

**Consent to Withdrawal of Life Support:
What the Supreme Court Said In
*Cuthbertson and Rubinfeld v. Rasouli***

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"It may be necessary to hang a man or pull down a house. But we take good care not to make the hangman and the housebreaker the judges of that. If we did, then no neck would be safe and no house stable."

George Bernard Shaw *The Doctor's Dilemma*

Introduction

When Mr. Shaw wrote that a hundred years ago, it would not have occurred to him that his precise question would be before Canada's Supreme Court, with a life [or death] hanging in the balance. Those were the stakes when the Court heard *Cuthbertson and Rubinfeld v. Rasouli*² on December 10, 2012. The Judgment was released October 18th, 2013.

Background

As a result of contracting meningitis following surgery to remove a brain tumour, Mr. Rasouli suffered severe brain damage. He was first diagnosed as being in a persistent vegetative state, but later "upgraded" to being minimally conscious. He remains at Sunnybrook to this day, with limited improvement, dependant on his health practitioners for everything. The intensive care physicians treating him do not think his life worth living and have taken the position that the decision to discontinue life support is theirs alone.

Mr. Rasouli's wife, Dr. Salasar, trained as a physician in Iran, disagrees. She and their children say he is aware and responsive and, in any event, his religious beliefs require that all things be done to keep him alive in spite of his condition. She therefore began court proceedings to prevent the discontinuation of life support. She contended that, if that was what the physicians wanted to do, they were obliged to take the matter to The Consent and Capacity Board ["CCB"] pursuant to s. 37 of Ontario's *Health Care Consent Act* ["HCCA"].

² 2013 SCC 53

The Application pursuant to s. 37, known as a “Form G” Application, is to determine whether the patient’s substitute decision-maker [“SDM”] complied with the principles for giving or refusing substitute consent when he, she or they gave or refused consent to a treatment proposed by a health practitioner. The CCB, unique to Ontario, has heard about 25 such cases over the past decade, more than all the courts in the country combined.

But, Mr. Rasouli’s physicians argued that this was not a “treatment” decision and therefore the CCB had no jurisdiction. In both Superior Court and the Court of Appeal, although for different reasons, the Judges sided with Dr. Salasal. They held that the unique wording in the HCCA that defined “treatment” to include the withholding or withdrawing of a treatment, covered what the doctors wanted to do, which was discontinue life support by withdrawing existing treatments that kept Mr. Rasouli alive and treating him palliatively in the expectation he would die.

The Superior Court Decision

The case was heard at first instance by Madam Justice Himel in February and March 2011.³ She framed the issues this way:

[1] ...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.

Justice Himel found for Mr. Rasouli, concluding,

[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

³ *Rasouli v. Sunnybrook Health Sciences Centre*, 2011 ONSC 1500 (CanLII)

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.

Justice Himel held that the physicians were not permitted to withdraw mechanical ventilation and move Mr. Rasouli to palliative care without consent.

The Court of Appeal Decision

The physicians' appeal was dismissed, though the *ratio decidendi* in the Court of Appeal⁴ was different. The Appellate Judges framed the issues this way:

[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.

[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

⁴ *Rasouli v. Sunnybrook Health Sciences Centre*, 2011 ONCA 482 (CanLII); the author was co-counsel to the Intervenor in the Court of Appeal.

decide whether the proposed course of action is in the respondent's best interests.

Note that, by the time the matter reached the Court of Appeal in May 2011, Mr. Rasouli's diagnosis had changed from "persistent vegetative state" to "minimally conscious state," an upgrade, although he still required treatments only available in an intensive care unit, where he remains to this writing.

The Court characterized the appellant physicians' position as submitting that,

[14] ... "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.

The Court ducked, as unnecessary to decide, what they called 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."⁵ But, that paragraph continues, "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."

However, in Mr. Rasouli's case, the Court held there was what it called a "treatment package," which seems identical to the HCCA definition of "plan of treatment," which is included in the definition of "treatment" and therefore requires consent. Mr. Rasouli's "treatment package," as proposed by the appellant physicians, and interpreted by the Court, was the withdrawal of life support measures and institution of end-of-life palliative care. In other words, to treat him palliatively, the treatment team first had to discontinue active life support and this constituted a "treatment package." The Court held that the treatment package required consent

⁵ *Ibid*, par. [46]

from Mr. Rasouli's SDM and that if she did not consent, the physicians could apply to the CCB.

The Supreme Court Judgment

Overview

Seven Justices heard the appeal. Chief Justice McLachlin wrote the majority judgment with Justices LeBel, Fish, Rothstein and Cromwell concurring. Justice Karakatsanis wrote the dissent, with Justice Abella concurring. In addition to the parties, the Court heard submissions from eight Intervenors.

The essence of the question before the Court was whether or not the physicians required consent to discontinue Mr. Rasouli's life support. The majority held that the question was answered by the wording of Ontario's HCCA and dismissed the physicians' appeal because "treatment" as defined included withdrawing and withholding treatment as well as providing it. The minority held that the case should be governed by the common law, which defined treatment as a positive act and did not include the withholding or withdrawing of a treatment in place.

While the case turns on an interpretation of a narrow statutory provision unique to Ontario, additional comments by the Supreme Court, known as "*obiter dicta*," are always persuasive as a guide to what the Court might do in similar cases. The judgment therefore has national implications for health practitioners, patients and their families.

