guide to Mental Health, Capacity, and Consent Law of Ontario" (1996: Thomson Canada Ltd., Scarborough) at 17.

useful to mention briefly the law in other jurisdictions and to provide an overview of relevant case law and academic commentary to illustrate the status of the common law on consent to withholding or withdrawing treatment in Canada.

1. Consent and the Withdrawal/Withholding of Treatment in the United Kingdom

(a) Legislation:

[56] Consent to medical treatment in the United Kingdom is regulated by the *Mental Capacity Act*, 2005 c.9, ("*Mental Capacity Act*"). U.K. law stipulates that consent must be obtained before any examination, treatment or care for competent adult patients. The law provides for persons to establish lasting powers of attorneys who can make decisions on their behalf in the event of their incapacity (s. 9, *Mental Capacity Act*). The law does not, however, provide for the appointment of a substitute decision-maker in the event that a person becomes incapacitated and does not have a power of attorney. At English common law, no one can give legally valid consent to medical treatment on behalf of another adult: see *Re F* [1989], 2: All ER545. However, doctors are able to treat incapable patients absent consent under the "principle of necessity" established in *Re F*. In making a decision as to how to treat an incapacitated patient doctors must apply the best interests test established in s. 4 of the *Mental Capacity Act*.

[57] Therefore, in the U.K., there is no reciprocal scheme to that of the *HCCA* requiring the consent of substitute decision-makers. Absent a power of attorney, decisions regarding the medical treatment of an incapacitated individual lie with the doctor.

(b) Case Law:

[58] U.K. case law has consistently held that doctors do not need consent to withdraw or withhold treatment. In *Re R*, [1991] 4 All E.R. 177, the court stated:

> It is trite law that in general a doctor is not entitled to treat a patient without the consent of someone who is authorized to give that consent...however consent by itself creates no obligation to treat. It is merely a key which unlocks a door...no doctors can be required to treat a child, whether by the court in the exercise of its wardship jurisdiction, by the parents, by the child or anyone else.

[59] The principles established in *Re R* were supported in *Re (J) a minor (wardship: medical treatment),* [1992] 4 All E.R. 614 (C.A.). In *Re (J),* the court dealt with the question of whether artificial ventilation should be removed from a 16 month old child. Local authorities had sought an order requiring the health authority to continue to provide all available treatment including "intensive resuscitation" to the child. An injunction preventing withdrawal of mechanical ventilation was ordered at trial. On appeal the court overturned the injunction and stated as follows at p. 516:

> The fundamental issue in this appeal is whether the court in the exercise of its inherent power to protect the interests of minors should ever require a medical practitioner or

> health authority acting by a medical practitioner to adopt a course of treatment which in the bona fide clinical judgment of the practitioner concerned is contraindicated as not being in the best interest of the patient. I have to say that I cannot at present conceive of any circumstances in which this would be other than an abuse of power as directly or indirectly requiring the practitioner to act contrary to the fundamental duty which he owes to his patient.

[60] In *Airedale NHS Trust v. Bland*, [1993] 1 All ER 821, the court considered whether a doctor needed consent to remove from life support a man who had been in a vegetative state for three years. The House of Lords concluded that the withdrawal of life support was not illegal without a court order. The court did order, however, that at least for a time, an application should be made to court for approval before ending life support treatments. Lord Keith wrote at p. 4:

> The decision whether or not the continued treatment and care of a PVS patient confers any benefit on him is essentially one for the practitioners in charge of his case. The question is whether any decision that it does not and that the treatment and care should therefore be discontinued should as a matter of routine be brought before the Family Division for endorsement and review .... this would be in the best interests of the protection of patients, the protection of doctors, the reassurance of the patients' families and the reassurance of the public. I respectfully agree that these considerations render desirable the practice of application.

[61] The U.K. cases consistently hold that doctors do not legally require consent to withdraw treatment. However, *Airedale* illustrates that despite this common law position, the U.K. courts still consider it prudent for doctors to seek court approval. This illustrates an acceptance of a role for the court in such decisions.

