S.C.C. No. 34362

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

BETWEEN:

DR. BRIAN CUTHBERTSON and DR. GORDON RUBENFELD

Appellants

- and -

HASSAN RASOULI BY HIS LITIGATION GUARDIAN AND SUBSTITUTE DECISION MAKER, PARICHEHR SALASEL

Respondents

- and -

THE CONSENT AND CAPACITY BOARD

Intervener

FACTUM OF THE APPELLANTS, Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld

(Rules 35 and 42 of the *Rules of the Supreme Court of Canada*)

McCarthy Tétrault LLP
Suite 5300, TD Bank Tower
Toronto ON M5K 1E6

Harry Underwood
Tel. (416) 601-7911
Fax (416) 868-0673
E. hunderwood@mccarthy.ca

Erica J. Baron
Tel. (416) 601-8106
E. ebaron@mccarthy.ca

Andrew McCutcheon
Tel. (416) 601-8344
E. amccutcheon@mccarthy.ca

Lawyers for the Appellants

Cavanagh Williams Conway Baxter LLP
Barristers and Solicitors
Suite 401
111 Prince of Wales Drive
Ottawa, ON K2C 3T2

Colin S. Baxter
Tel: (613) 780-2012
Fax: (613) 569-8668
Email: cbaxter@cwcb-law.com

Agent for the Appellants

PART I—APPELLANTS' POSITION AND CONCISE STATEMENT OF FACTS

1. This case raises the important question of who determines what medical treatments will be offered to a patient: a physician or the patient (or patient's substitute decision-maker). While the facts of this specific case raise the question of what medical treatments are offered to a patient approaching the end of life, there is no legal basis to distinguish between medical treatments at the end of life and any other medical treatments. The sole criterion that should govern whether any medical treatment is offered is whether the standard of care applicable to the physician requires the treatment to be offered to the patient. If there is no medical benefit to the patient, the standard of care cannot require the treatment to be offered. If the standard of care does not require a treatment to be offered to the patient, the question of patient consent to the treatment (or desire to receive the treatment) is simply not engaged.

2. This appeal raises four questions:

(a) *Is patient consent required to the withholding or withdrawal of medical treatment* that offers no medical benefit or is not required to be offered to a patient by the applicable standard of care ("non-indicated treatment")? The appellants submit that the answer is **no**.

(b) Is consent required to the withdrawal of non-indicated treatment if other positive treatment is to be administrated upon the withdrawal of the non-indicated treatment? The appellants submit that the answer is **no**.

(c) Is there a category of life-sustaining medical treatments that cannot be withdrawn or withheld without patient or substitute decision-maker consent even if the

treatment is a non-indicated treatment? The appellants submit that the answer is **no**.

(d) In the event that a physician concludes that a current treatment has become a non-indicated treatment, despite prolonging life, what steps is the physician obliged to take before withdrawing the non-indicated treatment? The appellants submit that a physician in those circumstances is obliged to:

(i) communicate this conclusion to the substitute decision-maker;

(ii) if requested by the substitute decision-maker, obtain a second opinion from a suitably qualified physician who has not previously been involved in the patient's care; and

(iii) allow the substitute decision-maker to arrange his or her own second opinion within a reasonable period of time in the circumstances of the case.

In the event any second opinion disagrees with the physician, either the substitute decision-maker or the physician may seek from the court, and the court should provide on a summary basis, a determination as to whether the standard of care requires continuation of the particular medical treatment by the physician.

A. OVERVIEW

3. Hassan Rasouli is 60 years old. He is a retired mechanical engineer. He was admitted to Sunnybrook Hospital (the "Hospital") for surgery to remove a brain tumour. Prior to his admission to the Hospital he could breathe, eat, walk, and communicate on his own.

4. Mr. Rasouli has been without consciousness since October 17, 2010 as a result of an infection of his brain which caused severe and diffuse damage. This was an unexpected turn of events. His neurological condition has been largely unchanged for well over a year. There is no evidence that he will ever recover any meaningful consciousness. At the time of the initial hearing of this matter before the Superior Court of Justice, Mr. Rasouli met the medical criteria for a diagnosis of persistent vegetative state (PVS).