The *Ratio Decedendi*

Justice McLachlin and the majority held that the case turned on statutory interpretation. She wrote,

[4] This case turns on statutory interpretation — what the *HCCA* provides. It is not a case about who, in the absence of a statute, should have the ultimate say in whether to withhold or withdraw life-sustaining treatment. Nor does the case require us to resolve the philosophical debate over whether a next-of-kin’s decision should trump the physicians’ interest in not being forced to provide non-beneficial treatment and the public interest in not funding treatment deemed of little or no value. The Ontario legislature has addressed the conflicting interests and arguments that arise in cases such as this in the *HCCA*. The Court’s task is simply to determine what the statute requires. I note that the parties did not address resource implications or *Charter* issues in this appeal.⁶

The *HCCA* does not address resource implications because it deals with individual treatment decisions. Allocation of resources is a policy question for legislatures, not courts.

Justice McLachlin did not get to her second question, whether or common law the Court should order that Mr. Rasouli’s life support can be removed without consent because that was unnecessary given her answer to the first question. Since no other province defines “treatment” to include the withholding or withdrawing of a treatment, the *ratio* is relevant only in Ontario.

The physicians’ argument was that “treatment” under the *HCCA* is “limited to what the attending physician or caregiver deems to be of *medical benefit* to the patient.”⁷ Justice McLachlin rejected this argument:

⁶ Unless otherwise noted, quotes are from *Cuthbertson and Rubenfeld v. Rasouli*, 2013 SCC 53. Citations are given where the quote does not include the paragraph number.

⁷ par. 14

[35] The difficulty with the physicians' argument is that it substitutes a physician-made criterion for treatment (medical benefit) for the criterion specified in the *HCCA* for consent (health-related purpose). These concepts sound similar, but they are in reality different.

[36] The concept of "medical benefit" is a clinical term used by physicians to determine whether a given procedure should be offered to a patient. ...

[37] The concept of "health-related purpose", by contrast, is a legal term used in the *HCCA* to set limits on when actions taken by health practitioners will require consent under the statute. Treatment is "anything that is done" for one of the enumerated purposes (therapeutic, preventive, palliative, diagnostic and cosmetic) or "other health-related purpose". Under the *HCCA*, only acts undertaken for a health-related purpose constitute treatment, and therefore require consent. The concept of health-related purpose in the *HCCA* does not interfere with a physician's professional assessment of whether a procedure offers a medical benefit. Its only function is to determine when the actions of health care practitioners require patient consent.

Put differently, physicians have a "medical" standard of care to meet in proposing and carrying out treatments, but now also a "legal" standard of care in obtaining informed consent to those treatments. The issue in this case was not "the correctness of the physicians' professional opinion...(but) whether maintaining Mr. Rasouli's life serves a health-related purpose within the meaning of the *HCCA*."⁸

The legislature defined "treatment" far broader than the definition advanced by the physicians. The legislation does not, in the definition or elsewhere, use the phrase "medical benefit" but uses a broader definition, "with a wide-ranging and non-exhaustive list of health-related purposes."⁹

Other provisions in the *HCCA* support this view. The statute's purposes, set out in s. 1, seek consistency with respect to consent, protection of patient autonomy and the provision of a meaningful role for the patient's family. Section 21 sets out the statutory requirements of substitute consent. While substitute consent must

⁸ par. 38

⁹ par. 39

respect a patient's previously expressed capable wish applicable to her circumstances, where there is no such applicable wish, substitute consent must be given in accordance with the patient's "best interests." However, that is a defined term and includes consideration of the patient's values and beliefs as well as consideration of relevant objective medical factors.

The majority view also rejected the submission that withdrawal of life support did not constitute treatment because it wasn't a treatment but rather a withdrawal of treatment:

[45] I conclude that this argument cannot succeed, essentially because withdrawal of life support involves — indeed may be viewed as consisting of — a series of acts that serve health-related purposes, and because the critical interests at stake where withdrawal of life support is concerned go to the heart of the purposes of the *HCCA*.

[46] On its face, the definition of "treatment" in s. 2(1) appears broad enough to include "withdrawal of treatment". The opening words of the definition could not be more expansive: "... anything that is done" for one of the enumerated health-related purposes or other health-related purpose is included in "treatment".

The legislature specifically indicated certain exclusions from the definition of treatment, such as assessment or examination of a patient and the taking of a health history. But, the legislature did not exclude withdrawing a treatment that offers little or no medical benefit. The *HCCA* also provides that Regulations may be passed prescribing actions that do not constitute treatment, but no authority is given to enlarge the definition of treatment. Justice McLachlin held that this fact "suggests that the legislature intended the overall concept of treatment to be broadly construed."¹⁰

¹⁰ par. 48

The legislature also referred to the withholding or withdrawal of treatment in defining “treatment.” It is defined to include a “plan of treatment.” A plan of treatment “may in addition, provide for the withholding or withdrawal of treatment in light of the person’s current health condition.”¹¹

However, Justice McLachlin noted “The scheme of the HCCA suggests that the legislature contemplated that withdrawal of treatment requires consent *in some cases*.”¹² *Quaere*, when can treatment be withdrawn without consent? The question has been addressed in only one Ontario case of which I am aware, discussed below. In this Judgment, there is no clear answer to the question but some hints are given:

[58] ... If consent is required for withdrawal of life support, patients could arguably compel the continuation of any treatment, regardless of its medical implications. The legislature cannot have intended this. Common sense suggests that many withdrawals of treatment — for example, refusal to renew a prescription for a drug that may harm a patient — must be excluded from the definition of “treatment” under the Act.

