CITATION: Rasouli v. Sunnybrook Health Sciences Centre, 2011 ONCA 482
DATE: 20110629
DOCKET: C53442

COURT OF APPEAL FOR ONTARIO

Doherty, Moldaver and Simmons JJ.A.

BETWEEN

Hassan Rasouli, by his litigation guardian
and substitute decision maker, Parichehr Salasel

Applicant (Respondent)

and

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

Respondents (Appellants)

AND BETWEEN

Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld

Applicants (Appellants)

and

Hassan Rasouli, by his litigation guardian and substitute decision maker,
Parichehr Salasel

Respondents (Respondents)

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

J. Gardner Hodder and Guillermo Schible, for the respondent Hassan Rasouli

Hugh Scher and Mark Handelman, for the intervener the Euthanasia Prevention Coalition

On appeal from the orders of Justice Susan Himel of the Superior Court of Justice dated March 9, 2011.

Heard: May 18, 2011

Moldaver and Simmons JJ.A.:

[1] Parichehr Salasel is the wife of the respondent, Hassan Rasouli. She is also his litigation guardian and substitute decision-maker under the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A (the “Act”).

[2] The respondent is hospitalized at the Sunnybrook Health Sciences Centre. He has been there since October 7, 2010, when he underwent surgery to remove a benign brain tumour. Unfortunately, post-operative complications occurred and the respondent developed bacterial meningitis. The infection spread throughout his brain leaving him with severe and diffuse brain damage.

[3] On October 16, 2010, the respondent was placed on a mechanical ventilator. He is receiving artificial nutrition and hydration through a tube inserted into his stomach. These life-sustaining measures are keeping him alive and he may survive for some months if they are continued. Without them, it is expected that he will soon stop breathing and die.

[4] Doctors Cuthbertson and Rubenfeld are the appellants in this matter. They are the doctors responsible for the respondent’s treatment and care. They, and many other

doctors who have examined the respondent[1], have concluded that he is in a permanent vegetative state which, in medical terms, means that he will never again regain consciousness. His case, they believe, is hopeless. Inquiries to have another hospital take up his care proved unsuccessful. All appropriate treatments have been exhausted, there is no realistic hope of medical recovery, and the respondent is not receiving any medical benefit from being kept on life support. In these circumstances, the appellants believe it is in the respondent's best interests that he be taken off life support and provided with palliative care until he dies. They have proposed that course of action to Ms. Salasel.

[5] The appellants acknowledge that they need Ms. Salasel's consent, in her capacity as substitute decision-maker for her husband, to administer palliative care to him. They maintain, however, that they do not need her consent to withdraw the life-sustaining measures as those measures have spent their course and are no longer medically indicated.

---

[1] Among the many doctors who have examined him, the respondent was assessed in January 2011 by a neurologist who had no prior involvement with him and who confirmed the diagnosis of permanent vegetative state. As well, the family was invited by the Hospital to obtain their own neurological opinion, if they wished to do so.

[6] Ms. Salasel sees the matter differently. She believes that where there is life, there is hope and she and her family wish to have the respondent kept alive. They do not accept that he is in a state of permanent and irreversible unconsciousness. On the contrary, according to her and her children, the respondent has reacted on occasion to their voices and continues to do so. Although he may be minimally conscious, they believe that he remains aware of his surroundings. Hence, Ms. Salasel opposes the course of action proposed by the appellants. She maintains that they require her consent to remove the respondent from life support and place him on palliative care. And if they are not prepared to abide by her wishes, they should apply under the Act to the Consent and Capacity Board (the "Board") and let the Board decide whether the proposed course of action is in the respondent's best interests.

[7] In the face of this impasse, the parties turned to the court for assistance. On behalf of the respondent, Ms. Salasel applied to the Superior Court of Justice for various forms of relief, including:

(1) An order restraining the appellants from implementing the proposed changes to the respondent's current treatment plan without first obtaining her consent; and

(2) An order requiring the appellants to refer their treatment proposal to the Board should they persist in challenging Ms. Salasel's authority to reject it on the respondent's behalf as being contrary to his best interests.

[8] For their part, the appellants cross-applied to the court for various forms of relief, including:

(1) A declaration that the respondent is in a permanent vegetative state;

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

(3) A declaration that they do not need Ms. Salasel's consent, either at common law or under the Act, to proceed with the treatment plan they have proposed; and

(4) A declaration that the Board has no jurisdiction to decide whether they can proceed with their proposed treatment plan.