2. Consent and the Withdrawal/Withholding of Treatment in the United States

(a) Legislation:

[62] In the U.S., legislation regarding the treatment of incapable persons varies by state. Some states have enacted legislation which establishes surrogate decision makers in the event a patient becomes incapacitated and has not previously appointed someone to make decisions on their behalf. For example, in New York *The Family Health Care Decisions Act*[3] at §2994-d.1 sets forth, in order of priority, the persons who may act as a surrogate decision maker for an incapable patient. It grants the surrogate the authority to make all health care decisions for the patient that the adult patient could make for him or herself, subject to certain limitations.

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[3] Chapter 8, Laws of 2010, adding N.Y. Public Health Law Article 29-CC ("The Family Health Care Decisions Act") and amending various other laws.

[63] Another example of such legislation is the Illinois *Health Care Surrogate Act*, 755 ILCS 40. This legislation states that when a doctor determines a patient is incapacitated and no living will or power of attorney is in place, the doctor must try to determine whether the patient has any relatives or friends available to serve as a surrogate decision maker. An order of priority is set out to determine who will serve as the decision maker under s. 25.

(b) Case Law:

[64] The leading case in the United States on end of life decisions and consent is *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990). In *Cruzan* the family requested the termination of life-sustaining treatments to their relative who was in a persistent vegetative state. Hospital employees refused to terminate life support without the authorization of the court.

[65] The Supreme Court of the United States affirmed the decision of the Supreme Court of Missouri finding it was acceptable to require "clear and convincing evidence" of a patient's wishes for the removal of life support. The court held that while individuals enjoyed the right to refuse medical treatment under the Due Process Clause, incompetent persons are not able to exercise such rights. Absent "clear and convincing" evidence that the patient desires treatment to be withdrawn, the court found the State of Missouri's actions designed to preserve human life to be constitutional. Because there was no guarantee family members would always act in the best interests of incompetent patients, and because erroneous decisions to withdraw treatment were irreversible, the court upheld the state's heightened evidentiary requirements

[66] In *Matter of Dinnerstein*, 380 N.E.2d (U.S. Mass. C.A. 1978), the Massachusetts Appeal Court determined that a decision to issue a "do not resuscitate order" does not require judicial approval. The court stated that the question of whether or not to issue a DNR order:

> [...] [I]s not one for judicial decision, but one for the attending physician, in keeping with the highest traditions of his profession, and subject to court review only to the extent that it may be contended that he has failed to exercise "the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession.[4]

[67] The *Dinnerstein* case supports the contention that the decision as to whether to withhold or withdraw treatment lies with health practitioners, and the court should not play a role in such decisions. However, in cases since *Dinnerstein,* a different approach has been taken.

[68] In *In the Matter of Earl N. Spring*, 405 N.E. 2nd 115, 120 (1980), the Massachusetts Supreme Judicial Court overturned *Dinnerstein* to the extent that it shifted the ultimate decision making authority from the court to the physician and family members.[5] The court stated that in Massachusetts there is a preference for judicial decision making in cases involving difficult

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[4] *Dinnerstein, supra.* at 139.

[5] *Spring, supra*. at 120.

medical decisions for incapacitated individuals. The court summarized at p. 634 the following factors that should be considered in deciding the need for judicial approval of a desired medical treatment:

1. the extent of impairment of the patient's mental faculties;
2. whether the patient is in the custody of a State institution;
3. the prognosis without the proposed treatment;
4. the prognosis with the proposed treatment;
5. the complexity, risk and novelty of the proposed treatment;
6. its possible side effects;
7. the patient's level of understanding and probable reaction;
8. the urgency of decision;
9. the consent of the patient, spouse, or guardian;
10. the good faith of those who participate in the decision;
11. the clarity of professional opinion as to what is good medical practice;
12. the interests of third persons; and
13. and the administrative requirements of any institution involved.