[59] ... A more nuanced view that withdrawal of treatment may sometimes, although not always, constitute “treatment”, better fits the provisions of the HCCA and the realities of medical care.

[60] At a minimum, if the processes involved in withdrawal of care are health-related, they do not cease to be treatment merely because one labels them cumulatively as “withdrawal of treatment”. This applies to withdrawal of life support, as described in this case. The reality is that in Mr. Rasouli’s situation, the distinction between “treatment” and “withdrawal of treatment” is impossible to maintain. The withdrawal consists of a number of medical interventions, most if not all done for health-related purposes. Viewed globally, a series of distinct acts may be viewed as “withdrawal” of treatment. But viewed individually, each act may be seen as having a health-related purpose, and hence constitute “treatment” requiring consent.

Not renewing a drug prescription may not be withdrawal of treatment but rather the refusal to propose a treatment—which remains the purview of health practitioners. In other words, a physician proposes a plan of treatment that includes a course of medication. The medications do no good or cause harm in the opinion of the physician, and she therefore declines to propose a second course of

¹¹ HCCA, par. 2, “plan of treatment” subpara. (c)

¹² par 50

the same treatment. This Judgment does not discuss the difference between “withholding/withdrawing” a treatment on the one hand and “not offering” on the other, an analysis that may make physician obligations clearer.

Justice McLachlin concluded her analysis of the appellants’ arguments with these observations:

[68] In summary, withdrawal of life support aims at the health-related purpose of preventing suffering and indignity at the end of life, often entails physical interference with the patient’s body, and is closely associated with the provision of palliative care. Withdrawal of life support is inextricably bound up with care that serves health-related purposes and is tied to the objects of the Act. By removing medical services that are keeping a patient alive, withdrawal of life support impacts patient autonomy in the most fundamental way. The physicians’ attempt to exclude withdrawal of life support from the definition of “treatment” under s. 2(1) of the *HCCA* cannot succeed.

Given the breadth of submissions made on behalf of the appellant physicians, it is surprising that they did not argue one of the specifically enumerated exclusions from the statutory definition of “treatment:” the definition, in s. 2 of the *HCCA*, excludes “a treatment that in the circumstances poses little or no risk of harm to the person.” The physicians could have argued, as a point of medicine, that given Mr. Rasouli’s condition, allowing him to die was not a “harm” to him and consent was therefore not required. In my view, it is unlikely this submission would have found favour with the majority, given their reliance on the plain meaning of the legislative definitions and the underlying respect for patient autonomy the Judgment evinces.

The result of this case is an affirmation that the plain words of the *HCCA* mean what they say: physicians require consent to withdraw a treatment. If they do not receive it, their remedy is a Consent and Capacity Board application.

Obiter Dicta

AUTONOMY

The Judgment does not embark upon an examination of the importance of individual autonomy, but rather assumes it. Justice McLachlin observed that all provincial statutes addressing treatment decisions “generally...give effect to the patient’s autonomy interest insofar as possible. If the patient’s autonomy is compromised by lack of capacity, [the statutes] seek to balance it against considerations related to the best interests of the patient.”¹³ She also observed that “By removing medical services that are keeping a patient alive, withdrawal of life support impacts patient autonomy in the most fundamental way.”¹⁴ In discussing the statutory principles for substitute consent when there is no previously expressed capable wish, she wrote,

These criteria include the medical implications of treatment for the patient, the patient’s well-being, the patient’s values, and any prior expressed wishes that were not binding on the substitute decision-maker. This legislative articulation of the best interests of the patient aims at advancing the values that underpin the *HCCA*: enhancing patient autonomy and ensuring appropriate medical treatment.¹⁵

One of the issues provincial consent legislation addresses is the erosion of a patient’s autonomy at common law when she becomes incapable. When courts get involved in adjudicating treatment issues in the absence of statutory guidance, focus shifts from respect for patient autonomy to what the patient’s best interests are.¹⁶ While the case law generally recognized the need to consider the patient’s values and beliefs as part of best interests tests, provincial statutes—and certainly the *HCCA*—have codified the importance of patient autonomy even for incapable patients.

¹³ par. 23

¹⁴ par. 68

¹⁵ par. 87

¹⁶ pars. 20, 21

The inherent respect for the principle of autonomy is part of the rationale for rejecting the physicians' argument that "medical benefit" should determine when something ceases to be a treatment and may be discontinued without consent: how do you respect a person's autonomy if you make purely medically objective determinations about "benefit" without regard to that person's own views of benefit and burden?

THE CONSENT AND CAPACITY BOARD¹⁷

Ontario is unique in Canada in having a tribunal with jurisdiction to adjudicate refusal of SDMs to consent to a proposed treatment. As did both lower Courts, the Supreme Court held that the appellant physicians' remedy when consent to a proposed treatment is not given is an application to The Board and the Judgment is complementary to the tribunal.