[9] The application and cross-application were argued before Himel J. for three days in February and March 2011. On March 9, 2011, the learned application judge released her reasons for decision. In the result, she found in favour of the respondent and against the appellants.

[10] The application judge dealt with Ms. Salasel's application and the appellants' cross-application in two separate orders. For present purposes, the key provisions of both orders are the same and read as follows:

> 1. THIS COURT ORDERS THAT the proposal of the respondent physicians [the appellants] to end life sustaining

> treatment to the applicant [the respondent] must be referred to the Consent and Capacity Board.
>
> 2. THIS COURT ORDERS THAT pending the decision of the Consent and Capacity Board, the respondent physicians are not permitted to withdraw mechanical ventilation and transfer the applicant to palliative care.

Issues Raised by the Appellants

[11] The appellants appeal from those orders. They submit that the decision under review sets a dangerous precedent because it requires them to obtain the consent of patients before withholding or withdrawing treatment that they consider to be of no medical value. This, they say, has the effect of standing the doctor/patient relationship on its head. Manifestly, patients have the right to refuse treatment. They do not, however, have the right to insist on treatment that their doctor regards as medically ineffective or inappropriate.

[12] In advancing their position, the appellants do not suggest that doctors can withhold or withdraw treatment as they see fit, with no risk of legal consequences. On the contrary, doctors must act in their patients' best interests 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. But that is a far cry from saying that a doctor must provide treatment to his or her patient that the doctor believes is medically ineffective or inappropriate, without first obtaining the patient's consent that such treatment can be withheld or withdrawn.

[13] According to the appellants, the decision under review puts aside these long-established principles and if allowed to stand, it will have serious consequences for the medical profession and the health care system as a whole.

[14] The appellants submit that the application judge did not adequately address this issue when she found that the withdrawal of life support from the respondent constituted treatment under the Act, such that it could only be carried out with Ms. Salasel’s consent. They submit that properly interpreted, “treatment” under the Act does not include the withholding or withdrawal of treatment that has no medical value to the patient. Hence, it can be done without the patient’s consent. That represents the common law which they say the Act was meant to reflect, not alter.

[15] Accordingly, they argue that the impugned orders should be set aside.

[16] For reasons that follow, we would dismiss the appeal. In so concluding, we do not minimize the concerns raised by the appellants. They are serious and warrant careful consideration. Feelings of sympathy for the respondent and his family cannot be allowed to dictate the result.

[17] That said, we are of the view that the application judge reached the correct result in this case. In short, we are satisfied that the plan of care proposed by the appellants does amount to “treatment” as defined in the Act. Our reasons differ somewhat from those of the application judge. They address head-on the concerns raised by the appellants.

[18] Before explaining why we believe that the plan of care the appellants wish to implement constitutes "treatment" under the Act, we propose to set out some of the relevant statutory provisions and to briefly review the reasons of the application judge.

Relevant Statutory Provisions

[19] There are many provisions in the Act that bear on the issue at hand, some directly, some indirectly. For present purposes, we believe that the following provisions are the most pertinent:

> 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;
>
> ...
>
> (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; ...
>
> ...
>
> 2. (1) In this Act,
>
> "plan of treatment" means a plan that,
>
> (a) is developed by one or more health practitioners,
>
> (b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and
>
> (c) provides for the administration to the person of various treatments or courses of treatment and may, in addition,

provide for the withholding or withdrawal of treatment in light of the person's current health condition;

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

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

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

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

(d) the communication of an assessment or diagnosis,

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

(f) a personal assistance service,

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

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

(2) A reference in this Act to refusal of consent includes withdrawal of 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.

...

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.

(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.
>
> ...
>
> 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.
>
> (2) The parties to the application are:
>
> > 1. The health practitioner who proposed the treatment.
> >
> > 2. The incapable person.
> >
> > 3. The substitute decision-maker.
> >
> > 4. Any other person whom the Board specifies.
>
> (3) In determining whether the substitute decision-maker complied with section 21, the Board may substitute its opinion for that of the substitute decision-maker.
>
> (4) If the Board determines that the substitute decision-maker did not comply with section 21, it may give him or her directions and, in doing so, shall apply section 21.

[20] Of those provisions, the operation of s. 21 of the Act warrants brief explanation. It sets out the principles that a substitute decision-maker must follow in deciding whether to give or refuse consent to a proposed treatment on behalf of an incapable person.