[69] *Spring* demonstrates that the U.S. courts have acknowledged that they have a role to play in the decision to withhold or withdraw treatment. This role was demonstrated in the more recent case of *Schindler v. Schiavo (In re Guardianship of Schiavo),* 780 So. 2d 176 (Fla. 2d DCA 2001). In *Schiavo*, a substitute decision-maker brought an application to the Sixth Circuit Court for Pinellas County, Florida, to have life support withdrawn from a woman who was in a persistent vegetative state. The woman's parents opposed the application. The court ordered the removal of life support. The decision was followed by numerous motions and appeals to the Florida Second District Court of Appeal. The end result was that life support was withdrawn. This case illustrates a U.S. court taking a very active role in an end of life decision, and not leaving the issue of final consent to the patient's doctors or substitute decision-maker.

[70] *Spring* and *Schiavo* illustrate that in the U.S., decisions as to whether to withdraw or withhold treatment are not necessarily left in the hands of health practitioners and the court does play an active role in determining these questions.

3. Canadian Case Law and Academic Commentary

[71] As noted by M. Metivier J. in *Children's Aid Society of Ottawa-Carleton v. M.C.*, [2008] O.J. No. 3795, 301 D.L.R. (4th) 194, (Ont. Sup. Ct.) at para. 11, "...there is very little case law in Canada on the meaning of the word treatment, and there is particularly little discussion of whether treatment can include a decision to cease treatment where a patient is terminally ill or has very little chance of survival".

[72] *Child & Family Services of Central Manitoba v. L. (R.)* [1997], 154 D.L.R. (4th) 409, 123 Man. R. (2d) 135 (C.A.), is one of the few cases that addresses this issue. In *Child & Family Services* the court found that:

> [10] The treatment of a patient, whether surgically, with drugs or by other intrusive means, involves a touching of the patient's person. Unless done with the consent of the patient, such a touching would ordinarily amount to an assault.
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> [...]
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> [13] It follows, in my opinion, that the word "treatment" when used in s. 25(3) is used only in a positive sense. There is no need for a consent from anyone for a doctor to refrain from intervening.
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> [14] There is no legal obligation on a medical doctor to take heroic measures to maintain the life of a patient in an irreversible vegetative state. [...] The only fear a doctor need have in denying heroic measures to a patient is the fear of liability for negligence in circumstances where qualified practitioners generally would have thought intervention warranted.
>
> [...]
>
> [17] [...] [N]either a consent nor a court order in lieu is required for a medical doctor to issue a non-resuscitation direction where, in his or her judgment, the patient is in an irreversible vegetative state.

[73] According to *Child & Family Services*, no consent is needed at common law for a doctor to withdraw or withhold treatment.

[74] *Rotaru v. Vancouver General Hospital Intensive Care Unit,* 2008 BCSC 318, [2008] B.C.J. No. 456, provides further support for the proposition that a doctor does not need consent to withhold treatment. In that case, the physicians did not believe that dialysis treatment should be provided to a palliative patient. The court surveyed United Kingdom decisions which consistently held that as a doctor has no requirement to provide treatment, a court cannot order them to do so: see *Re (J), supra* and *Re R, supra*. Burnyeat J. agreed with the view that he "could not conceive of any circumstances in which it would be other than an abuse of power to require a medical practitioner to act contrary to the fundamental duty which that practitioner owed to his or her patient". [6] On this basis, he refused to order the health practitioner to begin re-administering treatment that was provided to the patient in the past.

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[6] *Rotura*, *supra*, at para. 16.

[75] In *Children's Aid,* M. Metivier J. found that the correct principle to apply in decisions of this nature is that "the decision to withdraw or withhold life-sustaining treatment is inherently a medical one, "within the sole purview of a patient's treating doctors"".[7] At para. 33 she wrote "…consent is not needed for the doctors to make use of their professional judgment and discretion to cease treatment or give only palliative care." It is noted that in *Children's Aid* the application of the *HCCA* was not considered.