The value of the Board has previously been judicially recognized. This Judgment cites *M. (A.) v. Benes*:¹⁸

A case will come before the Board only when the health practitioner disagrees with the S.D.M.'s application of the best interests test under s. 21(2). The Board will then have before it two parties who disagree about the application of s. 21: the S.D.M., who may have better knowledge than the health practitioner about the incapable person's values, beliefs and non-binding wishes; and the health practitioner, who is the expert on the likely medical outcomes of the proposed treatment. The disagreement between the S.D.M. and the health practitioner potentially creates tension and the Act recognizes this by providing for a neutral expert board to resolve the disagreement. Indeed, after hearing submissions from all parties, the Board is likely better placed than either the S.D.M. or the health practitioner to decide what is in the incapable person's best interests. [para. 46]

In addition to referring to some of the Board's Decisions, Justice McLachlin also made these observations:

¹⁷ Disclosure: the author is a former Vice Chair and Senior Lawyer Member of the Board and now represents health practitioners, hospitals and substitute decision-makers in Board applications.

¹⁸ (1999), 46 O.R. (3d) 271, (C.A.)

[100] The legislature has given the Board the final responsibility to decide these matters. This is not to say that the courts have no role to play. Board decisions are subject to judicial review. This mechanism for court oversight ensures that the Board acts within its mandate and in accordance with the Constitution.

[101] Over the past 17 years, the Board has developed a strong track record in handling precisely the issue raised in this case.

[102] In some cases, the Board has upheld the decisions of substitute decision-makers to refuse withdrawal of life support as being in the best interests of the patient: *D.W. (Re)*, 2011 CanLII 18217; *S.S. (Re)*, 2011 CanLII 5000; *P. (D.), Re*. In others, it has reversed the decision of the substitute decision-maker and required consent to be given for the withdrawal of life support: *A.K.; E.J.G.; N., (Re)*, 2009 CarswellOnt 4748. The particular facts of each case determine whether withdrawal of life support is in the best interests of the patient.

[103] Bringing its expertise to the issue, the Board's decisions may be expected to bring consistency and certainty to the application of the statute, thereby providing essential guidance to both substitute decision-makers and health care providers in this difficult area of the law.

Respectfully, there may be inherent conflict in, on the one hand observing that the particular facts of each case determine whether withdrawal of life support is in the patient's best interests on the one hand and on the other expecting consistency and certainty to the application of the statute. However, the Board has adjudicated more "end of life" cases than all Canadian Courts combined and some principles have begun to emerge.

While detailed analysis of the Board's end of life Decisions is beyond the scope of this paper, it can be noted that Board Decisions address both the substantive legal question of whether or not an SDM complied with the principles for substitute consent and the procedural requirements imposed upon a physician during the process of obtaining informed consent.

Justice McLachin noted another benefit to the Board: when a dispute arises between treatment team and SDM, it is the treatment team that must commence proceedings. All Canadian cases from whatever province that start in court rather than at the

Board have involved physicians advising the patient's family that they intend to discontinue life support, leaving the family to initiate the legal process.

[114] Sixth, I am concerned about the practical impact of the proposed approach on patients, families, and physicians. It may heighten the vulnerability of incapable patients, since the legal burden will be on family or friends to initiate court proceedings to prevent the withdrawal of life support, rather than on physicians to obtain consent before acting. The implications of this shift are particularly troubling where the incapable patient lacks a network of family and friends with the financial resources to fund legal action, which could entail a trial on the medical standard of care. Furthermore, it is unclear on the proposed approach whether the physician could withdraw life support without judicial oversight if no legal action is taken by the patient's family or friends.

The "proposed approach" referred to in the preceding paragraph is leaving end of life disputes to the Courts.

Another benefit of the Board not directly referred to is independent counsel for the incapable patient in almost every case. The HCCA authorizes the board to direct Legal Aid to appoint counsel for the incapable patient.¹⁹

While in this case Mr. Rasoli's family advocated for him, it is not unheard of for family members *not* to have a patient's best interests at heart, or to be unwilling or unable to give consent in accordance with an advance directive of which they were unaware or with which they disagreed. Either way, if justice must be seen to be done, a person whose life (or manner and timing of death) is on the line should have an independent seat at the table. None of the Canadian end of life court cases addressed this issue and in all of them the patient was not a named party or was represented by a Litigation Guardian who was also one of the substitute decision-makers.

¹⁹ A recent case reviewed the role of counsel for an incapable patient: *AC (Re)*, 2013 CanLII 49105 (ON CCB)

Justice McLachlin observed that the Board process has worked well for 17 years and physicians have used the process. She would be “...reluctant to close off access to this established regime and cast these matters back into the courts.”²⁰

Finally, although not referred to in the Judgment, the Consent and Capacity Board approach has gained some recognition internationally as a better way of resolving end of life disputes.²¹

ETHICAL CONSIDERATIONS

The appellants’ third ground of appeal was that requiring consent for withdrawal of life support will place them in an untenable ethical position.²² Justice McLachlin summarized this submission as follows:

[71] A final argument raised by the physicians is that they may be placed in an untenable ethical situation if consent is required for withdrawal of life support. They could effectively be compelled to continue providing life support, even where they consider it to provide no medical benefit to, or even to harm, the patient. This could place physicians in breach of their legal and professional obligations to act in the best interests of the patient.

The next paragraph offers comfort to physicians both of an ethical and legal nature:

[72] Legally, a physician cannot be faulted for following the direction of the Board, any more than he could be faulted for abiding by a judge’s direction at common law not to withdraw life support. Implicit in the physicians’ request that a judge resolve the present dispute is acceptance that if a judge orders that life support cannot be withdrawn, they must comply. Their legal position under the *HCCA* is no different.