[21] Under s. 21(1)1., if the substitute decision-maker knows of a wish, applicable to the circumstances, expressed by the incapable person while he or she was capable, after

attaining age 16, then the substitute decision-maker must abide by that wish and give or refuse consent in accordance with it. (Ms. Salasel accepts that that provision has no application in her husband's case).

[22] Section 21(1)2. applies where the substitute decision-maker is unaware of any such wish (as is the case here) or where compliance with such a wish proves impossible. Under those circumstances, a substitute decision-maker must act "in the incapable person's best interests" in deciding whether to give or refuse consent to a proposed treatment.

[23] Section 21(2) of the Act sets out various factors that a substitute decision-maker must take into account in deciding whether the proposed treatment is or is not in the incapable person's best interests. Broadly speaking, those factors fall under two heads, one relating to the values, beliefs and wishes of the incapable person (s. 21(2)(a) and (b)), the other to the nature and medical value of the treatment proposed in the circumstances (s. 21(2)(c)).

The Reasons of the Application Judge

[24] The application judge provided detailed reasons for judgment. She recognized that the dispute between the parties turned first and foremost on a question of statutory interpretation. At para. 18 of her reasons, she framed the central issue as follows:

> 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* [the Act], health practitioners are required to obtain consent from a patient or their substitute decision-maker before withdrawing or ending life support.

[25] After instructing herself on the principles applicable “to the interpretation of legislative language”, the application judge observed that under s. 2(1) of the Act, the word “treatment” as defined includes a “plan of treatment”, and a “plan of treatment”, also a defined term, specifically contemplates as one of its elements, the “withholding or withdrawing [of] treatment in accordance with a patient’s health condition.”

[26] The application judge then noted that while the definition of a “plan of treatment” was instructive and of some assistance in resolving the issue before her, it was “circular in that the word ‘treatment’ must be defined in and of itself in order to determine what ‘withholding or withdrawal of treatment’ means.”

[27] Accordingly, the application judge looked to the definition of “treatment” under the Act and observed that it included “anything done for ‘therapeutic’ or ‘preventive’ purposes.” She then considered whether “the provision of life support” could be considered “therapeutic” or “preventive” and concluded that it could. At paras. 30-33 of her reasons, she stated:

> *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.”
>
> 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." 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".
>
> 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.
>
> 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". [Emphasis in original.]

[28] The application judge next considered the purpose and scheme of the Act and concluded that the "inclusion of withdrawing life support in the definition of treatment" furthered the goals of the Act, particularly those identified in ss. 1(a), (b) and (e) in that:

- All plans to withdraw life support that were not consented to by substitute decision-makers would have to be referred to the Board, thereby bringing consistency to the process which had heretofore been optional at the discretion of the individual treating physician.

- Treatment would be facilitated by following the scheme of the Act which contemplated the delegation of treatment decisions to substitute decision-makers, if available, and to the Public Guardian and Trustee, if not.
- As with other treatment decisions, supportive family members would be afforded a significant role in end of life decisions.

[29] The application judge then turned to the consequences of adopting "the inclusion of withdrawing life support in the definition of treatment". She succinctly identified the concerns expressed by the doctors as follows:

> The [doctors] 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.

[30] The application judge rejected this concern because in her view the definition of "plan of treatment" precluded the possibility of patients "picking and choosing their own treatment". At para. 45 of her decision, she stated:

> 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.

[31] Finally, the application judge addressed a concern that was raised by Sunnybrook Health Sciences Centre (the “Hospital”). Although the Hospital is not a party to this appeal, it argued before the application judge that if the withdrawal of life support is included in the definition of treatment under the Act, individuals who have no chance of recovery would nevertheless have to be kept alive for extended periods of time if consent to end life support was not forthcoming and this would impact severely on the limited resources of its intensive care unit.

[32] The application judge addressed that concern by referring to the speedy, cost-effective process under the Act whereby treating physicians could apply to the Board to have the substitute decision-maker’s decision reassessed where they felt that maintaining the patient on life support was not in the patient’s best interest.

[33] Significantly, on appeal, the appellants have not pursued the issue of resources or the fallout that could occur in intensive care units if the decision under review were allowed to stand. In response to pointed questions from the court, Mr. Underwood, with his usual candor, made it clear that the issue of resources played no part in the appellants’ submissions, nor did it influence their decision to pursue the appeal.

[34] Accordingly, given the position advanced before us, we approach the issue at hand on the basis that fiscal concerns have no bearing on our analysis.