[76] *Child and Family Services, Rotaru* and *Children's Aid* can be cited as authority for the proposition that health practitioners do not need consent to withhold or withdraw treatment. This line of jurisprudence is significantly predicated on the idea that doctors do not have an obligation to treat a patient or a duty to provide treatment. In the text *Legal Liability of Doctors and Hospitals in Canada,* Ellen I. Picard and Gerald B. Robertson discuss the issue under the title "Futile or Inappropriate Treatment" at page 345:

> As we have seen, once a doctor-patient relationship is formed, the doctor's obligation is to treat the patient. However, this does not mean that the doctor has a duty to provide (and the patient a correlative right to receive) whatever treatment the patient may request. If a patient requests treatment which the doctor considers to be inappropriate and potentially harmful, the doctor's overriding duty to act in the patient's best interests dictates that the treatment be withheld. A doctor who accedes to a patient's request (or demand) and performs treatment which he or she knows, or ought to know, is contra-indicated and not in the patient's best interests, may be held liable for any injury which the patient suffers as a result of the treatment.
>
> Likewise, there is no legal duty to perform treatment which the doctor reasonably believes to be medically futile, that is treatment which offers no reasonable prospect of therapeutic benefit to the patient. However, many commentators have emphasized the potential dangers and problems underlying the concept of medical futility, particularly if it is interpreted broadly and used to justify the withholding of treatment for socio-economic and value-laden reasons. It is essential that strict limits be placed on this concept. Useful guidance is to be found in the report of the Special Senate Committee on Euthanasia and Assisted Suicide, which recommended that "futility" in this context should be construed very narrowly to mean "treatment that will, in the opinion of the health care team, be completely ineffective."[8]

[77] The absence of a legal duty to perform and provide treatment supports the contention that at common law, doctors do not need consent to withdraw or withhold treatment.

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[7] *Children's Aid, supra,* at para. 26.

[8] (Alberta: Thomson Carswell, 2007).

[78] However, in certain cases, Canadian courts have found that they have a role in adjudicating end of life decisions, and that such decisions are not entirely within the unilateral discretion of doctors.

[79] In *Sawatzky v. Riverview Health Centre Inc*., [1998] M.J. No.506, 167 D.L.R. (4th) 359, the Manitoba Court of Queen's Bench considered the application of a wife for an injunction preventing a hospital from imposing a "do not resuscitate" order on her husband. At the time, the husband had a tracheostomy and difficulty communicating. The "do not resuscitate" order was imposed without consultation with the wife. The court allowed the application, noting that, while at U.K. common law doctors do not require consent to implement such orders, these cases had not considered the issue in the context of the *Charter*.[9] Beard J. found that there was a role for the courts in considering whether treatment should be withheld or withdrawn:

> [38] While courts and judges do not have any expertise in making medical decisions, they do have expertise in resolving factual disputes and in making legal decisions. In the case of non-consensual medical decisions, be they decisions to provide, withdraw or refuse care or treatment, there is a role for the courts to play in making factual determinations and advising of the legality or illegality of disputed decisions before the patient is dead. The very suggestion that there is the option of a claim in negligence raises the fact that doctors can and, on occasion, do make mistakes. Further, many of the decisions that they make are qualitative and there is much room for individual disagreement on the correctness of the decision. Such findings would surely guide the doctor as she/he makes these decisions.
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> [39] There is also a public interest aspect involved in some of these issues which needs to be recognized including, as was stated by Lord Keith in the Airedale case, the protection of the patients, the reassurance of the patients' families and the reassurance of the public. At the end of the day, it is the doctors who will have to make the medical decisions, but they will do so knowing the facts and the likely legal outcome of those decision. As is often said, justice must not only be done but be seen to be done. This is appropriate whether speaking of justice in the courtroom or justice in terms of medical care.