²⁰ par. 115

²¹ *Surrogate Selection, An Increasingly Viable, But Limited, Solution To Intractable Futility Disputes*, Thaddeus Mason Pope, 2010 St. Louis University Journal of Health Law & Policy, pp. 183 to 252, at pp. 241-243

²² par. 33

In other words, a physician who takes a matter to the Board and treats according to its Decision is safe from both legal and professional consequences, in the view of the Chief Justice of Canada. Why more physicians and hospital risk managers have not yet seized upon this bulletproofing is beyond me.

Besides, the law is the minimum ethic. It's what has to be done. These laws are designed to protect and respect the autonomy of patients who are at their most vulnerable and in the hands of health practitioners who owe them the highest standard of care the law can imagine.

Even so, there can be moral distress in treating a patient when a health practitioner believes doing so is a harm to the patient. Justice McLachlin was alive to this concern, but also recognized that such tensions are inherent in the practice of medicine. "Indeed, the law of consent to medical treatment evolved through cases in which the patient did not wish to be treated, but the physician felt a professional obligation to treat..."²³

And,

[75] *Wherever one tries to draw the line, it is inevitable that physicians will face ethical conflicts regarding the withdrawal of life support. No legal principle can avoid every ethical dilemma.* What may be needed is a practical solution that enables physicians to comply with the law and to satisfy their professional and personal ethics. In this case, for example, the physicians explored the possibility of transferring Mr. Rasouli to a different Toronto hospital. Alternate staffing arrangements within Mr. Rasouli's present hospital could also be considered. Finally, other physicians qualified to undertake Mr. Rasouli's care may not hold an ethical objection to continuing the administration of life support. Such practical solutions could go far in averting any ethical conflict.

[76] While the end-of-life context poses difficult ethical dilemmas for physicians, this does not alter the conclusion that withdrawal of life support constitutes treatment requiring consent under the *HCCA*. *(Emphasis added)*

²³ par. 73

It should, however, be noted that Mr. Rasouli was not transferred to another hospital. Most if not all have patients in similar situations and I suspect few would wish to accept a patient already in another ICU who comes not only with medical but also legal problems.

The Minority Judgment

Justices Abella and Karakatsanis dissented. In their view, the physicians were correct that the decision as to when life support should be discontinued was theirs alone, that the common law governed not the statute.

[124]Thus, the court, and not the Consent and Capacity Board, is the appropriate forum for resolving any disputes between the doctors and the incapable patient's substitute decision-maker.

[125] In my view, the *HCCA* does not apply to the *withdrawal* of treatment. The *HCCA* codifies the deeply rooted common law right to refuse treatment, no matter the medical consequences. It does not, however, give patients, or their substitute decision-makers, the right to insist on the continuation of a treatment that is futile, harmful, or contrary to professional medical standards of care.

The dissenting Justices would have allowed the physicians' appeal and remitted the matter back to Superior Court to make the necessary findings of fact. They concluded that the legislation did not require a physician who proposes to withdraw a treatment required substitute consent and that the statutory definition of "treatment" did not include the withholding or withdrawal of a treatment. They also concluded that the legislative history of the *HCCA* did not disclose "an intention to create "a right for a patient to insist on treatment that a physician considers medically futile. Rather, the Act is designed to provide for findings of incapacity and an orderly and principled regime for substitute decision-makers."²⁴

²⁴ par. 134

And further,

[136] However, the converse is not true. As discussed below, there is no clear right under the Act or at common law for a patient to insist on a particular treatment if the doctor is not prepared to provide or continue to provide it. The *HCCA* reflects the consensus at common law, and does not require that a patient's wishes prevail. When the issue is the withdrawal of treatment that is no longer medically effective or is even harmful, a patient's choice alone is not an appropriate paradigm. A patient's autonomy must be balanced against broader interests, including the nature of her condition, the implications of continuing the treatment, the professional obligations of her physicians, and the impact on the broader health care system. This reflection of the common law is evident from the purposes, provisions, and scheme of the Act.

The Dissent also proposes a limited role for the Consent and Capacity Board—section (ii) of the dissent uses that phrase in the title.

[148] Finally, a health practitioner can apply to the Board under s. 37 to determine whether the substitute decision-maker complied with the requirements for providing consent under s. 21. Once again, pursuant to s. 21, the best interests test applies only if there are no clear known wishes. There is no provision that gives the Board authority to permit a substitute decision-maker to ignore known wishes and to determine and act on the best interests of the patient if the patient, over the age of 16 years, expressed a clear and applicable wish.

[149] Thus, where there are known wishes, the only available applications to the Consent and Capacity Board are (1) to obtain clarification of those wishes if unclear; or (2) to consider whether the wishes would likely have been different because of a change in the effectiveness of the treatment; or (3) to ensure the known wishes are being respected.

[150] A clearly expressed and still applicable wish to refuse treatment must therefore be followed by the substitute decision-maker, the physicians, and, crucially, by the Consent and Capacity Board. In this context, if the legislation was intended to go beyond the common law right to refuse medical treatment — to provide a patient or their substitute decision-maker with the right to insist on the continuation of treatment — it would have done so in clear terms. It provides no such right.