5. Mr. Rasouli has been admitted to the Critical Care Unit at the Hospital for over fifteen months. He cannot breathe reliably without the assistance of a mechanical ventilator, which is connected to a tube that has been surgically inserted into his trachea. He cannot eat or drink and is fed and hydrated through a tube and intravenous lines. He cannot communicate, orally or in writing. He cannot leave the Hospital of his own volition. If the current course of treatment is continued, it is likely that he will die from one of the many complications related to being permanently confined to a hospital bed and on a ventilator.

6. When the extent of the brain damage and the gravity of his prognosis were apparent, Mr. Rasouli's attending physicians, which include the appellants, advised his family that the medical team had concluded that continued mechanical ventilation was no longer medically indicated because Mr. Rasouli would never recover from his underlying illness and would never regain consciousness. They also advised that they would not offer resuscitation in the event of a cardiac arrest. They proposed that Mr. Rasouli receive palliative care only. Mr. Rasouli's wife, Parichehr Salasel, did not accept the decision and applied for a permanent injunction to prevent a withdrawal of life-support absent her consent or an order of the Consent and Capacity Board. The appellants cross-applied for an order that the medical team did not require consent to withdraw or withhold life-support measures in the circumstances of this case.

7. Madam Justice Himel of the Superior Court of Justice (the "applications judge") concluded that consent was required to withdraw life-support measures from Mr. Rasouli because, she held, the withdrawal of medical treatment, even where no longer medically indicated, requires consent pursuant to the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A (the "Act").

8. The Court of Appeal dismissed the appeal. The Court of Appeal concluded that consent was required because the physicians proposed to administer positive care requiring consent (palliative care in this case) immediately upon withdrawal of life-support measures and because death would then be imminent. On the Court of Appeal's reasoning, consent was required to the withdrawal of the mechanical ventilation because it was "integrally linked" to the positive administration of palliative care. In so finding, the Court of Appeal stated its view that, where there is no medical benefit to a treatment, consent is not required if (a) the treatment is to be withheld; (b) the treatment is to be withdrawn and no other positive treatment requiring consent to be administered upon the withdrawal; or (c) the treatment is to be replaced with another treatment but the patient's death would not then be imminent.

B. PERSISTENT VEGETATIVE STATE

9. PVS involves an irreversible loss of consciousness due to a brain injury, which can be caused by a traumatic event such as a motor vehicle accident or a non-traumatic event such as an infection. Many PVS patients can breathe without mechanical support. They can exhibit a range of spontaneous movements, and reactions to external stimuli can also be preserved. The typical PVS patient may engage in activities such as opening and moving eyes, crying, smiling, frowning, yawning, chewing, swallowing, moving limbs spontaneously without purpose, and

grunting. Although this behaviour can produce the illusion of voluntary acts, they are not actually so – these are merely reflex responses, which are compatible with complete unawareness.

Reference: Affidavit of Dr. Swartz sworn February 14, 2011, Record of the Appellants ("Record"), Vol. 3, Tab 12, pages 63-64, para. 8 and Exhibit "C", pages102-103.

10. The diagnosis of PVS is made primarily on the basis of clinical observation over a period of time. There are well-recognized criteria for the diagnosis, which are stated in the report by the Multi-Society Task Force on PVS entitled "Medical Aspects of the Persistent Vegetative State", published in the *New England Journal of Medicine* in 1994:

> The vegetative state can be diagnosed according to the following criteria: (1) no evidence of awareness of self or environment and an inability to interact with others; (2) no evidence of sustained, reproducible, purposeful, or voluntary behavioural responses to visual, auditory, tactile, or noxious stimuli; (3) no evidence of language comprehension or expression; (4) intermittent wakefulness manifested by the presence of sleep-wake cycles; (5) sufficiently preserved hypothalamic and brain-stem autonomic functions to permit survival with medical and nursing care; (6) bowel and bladder incontinence; and (7) variably preserved cranial-nerve reflexes (pupillary, oculocephalic, corneal, vestibulo-ocular, and gag) and spinal reflexes.

As the report also states, PVS can be judged permanent three months after the date of injury in a non-traumatic case. That is because the prospect for any recovery declines markedly after three months.