[80] In *Golubchuk v. Salvation Army Grace General Hospital*, 2008 MBQB 49, [2008] M.J. No. 54, the court considered the issue of the removal of life support. The substitute decision-maker had not consented to the health practitioner's proposal to remove a ventilator. P. Schulman J. allowed an injunction to prevent the doctor from removing the ventilator. Before determining that the injunction was appropriate, he rejected the hospital's argument that the court had no role in the matter as the health practitioner did not need consent to withdraw medical

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[9] *Swatzky*, *supra*, at para. 28.

treatment. In concluding that the court did have a role, he cited Professor B. Sneiderman's commentary of *Child and Family Services* as follows:

> [18] Prof. Sneiderman's commentary on the *R. L.* case is relevant here. At p. 207, he stated:
>
> > The focus is thus not upon the patient's medical condition nor upon the treatment to be withheld or withdrawn. Rather it is upon the crucial circumstances requiring consent — <u>treatment that involves physical contact with the patient's body</u>. It follows that if there is no such contact, the physician can act unilaterally even if the patient is not vegetative and the treatment refrained from is not cardiopulmonary resuscitation (CPR).
>
> He stated at p. 214:
>
> > . . . In other words, if there is no touching, then consent is not required. <u>If</u> however, <u>a sedating dose of morphine were indicated</u> because the patient might otherwise gasp for breath, <u>then consent would be required</u>. It is true that if the physician did nothing and allowed the patient to suffer needlessly before dying of respiratory failure, then the family could sue for negligence. Still, this scenario sure illustrates the peculiar nature of a ruling that takes the overall treatment plan for a patient and bisects it into treatment, which requires consent, and refraining from treatment, which does not.

Justice Schulman went on to discuss what would need to occur to remove the ventilator and stated:

> [23] Given the facts that the removal of the ventilator probably involves some interaction with the plaintiff's body; that it involves the providing of narcotics over the plaintiff's objection in the sense that, if the ventilator is not disconnected, it will not be necessary to give it; and that removal will lead to the passing of the plaintiff sooner in time than if he remained on the ventilator, what is this court's appraisal of the strength of the plaintiff's case?

[81] It should be noted that in *Children's Aid Society* one of the grounds on which *Golubchuk* was distinguished was that the proposed withdrawal of treatment in *Golubchuk* involved physical intervention.

[82] *Sweiss v. Alberta Health Services*, 2009 ABQB 691, [2009] A.J. No. 1303, is another case that involved the decision to remove mechanical ventilation from a patient. The substitute decision-maker did not consent to the withdrawal of the machine, and the court granted an injunction preventing its withdrawal. While the hospital argued that the application for an injunction should be dismissed because no consent is required for a physician to refrain from intervening, the court did not address this issue specifically in its reasons. However, the court clearly did not accept this argument as it granted the injunction. *Sweiss* serves as an interesting

example of another case in which the court did not find that health practitioners do not require consent to withdraw treatment.

[83] *Sawatzky, Golubchuk* and *Sweiss* demonstrate that the common law position on whether consent is needed to withdraw or withhold treatment in Canada is not firmly decided. The inconsistencies in Canadian case law on the issue and the existence of jurisprudence supporting a duty to obtain consent in withdrawal of treatment circumstances, lead to the conclusion that the law on whether consent is needed to withdraw or withhold treatment in Canada is not well-settled.

2. Does the Canadian *Charter of Rights and Freedoms* apply to this case?

[84] In addition to seeking injunctive relief, the applicant relies on the *Canadian Charter of Rights and Freedoms* and submits that the *HCCA* should be read in accordance with *Charter* values. The applicant's position is that the *Charter* applies to hospitals when they are engaged in the administration and delivery of health services. He submits that doctors are in the same position as hospitals, as it is through doctors that hospitals serve the public and doctors are paid by the government for their services. Therefore, the applicant submits that the respondents' decision to withdraw mechanical ventilation must be made in accordance with the *Charter.* Further, a decision to terminate treatment would be a breach of Mr. Rasouli's s.7 rights to "life, liberty and security of the person" as guaranteed under the *Charter.* Given the application for a declaration that the *Charter* applied and that Mr.Rasouli's s. 7 rights would be breached, I ordered that the applicant should give notice to the Attorney General of Ontario in accordance with s. 109 of the *Courts of Justice Act*, R.S.O. 1990, c. C.43. The Attorney General's representative was notified and advised the court that he did not wish to participate in the proceeding.