Although, the legislation does provide the substitute decision-maker with the right to consent or refuse consent to a plan of treatment that includes a provision for the withholding or withdrawing of a treatment. However, the dissenting Justices did not think that the reference to withholding and withdrawing treatment contained in

the definition of “plan of treatment” did not support for interpreting “treatment” generally to include its withholding or withdrawal. The legislature, they said, could have specifically included it in the definition of “treatment” if it wished to do so.²⁵

[155] Instead, withholding or withdrawal of treatment is included only as an optional *additional* element in the context of an overall plan that is focused on providing “various treatments or courses of treatment” to deal with a health problem. While the definition of a “plan of treatment” may create some arbitrariness by including some withdrawals of treatment and not others, the Act has addressed *only* those withdrawals of treatment that are bound up with an overall plan that provides for more than one treatment or course of treatment.

Justices Karakatsanis and Abella further concluded that the HCCA did not “alter the common law of consent by creating an entitlement to treatment.”²⁶

In paragraphs 160 through 163, the dissenting Justices wrote that there was no coherent basis upon which to conclude that some withdrawals require consent and others do not, that determining if consent is required to withdraw should not depend upon the process involved in withdrawal or upon whether withdrawal is in conjunction with other treatment to ease distress, or upon how invasive the process of withdrawal is. While palliative care requires consent, withdrawal is not always tied to palliation. In their view, “The requirement for consent for withdrawal should not rest on whether palliative care is required or has proceeded the withdrawal of life support. They are separate issues” and there is nothing in the Act to support tying them together as a “treatment package.”

The Dissent goes on to observe that withdrawal of treatment must be according to the medical standard of care and that physicians have a fiduciary duty to patients, which duty plays a role in the withdrawal of a treatment.

²⁵ par. 155

²⁶ par. 157

The dissenting Justices held it was this fiduciary duty to patients that required physicians to follow a fair, inclusive and accommodating process.

[203] In keeping with these duties, the various policy statements illustrate a process of giving notice, of seeking further medical opinions if requested, and of making efforts to transfer care to another institution willing to continue administering treatment. Indeed, in this case, each of these avenues was made available to the respondent's substitute decision-maker.

[204] Where a family member, or a substitute decision-maker, disagrees with the medical practitioner's decision to withdraw life support, she may apply to the court to challenge the physician's decision. That is what the substitute decision-maker did in this case.

Note the majority view that it was fairer to compel the physician to commence legal proceedings than the family.

The Majority opinion addressed the Dissenters' arguments in paragraphs 104 through 115. They did not agree that the important role the HCCA accords prior wishes indicated a legislative intention that the statute *not* apply to withdrawal of life support. The majority concluded that holding that "consent is required under the HCCA "only where withdrawal of life support is part of a "plan of treatment" merely pushed the analysis back one step to the thorny problem of defining "plan of treatment."²⁷

The Majority view was critical of how the Dissent proposed to protect patients:

[114] ...It may heighten the vulnerability of incapable patients, since the legal burden will be on family or friends to initiate court proceedings to prevent the withdrawal of life support, rather than on physicians to obtain consent before acting. The implications of this shift are particularly troubling where the incapable patient lacks a network of family and friends with the financial resources to fund legal action, which could entail a trial on the medical standard of care. Furthermore, it is unclear on the proposed approach whether the physician could withdraw life support without judicial oversight if no legal action is taken by the patient's family or friends.

²⁷ par. 106

[115] One of the legislature's primary motivations in enacting the *HCCA* was to simplify the law governing the treatment of incapable patients. The *HCCA* sets out clear rules requiring consent before treatment can occur, identifying who can consent for an incapable patient, stating the criteria on which consent must be granted or refused, and creating a specialized body to settle disputes. The legal framework of the *HCCA* has been used to resolve end-of-life disputes in Ontario for 17 years. I would be reluctant to close off access to this established regime and cast these matters back into the courts.

Analysis

Withholding and Withdrawing Versus Not Proposing

The Judgment does not address the distinction between withholding or withdrawing a treatment on the one hand and not proposing a treatment on the other. While consent is required for the former, nothing in this Judgment or anywhere else in the law entitles patients or substitute decision-makers to demand a treatment be commenced. There remains a clear distinction between proposing a treatment, which remains entirely within the purview of health practitioners, and withholding or withdrawing a treatment, which require consent.

In those Canadian cases in which families commenced litigation to compel continuation of life support,²⁸ interim injunctions have been granted directing continuation of life support pending trial. However, in the only case of which I am aware in which a surrogate sought a mandatory injunction to compel the reinstatement of treatments, the Judge at first instance expressed grave doubt as to the authority of any Court to compel a physician to *commence* a treatment.²⁹

While Justice Burnyeat declined to grant the injunction to restart invasive treatments on the basis that doing so was not in the patient's best interests (which is part of the test for granting injunctions in end of life cases), he wrote,

²⁸ *Golubchuk v. Salvation Army Grace General Hospital*, 2008 MBQB 49, 227 Man. R. (2d) 274; *Sweiss v. Alberta Health Services*, 2009 ABQB 691, 483 A.R. 340, for example

²⁹ *Rotaru v. Vancouver General Hospital Intensive Care Unit*, 2008 BCSC 318 (CanLII)

[16] When faced with a similar situation, the Lord Justices in *Re J, supra*, were of the view that they 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. The statements to that effect set out in clear and strong language the position taken in *Re J, supra*. I agree with that view.³⁰

One of the concerns expressed by the appellants in *Cuthbertson and Rubinfeld v. Rasouli* is that requiring consent to withdraw a treatment will result in physicians being afraid to *initiate* a treatment that might have temporary benefit or be appropriate at the time but later become inappropriate.