[35] Having determined that the definition of treatment under the Act includes the withdrawal of life support and thus consent must be obtained, the application judge was not obliged to consider whether consent to withdraw life support would also be required at common law. Nonetheless, she reviewed the common law jurisprudence and concluded that the "common law in Canada on this issue is unclear".

[36] We do not propose to summarize the application judge's reasons relating to the common law because, in our view, the Act provides a complete answer. Nor do we intend to comment on the application judge's analysis relating to the *Charter of Rights and Freedoms* and whether the *Charter* applies to the appellants' proposal to withdraw life support from the respondent. We simply acknowledge, per this court's decision in *M. (A.) v. Benes* (1999), 46 O.R. (3d) 271 at para. 22, that the Act should be construed in a manner consistent with the *Charter*. We make no comment on the respondent's argument that personal autonomy considerations under s. 7 of the *Charter* confer upon him a right to demand the continuation of medically ineffective or inappropriate treatment.

Analysis

[37] The principal issue to be decided is whether the application judge erred in concluding that the withdrawal of life support constitutes "treatment" under the Act. The application judge determined that it did, essentially for the reasons found at paras. 30-33 of her decision, which we have set out above at para. 27.

[38] In a nutshell, the application judge found that the withdrawal of life support constitutes “treatment” under the Act for the following reasons:

(1) The provision of life support falls within “preventive” and “therapeutic” treatment and thus comes within the definition of “treatment” under the Act.

(2) Because the provision of life support constitutes “treatment”, its withdrawal necessarily entails the “withdrawal of treatment”.

(3) “Withdrawal of treatment” is specifically referred to in the definition of a “plan of treatment” under the Act and it is recognized, at least potentially, as forming a component part of any such plan.

(4) Under the Act, “treatment” is defined to include a “plan of treatment”.

(5) Hence, the proposal of the doctors to remove the respondent from life support comes within the definition of a “plan of treatment” and is therefore “treatment” under the Act.

[39] The appellants take issue with the application judge’s line of reasoning, at least in part. They do not question that life support measures can serve a therapeutic or preventive purpose for patients and that the provision of life support in those circumstances will constitute “treatment” under the Act. But those cases, they argue, are to be distinguished from cases like the present one, where the life support measures being provided to the respondent are of no medical benefit to him and may even lead to harmful side effects.

[40] According to the appellants, the respondent is in a perpetual state of unconsciousness and there is no prospect of any improvement in his condition. That being so, the provision of life support is futile and may properly be regarded as worthless. As such, they submit that it does not constitute treatment at all. And that, they contend, is where the application judge went wrong. Specifically, in reaching her conclusion that the withdrawal of life support constitutes the withdrawal of treatment within the meaning of a "plan of treatment" under the Act, they maintain that she looked at the intended purpose of life support measures, which can and often do serve preventive and/or therapeutic purposes, rather than looking at the purpose which the life support measures in the respondent's case were serving, which the appellants submit is non-existent. In short, the appellants contend that the application judge misconstrued the meaning of "treatment" and a "plan of treatment" in effectively holding that these terms in the Act include the withholding or withdrawal of medical care that has no medical value or justification.

[41] For reasons that follow, we find it unnecessary to finally decide whether the appellants are correct in their submission that treatment under the Act necessarily involves treatment that, in the opinion of the treating physician, has some medical value – although we hasten to add that we think there is much to be said for the appellants' position. Much as we accept that the Act is to be construed in a fair, large and liberal manner and that the dignity and autonomy of patients must be respected, especially in end-of-life decisions involving patients who are totally vulnerable, we have difficulty

accepting that the legislature intended to include within the definition of treatment measures that attending physicians consider to be of no medical value and therefore worthless. More to the point, if the legislature intended that consent was required to the withholding or withdrawal of life support measures that are considered to be medically ineffective or inappropriate, we would have expected clearer language to that effect.

[42] And of course, if medically valueless measures are not to be regarded as treatment at all, as the doctors contend, then doctors would be free to withhold or withdraw such measures without first having to obtain their patients' consent; and patients would not be able to demand such measures from their doctors.

[43] Assuming that is the correct approach, it does not detract from a doctor's overriding duty to act in his or her patient's best interest. And if a doctor withholds or withdraws medical care on the basis that it is valueless, he or she will be held accountable if the decision is found to have fallen below the requisite standard of care.