[85] In *Stoffman v. Vancouver General Hospital,* [1990] 3 S.C.R. 483, 76 D.L.R. (4th) 700, the Supreme Court of Canada held that the *Charter* does not apply to the day to day operations of hospitals. In a subsequent decision, *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, the Supreme Court of Canada considered the application of the *Charter* to a hospital's decision not to provide sign language interpretation services to patients. The court found at para. 51:

> [...] in the present case there is a "direct and . . . precisely-defined connection" between a specific government policy and the hospital's impugned conduct. The alleged discrimination -- the failure to provide sign language interpretation -- is intimately connected to the medical service delivery system instituted by the legislation. The provision of these services is not simply a matter of internal hospital management; it is an expression of government policy. Thus, while hospitals may be autonomous in their day-to-day operations, they act as agents for the government in providing the specific medical services set out in the Act.

[86] On this basis, the court found that the *Charter* applied to the hospital’s decision. The question of whether the *Charter* applies to the decisions of individual doctors providing medical care was not considered by the Supreme Court.

[87] It has been argued that the reasoning in *Eldridge* is equally applicable to doctors as it is to hospitals. This argument is predicated on the reasoning that doctors in providing treatment and making decisions about the allocation of health care resources act as government agents in the same manner as hospitals do. Therefore, a doctor’s decision is as equally subject to the *Charter* as that of a hospital.[10]

[88] However, as noted by Ellen I. Picard and Gerald B. Robertson in their text *Legal Liability of Doctors and Hospitals in Canada*:

> In the great majority of cases, patients engage and pay their doctor (usually through medicare plans) and have the power to dismiss them. The hospital does not employ the physicians nor are they carrying out any of the hospital’s duties to the patient. They are granted the privilege of using personnel, facilities and equipment provided by the hospitals but this alone does not make them employees. They are independent contractors who are directly liable to their patients, and the hospital is not vicariously liable for their negligence.[11]

[89] Doctors owe a duty of care to their patients that begins upon the formation of the doctor-patient relationship. When this duty is breached it is the individual doctors who are liable in negligence, not the hospital.[12]

[90] A doctor’s status as an independent contractor owing an individual duty of care to a patient is such that the doctor may not be considered a government agent in the same manner as a hospital as determined in *Eldridge*. Furthermore, the fact that hospitals cannot be held vicariously liable for the actions of doctors puts into question the argument that doctors’ decisions are subject to the *Charter* because they are being made on behalf of the hospital. The current common law relationship between hospitals and doctors, as well as between doctors and patients, provides a basis for the assertion that the decisions of doctors are not subject to the *Charter* in the same manner as those of hospitals.

[91] Peter Hogg argues that the court erred in *Eldridge* in characterizing the delivery of medical services as subject to the *Charter*. He states:

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[10] See: Glen Rutland, “Futile or Fruitful: The Charter and the Decision to Withhold or Withdraw Life-Sustaining Treatment” (2009) 17 Health L. J. 81 at 91; Martha Jackman, “The Application of the Canadian Charter in the Health Care Context” (2001) 9:2 Health L. Rev. 22 at 24.

[11] *Supra* note 12 at 478.

[12] *Ibid.*, at 213.