The most common and morally distressing treatment offered that physicians later wish to withhold is “full code,” meaning that the treatment team will do all things necessary in their attempt to save a person’s life if his or her heart stops. When a patient “codes,” one of the treatments used to attempt resuscitation is chest compressions, an attempt to restart the heart by pushing down on the patient’s chest, compressing the sternum about 100 times a minute for 15 minutes. In a frail, elderly patient, the result is frequently cracked or broken ribs and sternum and sometimes a punctured lung. The success rate in an intensive care unit for a frail person with multiple comorbidities is less than 2% and the probability of another heart failure (again requiring chest compressions) is stratospheric.

So, one issue in many “end of life” cases is whether or not the “offer” of chest compressions inherent in a “full code” patient may be withheld. Part of the problem is that virtually all hospitals deem every patient “full code” upon admission. The initial plan of treatment therefore includes chest compressions and therefore, presumptively, requires consent to be changed to “Do Not Resuscitate” or even a chart entry that chest compressions will be withheld in the event of cardiac arrest.

³⁰ *ibid.*, citation omitted

That was the situation in a recent case that started at the Consent and Capacity Board and found its way to the Court of Appeal.³¹ The patient's substitute decision-makers would not consent to the withholding of chest compressions when asked, to which the attending physician replied that consent was not needed and wrote the new chart order. The family took the matter to Superior Court, seeking an injunction that "full code" status be reinstated. Their application was dismissed there and again in the Court of Appeal.

Hamilton Health Sciences used a document titled "Physician Ordered Scope of Treatment," a "POST." Although the physician who completed it had written on it, "Everything to be done," the printed part indicated that "The following treatments may be used in the event of cardiac arrest," beneath which was listed, among other treatments, "chest compressions," "may" being the important word. The Court held,

In our view the application judge was correct in finding that the November 2012 treatment plan (which was consented to) gives the responsible physician discretion regarding which components of cardiopulmonary resuscitation are to be used and which are not. One such component is cardiac compression. In these circumstances, the contested order was simply one available to the doctor within that plan. It cannot be said to be a withdrawal of treatment from that treatment plan. No question therefore arises of the need for consent. Rather, it is, as the application judge said, effectively a request to impose CPR treatment which, for this patient, carries no possibility of medical benefit, but would only inflict harm on him.³²

My concern with this case is not the result as much as the fact that consent was sought and when not given, dispensed with and the fact that this discretion was not brought clearly home to the substitute decision-makers when the plan of treatment of which this was part was initiated.

While this case was decided before *Cuthbertson and Rubinfeld v. Rasouli*, the approach may well withstand further judicial challenge and represents one way of working within the *ratio* of the Supreme Court judgment.

³¹ *Cefarelli v. Hamilton Health Sciences*, 2013 ONCA 413 (CanLII)

³² *ibid.*, par. 4

It should be acceptable for physicians to offer treatments conditionally or temporarily, then withhold them if the patient's condition changes such that they are no longer indicated. Alternately, this approach may be limited to chest compressions, which constitute a violent assault on an often very sick person with no realistic prospect of benefit.

However, conditionally offered treatments also reflect the reality of intensive care treatment for very ill patients with multiple health problems: everything is a trial. And sometimes, what treats one condition exacerbates another. For example a patient may have a blood clot. One indicated treatment is blood thinners. But if the patient needs surgery, for example to remove an ischemic portion of intestine or even to insert a feeding or tracheotomy tube, blood thinners must be discontinued.

I think the conditionality of the treatment offer must be fully brought home to patients and their surrogates from admission to hospital or the beginning of treatment. This is not only a fairness issue, but also an issue of maintaining trust in the health care system.

Ethical Considerations

RESOURCE ALLOCATION

Intensive care beds are a scarce and expensive resource: Ontario has about a thousand ICU beds and each costs about one million dollars a year—and their vacancy rate is virtually zero.

However, this case was about a treatment decision for a particular patient and not about resource allocation in any sense. Resource allocation is a policy decision, to be left to the legislature. And, as the Chief Justice noted about the Ontario statute, it is open to the Lieutenant Governor in Council to make regulations “prescribing

things that do not constitute treatment for the purpose of the definition of ‘treatment’ in subsection 2(1).”³³

THE LAW IS THE MINIMUM ETHIC

Another ethical issue is respect for a patient’s legal rights. The Supreme Court has spoken and I wonder how any physician or other health practitioner can hold himself out as respecting a patient’s autonomy without fully respecting the rights that this case illuminates. Simply put, the law is the minimum ethic.

THE PHYSICIAN’S OBLIGATIONS AND INFORMED SUBSTITUTE CONSENT

There are many other ethical issues worthy of discussion but I will limit myself to one: the situation at the opposite end of the treatment spectrum from where Mr. Rasouli finds himself.

The HCCA is quite clear that, except for emergency situations, no treatment may be commenced in the absence of informed consent. A capable patient consents on his or her own. If a patient is incapable, treatment may commence once “the person’s substitute decision-maker has given consent in accordance with this Act.”³⁴

The phrase, “in accordance with this Act” must mean that consent has to accord to the principles for substitute consent set out in HCCA s. 21. So, consent must respect previously expressed, capable and applicable wishes and if none then be given in accordance with the patient’s best interests, as defined in HCCA s. 21(2). Anecdotally, most hospitals with large intensive care units (say, more than a dozen beds) have at least one patient who has been there for months if not years, who has no awareness of her surroundings and no prospect of any recovery and whose

³³ HCCA s. 83(1)(f)

³⁴ HCCA s. 10(1)(b)

condition will only deteriorate, such as a person with late stage Alzheimer's Dementia.