Reference: Affidavit of Dr. Swartz, Record, Vol. 3, Tab 12, page 66, para. 16 and Exhibit "C", page 102.

C. MR. RASOULI'S NEUROLOGICAL STATUS

11. Mr. Rasouli's neurological status results from a condition known as ventriculitis, which is extremely destructive to brain tissue, and almost uniformly fatal. In Mr. Rasouli's case, it caused extensive death of brain tissue through cerebritis (a generalized inflammation of the brain) and

multi-focal infarcts (strokes) of the brain tissue. Inflammation near the back of the brain caused clotting and narrowing of the artery leading to the brainstem, resulting in infarction of that brain structure. His spinal cord (including peripheral nerve roots) may also have been damaged by the infection. As a result of this damage to his brain, Mr. Rasouli cannot reliably breathe with mechanical assistance.

Reference: Affidavit of Dr. Swartz, Record, Vol. 3, Tab 12, pages 66-67, para. 18.

12. On a neurological examination carried out on October 17, 2010, Dr. Richard Swartz, Mr. Rasouli's attending neurologist, determined that he demonstrated no evidence of awareness of himself or his environment, no response to visual, auditory, tactile, or noxious stimuli, and no evidence of language comprehension or expression. His observed responses were confined to reflex responses of a type generally accepted by clinicians to be compatible with PVS. He showed no responses that were either atypical or incompatible with a diagnosis of PVS. On motor examination, he demonstrated flaccid quadriparesis with reduced tone and absent motor reflexes.

Reference: Affidavit of Dr. Swartz, Record, Vol. 3, Tab 12, page 67, paras. 19-22.

13. As of October 17, 2010, Mr. Rasouli satisfied all the criteria for PVS except for the persistence of his condition which, by definition, must be at least three months. It was overwhelmingly likely that Mr. Rasouli lacked any degree of awareness and also overwhelmingly likely that he would never recover any. Four reassessments of Mr. Rasouli in the following four months revealed minimal changes in his neurological status, all of which were compatible with a diagnosis of PVS, thus underlining the remoteness of any further material improvements.

Reference: Affidavit of Dr. Swartz, Record, Vol. 3, Tab 12, page 63, para. 6, page 64 paras. 11-12, page 67 para. 24 and Exhibit "B", pages 85-99.

14. A full separate neurological assessment was also conducted on January 20, 2011 by a staff neurologist (Dr. Jon Ween) who had not previously been involved in Mr. Rasouli's care. He concurred with Dr. Swartz's findings and diagnosis.

Reference: Affidavit of Jon Ween, sworn February 13, 2011, Record, Vol. 3, Tab 13, pages 119-120, paras. 4-5, 7-8, 10 and Exhibit "B", pages 136-138.

15. A variety of diagnostic tests, including imaging of the brain, supported Drs. Swartz and Ween's clinical findings and the clinical diagnosis of PVS.

Reference: Affidavit of Dr. Swartz, Record, Vol. 3, Tab 12, pages 68-69, paras. 25-26.

16. Mr. Rasouli's family members said that they had seen him engage in certain movements, such as raising his left eyebrow, blinking, crying, raising and moving his hands, swinging his knees, and trying to stretch his body. It is clear that Mr. Rasouli's family loves him very much, and that they desperately wanted to believe that he was conscious and improving. Unfortunately, it is also clear this coloured their interpretation of his behaviour.

Reference: Affidavit of Parichehr Salasel, Record Vol. 3, Tab 16, pp. 176-177 paras. 46-49, and pages 177-178, paras. 53-60.

17. A PVS patient will often engage in movements that create the illusion that the patient is conscious when in fact these movements are involuntary reflex actions. Although the family asserted that he responded to their commands, they lack the training and experience that are required to distinguish between involuntary movements and true signs of neurological change or responsiveness. Attempts by medical professionals fluent in Mr. Rasouli's mother tongue to prompt what the family believed to be voluntary movements were unsuccessful.

Reference: Affidavit of Dr. Swartz, Record, Vol. 3, Tab 12, at page 63 para. 8, page 67, para. 24 and *Exhibit "C" at page 102.*

Affidavit of Dr. Cuthbertson, Sworn February 14, 2011, Record, Vol. 1, Tab 11, pages 96-97, paras. 58-59.