[44] The respondent's litigation guardian takes a different position – as does the intervener. Ms. Salasel rejects the underlying premise upon which the appellants' argument is based. She does not accept that the life support measures her husband is receiving are of no medical value. Doctors are not infallible and the appellants may be mistaken in their diagnosis. It is too soon to tell. In line with this, it can hardly be said that the life support measures the respondent is receiving are worthless. On a basic level, they are what is keeping him alive. When considering what the word "treatment"

means in the context of a “plan of treatment” under the Act, Ms. Salasel points out that while the appellants may consider her husband’s condition to be a “living death”, in the eyes of the law, he remains a human being. As such, he is entitled to remain alive, with the assistance of life support measures, until such time as she feels there is no further hope for his recovery.

[45] On this view, the legislature contemplated cases such as the respondent’s when it defined a “plan of treatment” to include the “withholding or withdrawal of treatment in light of the person’s current health condition”. Whatever the common law may be, by using that language, the legislature intended to make it clear that the withdrawal of life support is to be construed as “treatment” for which consent under the Act is required, and where consent is not forthcoming, the patient’s treating physician cannot act unilaterally. Rather, if the physician is not content with the refusal of a substitute decision-maker to provide consent to the withdrawal of life support, the physician’s recourse is to refer the matter to the Board for disposition.

[46] As indicated, in order to decide this appeal, we need not resolve the metaphysical debate over whether life saving measures in cases such as the respondent’s are of no medical value because they are futile, or of high medical value because they are keeping him alive while his family continues to hold out hope for his recovery. For present purposes, we are prepared to accept that the Act does not require doctors to obtain

consent from a patient or substitute decision-maker to withhold or withdraw “treatment” that they view as medically ineffective or inappropriate.

[47] With that, we turn to consider whether the proposal put forward by the appellants – removing the respondent from the mechanical ventilator and placing him on a program of palliative care until he dies – nonetheless constitutes “treatment” under the Act for which Ms. Salasel’s consent is required. In our view, it does.

[48] Palliative care is not defined in the Act. *Stedman’s Medical Dictionary*, 28th ed. (Baltimore: Lippincott Williams & Wilkins, 2006), defines palliative as “the alleviation of symptoms without curing the underlying disease”.[2] Palliative care is included in the definition of “treatment” under the Act. Manifestly, it encompasses end-of-life care provided to a patient to keep the patient comfortable pending his or her imminent death, upon removal of a life-sustaining mechanical ventilator (“end-of-life palliative care”). As such, the appellants must obtain Ms. Salasel’s consent to administer end-of-life palliative care upon removal of the mechanical ventilator.

[49] In oral argument, Mr. Underwood fairly conceded that end-of-life palliative care will only be administered to the respondent once he is taken off the mechanical ventilator and that no responsible substitute decision-maker would refuse to consent to palliative care for an end-of-life patient being removed from a mechanical ventilator.

---

[2] Organizations such as the World Health Organization and the Canadian Hospice Palliative Care Association have provided extended definitions of palliative care. For present purposes, we need not determine the exact scope of the term as it appears in the Act.

[50] In other words, in the respondent's circumstances, removal of the ventilator is a necessary precondition to the administration of end-of-life palliative care and end-of-life palliative care is a necessary response to removal of the ventilator. The two go hand in hand. One is integrally linked to the other. And they foretell a single certain result – the respondent's imminent death once the ventilator is removed.

[51] The concept of palliative care in these circumstances necessarily recognizes that death is imminent. Once life sustaining measures are withdrawn, as they must be before end-of-life palliative care is administered, there is no turning back. The patient has no other options or choices. Death is a certainty. All that remains is to keep the patient as comfortable as possible until the end comes.

[52] That is the essence of end-of-life palliative care. And where it is recommended as an adjunct to the withdrawal of life support, the two, in our view, cannot be separated. They are a "treatment package" and that is how they should be viewed for purposes of the Act.

[53] The respondent's situation is to be distinguished from situations where the medical community simply has nothing more to offer a patient by way of treatment – but death is not imminent. To take one example, discontinuing chemotherapy because it is not benefitting the patient is not the same thing as removing a patient from life support and moving him or her directly to end-of-life palliative care. In the former situation, assuming there are no other therapeutic or preventive measures available, the patient is

being told that there is nothing further that can be done and when the time comes – which may be a week, a month, or six months – steps will be taken to keep the patient's end-of-life suffering to a minimum. 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.