> [...] It seems implausible to characterize the provision of medical services by hospitals as an exercise of statutory authority, considering that the hospitals did not need any power conferred by statute to provide a full range of medical services- they were doing so long before funding under the hospital insurance program started in 1958. It is submitted that *Eldridge* is inconsistent with *Stoffman*, and the absence of statutory compulsion should have led to the conclusion that the Charter did not apply in *Eldridge*.[13]

[92] These comments support the proposition that the reasoning in *Eldridge* should not be extended to apply to the decisions of doctors. There is, however, some jurisprudence suggesting that the *Charter* does apply to the provision of health services in Canada: see *Chaoulli c. Québec (Procureur général)*, 2005 SCC 35, 254 D.L.R. (4th) 577.

[93] Applying the relevant jurisprudence to the circumstances of the case before me, I am not persuaded that the *Charter of Rights* applies to the proposed decision of the physicians to withdraw treatment.

3. Is Injunctive Relief appropriate in this case?

[94] The applicant seeks injunctive relief to prevent the doctors from withdrawing life sustaining treatment from Mr. Rasouli. Counsel argues that it is just and convenient that the respondent doctors be restrained from implementing the proposed treatment plan pending the matter being referred and decided by the CCB.

[95] The doctors take the position that no injunction can lie to restrain the withdrawal of life sustaining treatment.

[96] The applicant submits that in considering whether to grant an injunction in this case the court should consider the following factors outlined in *Harper v. Canada (Attorney General),* 2000 CarswellAlta 1158, 2000 SCC 57: (i) whether there is a serious issue to be tried; (ii) whether absent an injunction there will be irreparable harm to the individual seeking the injunction; and (iii) the balance of (in)convenience.

[97] The respondents submit that the proper test to be applied in cases such as this is the “best interests” test. As described in *Sweiss v. Alberta Health Services,* 2009 ABQB 691, [2009] A.J. No. 1303, at para. 63, in applying the best interests test in cases of medical urgency the court should take the following into account: (i) the medical condition of the patient; (ii) the recommended medical treatment, including doing something, nothing or very little; (iii) the wishes and beliefs of the patient, if they are known; and (iv) what is just and equitable in all of the circumstances of the case.

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[13] Peter W. Hogg, *Constitutional Law of Canada*, (Ontario: Thomson Canada Limited, 2007) at Vol. II, Chap. 37.2(c), 88.

[98] The test for injunctions established in *Harper* affirmed the Supreme Court's articulation of the test in *RJR-MacDonald Inc. v. Canada (Attorney General),* [1994] S.C.J. No. 17, [1994] A.C.S. no 17:

> [43] Metropolitan Stores adopted a three-stage test for courts to apply when considering an application for either a stay or an interlocutory injunction. First, a preliminary assessment must be made of the merits of the case to ensure that there is a serious question to be tried. Secondly, it must be determined whether the applicant would suffer irreparable harm if the application were refused. Finally, an assessment must be made as to which of the parties would suffer greater harm from the granting or refusal of the remedy pending a decision on the merits. It may be helpful to consider each aspect of the test and then apply it to the facts presented in these cases.

[99] This is the traditional test applied to injunctions, and has been adopted by courts in determining whether to grant injunctive relief in the following cases dealing with the withdrawal and withholding of treatment: *Jin v. Calgary,* 2007 ABQB 593, [2007] A.J. No. 1100; *Sawatsky v. Riverview,* [1996] 6 W.W.R. 298 (Man. Q.B.); and *Golubchuk v. Salvation,* 2008 MBQB 49, [2008] M.J. No. 54.

[100] The issue before me is whether the court should depart from the traditional injunction test in the context of medical urgency. As noted in *Sweiss* at paras. 49-51:

> The traditional test applied for the granting of an injunction in this context has been the three-part test outlined in *RJR-MacDonald* and other cases. [...]
>
> However, in more recent decisions the courts have moved away from the traditional approach and applied other tests. Alberta Health Services and Dr. Williams brought the following cases in support of their contention that different considerations ought to be applied when an injunction is sought in this context: *Re J. (A Minor)*; *Re I.H.V.; Rotary v. Vancouver General Hospital*.
>
> The differences in the cases put before me demonstrate that the law in this area is unsettled. However, I find that the traditional test for injunctive relief is inappropriate in the context of medical urgency or crisis and different factors ought to prevail. In my view, the three considerations that form the basis of the *RJR-MacDonald* test are somewhat nonsensical. [...]