Affidavit of Dr. Fazl, sworn February 14, 2011, Record, Vol. 3, Tab 14, pages 140-141 at paras. 4, 5, 6, 8 and Exhibits "A", "B" and "C", pages 143-150.

18. Neither the applications judge nor the Court of Appeal made any factual determination of whether Mr. Rasouli was in a PVS. Mr. Rasouli's actual condition was not relevant to those courts in light of their findings on the issue of law. However, the evidentiary record contains no medical evidence to dispute that Mr. Rasouli met the criteria for PVS in that no expert medical evidence was put forward by the respondents in the courts below.[1]

D. THE DECISION TO WITHDRAW LIFE-SUPPORT

19. By November, 2010, Mr. Rasouli's treating physicians, drawn from the critical care, neurology, neurosurgery, and infectious diseases services, had all concluded that because of his underlying, irreversible brain damage, he could receive no medical benefit from life-sustaining treatment, including mechanical ventilation. The physicians decided that such treatment should no longer be offered to him. Having reached that decision, the physicians proceeded compassionately and carefully as follows:

(a) They arranged a series of meetings with the family and medical staff, nursing staff, a social worker, and an ethicist at which they carefully explained the rationale for the decision to Mr. Rasouli's family, and sought the family's acquiescence;

[1] To the contrary, the family did not obtain a second neurological opinion because they acknowledged that it would not vary from the opinions already obtained. See Affidavit of Dr. Cuthbertson, Exhibit "A", Record, Vol. 2, page 124.

(b) Inquiries were made to see if another hospital might be prepared to assume Mr. Rasouli's care, which were unsuccessful;

(c) A second neurological opinion was obtained;

(d) The family was given the time and opportunity to obtain its own neurological opinion; and

(e) The family was given the time and opportunity, before treatment was discontinued, to apply to the court for an injunction.

Reference: Affidavit of Dr. Cuthbertson, Record, Vol. 1, Tab 11, pages 90-93, paras. 30-35, 39-41 and Exhibit "A", Vol. 1, Tab 11-A, pages 163-164, Record, Vol. 2, Tab 11-A, pages 30-31, 34, 38-39, 43-44, 46, 48, 51, 52.

Cross Examination of Brian Cuthbertson conducted on February 14, 2011, Record, Vol. 4, Question 20, page 43, line 25 to page 44 line 8.

Affidavit of Parichehr Salasel sworn February 10, 2011, Record, Vol. 3, Tab 16, Exhibit "D", page 193.

E. PROCEEDINGS IN AND DECISIONS OF THE COURTS BELOW

SUPERIOR COURT OF JUSTICE

20. The respondent brought an application to prevent the appellants from withdrawing mechanical ventilation from Mr. Rasouli absent consent either from his substitute decision-maker or an order from the Consent and Capacity Board.

Reference: Notice of Application in Court File No. CV-11-419084, Record, Tab 7, page 68.

21. The appellants sought a declaration that, *inter alia*, consent was not required in respect of the withdrawal of mechanical ventilation in the circumstances of this case, namely, a patient diagnosed in a PVS.

Reference: Notice of Application in Court File No. CV-11-419611, Record, Tab 8, page 75.

22. The applications judge found that consent was required to withdraw life-support, in this case, mechanical ventilation. Relying on the Act, she reasoned that the withdrawal of life-support requires the consent of a patient or substitute decision-maker because life-support is, by medical dictionary definition, treatment; its withdrawal is therefore a withdrawal of treatment; the withdrawal of treatment is included within the definition of "plan of treatment" contained in the Act; "plan of treatment" is included in the statutory definition of "treatment"; and "treatment" requires consent under the Act.

Reference: Reasons for Decision dated 2011-03-09 (the "Superior Court Decision"), Record, Tab 2, pages 4 and 10, paras. 9-10, 30-31, 37-38.

COURT OF APPEAL

23. The physicians' appeal from the decision of the applications judge was dismissed by the Court of Appeal. The Court of Appeal held that the withdrawal of mechanical ventilation followed by the administration of palliative care in circumstances where death was imminent would constitute "treatment" under the Act, for which the patient's substitute decision-maker's consent is required.