[54] In our view, that distinction largely addresses the appellants' concerns arising from the decision under review, that doctors will be prevented from withholding or withdrawing measures they consider to be medically valueless, without first having to obtain their patients' consent to do so. Equally, it shuts the door on their concern that patients will be able to demand treatment that their doctors consider to be medically worthless.

[55] It also puts to rest the appellants' concern about withholding treatment in the first place. That concern arises because the terms "withholding treatment" and "withdrawing treatment" are used together under the Act. No distinction is drawn between them. And yet, according to the appellants, while the application judge did not say so explicitly, she implicitly drew a distinction between the withdrawal of life support measures, which she says requires a patient's consent, and the withholding of such measures in the

first place, for which she apparently believes consent is not required. That, the doctors submit, creates an inconsistency in the Act.

[56] Assuming the appellants are correct in this, the problem disappears on the analysis we have suggested. If life support measures are withheld from the outset because they are considered to be of no medical value, there is nothing to transfer from before moving to palliative care. The two are not integrally linked. Beginning end-of-life palliative care does not require, as an initial first step, ending life support.

[57] Patients need not fear that this distinction between withholding life support measures from the outset and withdrawing them after they have been put in place will cause doctors to choose the former over the latter. Doctors must act in their patients' best interests, and if they fall below the requisite standard of care in withholding treatment from the outset, they can be held accountable.

[58] Interpreting end-of-life palliative care to include the withdrawal of life support measures where those measures are in place and must be terminated before end-of life palliative care can begin, simply means that in cases like the one at hand, treating physicians will have to obtain the substitute decision-maker's consent to the entire treatment package. Where consent is withheld, and the treating physician is not satisfied that the substitute decision-maker has complied with the requirements of s. 21 of the Act, then he or she may resort to s. 37 of the Act and refer the matter to the Board for determination.

[59] Recourse to the Board may not be a perfect solution from the appellants' perspective. If a substitute decision-maker has acted under s. 21(1)l. on a wish that incapable person expressed while capable, after attaining 16 years of age, and the Board is satisfied this is so, the Board's hands are tied and this effectively ends the matter. There will be no inquiry to determine if the substitute decision-maker has acted in the incapable person's best interests under s. 21(1)2. of the Act.

[60] But that is the legislature's will. And it involves policy considerations that come within the legislature's purview and are best left to the legislature to sort out.

[61] Apart from that draw-back, recourse to the Board clearly has its beneficial aspects. In her reasons for judgment, the application judge references the many advantages that flow from the process the legislature has implemented, the most noteworthy being an expeditious hearing before an expert Board. We do not intend to repeat her observations at paras. 48-50. Suffice it to say that we agree with them. This court's decision in *M. (A.) v. Benes*, *supra*, also contains a description of the Board's mandate and the functions it is required to perform.

[62] In sum, while the recourse available to a doctor who disagrees with the decision of a substitute decision-maker in an end-of-life case may not be perfect from the doctor's perspective, the process seems to have worked well since the Act came into existence some 15 years ago. End-of-life situations are always emotionally laden. The process created under the Act provides doctors with a safety valve in cases where the patient has

not expressed a prior wish under s. 21(1) of the Act. Most doctors, we believe, would see that as a good thing, rather than viewing it as an impediment to their professional independence and autonomy.

[63] Moreover, as Mr. Underwood stated at the outset of his submissions, the problem that has arisen in this case is not a common one. In most situations, life-ending decisions are worked out over time through a combination of patience, understanding, professional guidance and counselling. In this regard, the College of Physicians and Surgeons and individual hospitals deserve credit for the very sensitive protocols they have put in place to address life-ending decisions and the trauma that family and loved ones face when required to make them.

[64] We do not believe that by interpreting palliative care to include the withdrawal of life support measures, the floodgates will open and intensive care units will be deluged with patients who have no chance of improvement but who require life-sustaining measures to survive. If that proves to be the case, then the legislature can, and no doubt will review the situation.

Conclusion

[65] The proposal of the appellants to withdraw the respondent from life support and place him on end-of-life palliative care constitutes “treatment” under the Act, for which the consent of Ms. Salasel is required. If her consent is not forthcoming, the appellants’ proposal must be referred to the Board. Save for requiring that any amendments be

made to the formal orders below so that they conform to these reasons, we would thus dismiss the appeal, without costs, as agreed to by the parties and the interveners.

Signed: “M. J. Moldaver J.A.”

“Janet Simmons J.A.”

“I agree D. Doherty J.A.”

RELEASED: “DD” JUNE 29, 2011