[101] The Alberta Court of Queen's Bench in *Sweiss* goes on to apply the best interests test as outlined above, commenting that the traditional test is inappropriate for the following reasons at paras. 52-53:

> First, in the majority of cases there is no intention that the matter will proceed to trial. Moreover, the underlying dispute does not lend itself to adversarial litigation and forces resolution. Thus, considering whether there is a "serious issue to be tried" does not appear to be appropriate as (i) the matter before the court is always serious; and (ii) the matter must be addressed but trial is likely not the method the parties intend.

> Second, in this context the determination of whether to grant an injunction often determines whether an individual lives or dies. There will never be an application made in this context where irreparable harm would not flow should the injunction be refused. Accordingly, the second prong of the *RJR-MacDonald* does not fit these circumstances either.

[102] I have determined that the doctors do need the consent of the substitute decision-maker under the statutory scheme of the *HCCA* to remove Mr. Rasouli from life support. Accordingly, no injunction need be granted. However, I agree with the reasoning of the Alberta Court of Queen's Bench in *Sweiss*, and find that the appropriate test to be applied when determining whether to grant an injunction in cases of medical urgency is the best interests test.

CONCLUSIONS:

[103] "Treatment" under the *HCCA* includes the withdrawal of life support. Therefore, doctors require consent when withdrawing life support in Ontario. End of life cases present very difficult considerations for all parties involved. It is clear from the evidence that the hospital, doctors and substitute decision-maker in this case all have as their priority the best interests of the applicant. We are fortunate in Ontario that our legislature has provided a statutory scheme to assist doctors and substitute decision-makers in determining when an incapable person should be removed from life support, complete with recourse to an independent, expert tribunal in the event that a dispute arises in applying the best interests test. This statutory scheme will allow the applicant's doctors to challenge the substitute decision-maker's decision refusing consent to the proposed plan at the CCB. While no end of life decision can be easy, the process established by the *HCCA* provides consistency and ensures a full consideration of an incapable person's best interests in cases such as this.

RESULT:

[104] For the reasons outlined, I am of the view that the physicians' proposal to end life sustaining treatment to Mr. Rasouli, a decision which is supported by the Hospital and opposed by Mr. Rasouli's substitute decision-maker, must be referred to the Consent and Capacity Board.

[105] Pending the decision of the Board, the physicians are not permitted to withdraw mechanical ventilation and transfer Mr. Rasouli to palliative care. Should the circumstances change, the parties may return to court.

[106] I am of the view that the *Canadian Charter of Rights and Freedoms* does not apply to the proposed decision of the physicians to withdraw mechanical ventilation.

[107] If the parties are seeking an order for costs, failing agreement, they shall file written submissions at Judge's Reception at the Court House, 361 University Avenue, Toronto, Ontario, according to the following timetable: the applicant by March 25, 2011 and the respondents by April 10, 2011.

Himel J.

Date: March 11, 2011

CITATION: Rasouli v. Sunnybrook Health Sciences Centre
and Cuthbertson, 2011 ONSC 1500
COURT FILE NOS.: CV-11-419084
CV-11-419611
DATE: 20110309

ONTARIO

SUPERIOR COURT OF JUSTICE

Hassan Rasouli, by his Litigation Guardian and substitute decision-maker, Parichehr Salasel, Applicants

AND:

Sunnybrook Health Sciences Centre, Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld, Respondents

AND:

Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld, Applicants

AND :

Hassan Rasouli, by his Litigation Guardian and substitute decision-maker, Parichehr Salasel, Respondents

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REASONS FOR DECISION

Himel J.

Released: March 9, 2011