Sometimes, life support does not continue life but rather prolongs the dying process. Yet, physicians sometimes continue to accede to the demands of family that "everything be done." In my view, treating a patient contrary to his or her best interests because the family demands it is unethical and contrary to the statute. Recourse is to The Consent and Capacity Board in Ontario and the courts in other provinces.

Legal Considerations and Health Practitioners' Best Practices

Lawyers always say that cases are won or lost before the trial begins—preparation is the key. F. Lee Bailey once said, "If a lawyer pulls a rabbit out of a hat in a courtroom, it's only because he arrived with 50 rabbits and 50 hats."³⁵ And, the best way to avoid litigation is to be fully prepared for it.

As it happens, preparing for Consent and Capacity Board hearings or trials in large measure comprise the best practices health practitioners and facilities should follow to ensure that treatments proposed and consented to accord to the patient's values and beliefs and best medical interests. When I act for physicians in these cases, the first thing I want to see are the notes regarding identification of the correct substitute decision-makers and discussion of patient's values and beliefs—and in my view those discussions should be part of the admission process, with the patient if capable, with family and friends if incapable.

When the instant case was in the Court of Appeal, Justice Moldaver (before his appointment to the Supreme Court) expressed astonishment that Mr. Rasouli could be admitted to hospital to have his skull cut

³⁵ No citation and possibly apocryphal.

open and a tumor removed from his brain and no one asked him what his wishes would be if things went horribly wrong (as they did)!³⁶

While beyond the scope of this paper much has been written, and checklists created, to help health practitioners address these questions as part of the admission process.³⁷

What Impact Will This Case Have?

IN ONTARIO

Generally

The majority Judgment reaffirms Ontario's existing law: a physician's recourse when consent to withholding or withdrawing treatment is requested and not given is to the Consent and Capacity Board, rather than compelling their patient's substitute decision-makers to commence Superior Court applications. The majority accepted the plain meaning of the HCCA and recognized 17 years of successfully resolving these disputes before the Board. They ruled accordingly. They recognized the ethical conflicts physicians sometimes face in these difficult cases, but put the interests of patients first.

The Court also tactfully reminded the Legislature that they retained the right to make regulations limiting the scope of treatment. Physicians may decide that lobbying the legislature is the way to achieve the goal that eluded Doctors

³⁶ For that matter, he was also not told that, if things did go horribly wrong, his intensive care treatment team would take the position that they had the right to unilaterally withdraw life support, instead of making application to the Board as is done in other hospitals. *Quaere*, whether that failure vitiated the "informed" aspect of his consent to surgery?

³⁷ See for example, Choong et al., *A framework for resolving disagreement during end of life care in the critical care unit*, Clin Invest Med 2010; 33 (4): E240-E253 and Sibbald et al., *A checklist to meet ethical and legal obligations to critically ill patients at end of life*, Healthcare Quarterly Vol.14 No.3 2011

Cuthbertson and Rubinfeld in this case. But, do we need more legislation when we have a system that seems to work?

Previously Expressed Applicable Wishes

One of the complaints physicians have is that, if there are previously expressed capable wishes applicable to the patient's condition that say, "Do everything," they have no recourse because of the wording of HCCA s. 21(1) requiring that substitute consent respect those wishes.

Respectfully, I disagree. Avenues remain to be explored.

First, there is the notion of 'discretionary treatments,' as approved by the Court of Appeal in *Cefarelli, supra*.

Second, no cases have yet explored what the statute means when it states that previously expressed wishes that are "impossible" to respect need not be followed.³⁸

Third, even in the face of a previously expressed wish applicable to the circumstances that is not impossible to follow (whatever that means), I submit it is open to the Board and the Courts to adopt the reasoning in an American case that has been cited by the House of Lords and frequently by the Board:

...when cherished values of human dignity and personal privacy, which belong to every person living or dying, are sufficiently transgressed by what is being done to the individual, we should be ready to say – enough.³⁹

Certain overarching principles guide judges and adjudicators in the interpretation of statutes, for example The Canadian Charter of Rights and Freedoms. The *Re Conroy* principle might reach that status in determining whether or not a wish is possible to follow.

³⁸ HCCA. S. 21(1).2

³⁹ *Re Conroy* (1985) NJ 321, 398-399

ELSEWHERE IN CANADA

While this case turns on the specific wording of the Ontario statute, at least some of the *obiter dicta* should be heeded in other provinces. For example, the Chief Justice has suggested that physicians should bring the court application, instead of putting the burden on the incapable patient's family and friends, and has explained her reasoning. Ignore her words at your peril....

As well, given the approbation of Ontario's conflict resolution scheme embodied in the Consent and Capacity Board, it may be that other provinces consider a similar tribunal. Again, the Chief Justice likes it.

ACROSS CANADA

If nothing else, this case and its attendant publicity have reminded health practitioners of the importance and occasional thorniness of end of life disputes. Let us hope we can minimize their number, duration and the distress they cause.

Lawyers should be more thorough in discussions of advance care directives with clients, alerting them to the importance of not only a written document but also of discussions with family members about end of life wishes, values and beliefs. And, physicians and hospitals need to pay more attention to the methods of informed substitute consent, to alerting patients to the importance of having end of life discussions and the reality of what goes on in intensive care units.