Reference: Reasons for Decision of the Court of Appeal for Ontario dated 2011-06-29 (the "Court of Appeal Decision"), Record, Vol. 1, Tab 5, page 57, para. 47.

24. The Court of Appeal dismissed the appeal for different reasons than the applications judge. The Court of Appeal accepted that neither the withholding of non-indicated treatment nor the withdrawal of non-indicated treatment, taken alone, requires consent. According to the Court of Appeal, only treatment that a physician is willing to offer or continue requires consent, but with one exception – it found that the withdrawal of life-support leading imminently to death is

active treatment when the attending doctors propose, along with the removal of life-support, to provide palliative care to the patient pending death.

Reference: Court of Appeal Decision, Record, Vol. 1, Tab 5, pages 56, 63, paras. 46, 65.

25. The Court of Appeal correctly found that palliative care is "treatment" requiring consent. However, it went on to find that because the removal of the ventilator triggers the administration of palliative care in light of the patient's imminent death, the two are "integrally linked", and should be viewed for the purposes of the Act as a "treatment package". Since end of life palliative care includes the withdrawal of life-support measures, which according to the Court of Appeal must be terminated before palliative care can begin[2], and palliative care requires consent, the Court of Appeal concluded that physicians are obliged to obtain the substitute decision-maker's consent to the entire "treatment package" before withdrawing mechanical ventilation.

Reference: Court of Appeal Decision, Record, Vol. 1, Tab 5, pages 57-58, 60-61, paras. 48, 50-51, 58.

26. The Court of Appeal left undecided Mr. Rasouli's actual condition as well as the question of whether the continuation of life-support is in his case futile or would instead provide a medical benefit. It found that it did not have to decide that issue. Accordingly, it did not consider the implications of a finding that physicians may be legally obliged to provide care even though the applicable standard of care may not oblige them to.

Reference: Court of Appeal Decision, Record, Vol. 1, Tab 5, pages 56-57, 61, paras. 46, 59-60.

27. The Court of Appeal suggested its approach addressed the physicians' concern about the implications of the applications judge's interpretation of the Act. Broadly speaking, her interpretation would allow patients to pick and choose the treatment they are to receive

[2] A factual finding for which there was no evidence.

regardless of medical indications because, by withholding consent, patients could prevent the withdrawal of treatment. And this problem would apply not just at the end of their lives but at any time.

Reference: Court of Appeal Decision, Record, Tab 5, page 59, para. 54.

28. It was the physicians' position that the applications judge erred because "treatment" under the Act does not include the withholding or withdrawal of non-indicated treatment which therefore a physician is not prepared to offer to the patient. In particular, life-support is not treatment when it is futile and when the physicians propose not to continue to provide it. Hence the patient's consent to its withdrawal is not required.

Reference: Court of Appeal Decision, Record, Vol. 1, Tab 5, pages 40-41, 53-55, paras. 10-14, 39, 40, 42.

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

Reference: Court of Appeal Decision, Record, Vol. 1, Tab 5, pages 40-41, 55, paras. 12, 43.

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

Reference: Court of Appeal Decision, Record, Vol. 1, Tab 5, pages 41-42, 54-57, and 59, paras. 16, 17, 41, 46, 54.

31. In an apparent response to the physicians' concerns, the court noted that its approach did not affect a physician's discretion to withhold treatment altogether. It observed that when physicians withhold life-support, because it is futile or offers no medical benefit, and provide palliative care only, the two cannot be said to be integrally linked because there is "nothing to transfer from" before moving from one to the other.

Reference: Court of Appeal Decision, Record, Vol. 1, Tab 5, pages 59-60, paras. 55-56.

32. The court also appears to have considered that its approach will not prevent physicians from withdrawing other forms of treatment apart from life-support. It distinguished life-support from other cases where active treatment is withdrawn as a non-indicated treatment, but death is not imminent. It instanced the discontinuation of chemotherapy where not benefiting the patient, saying this:

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

Reference: Court of Appeal Decision, Record, Vol. 1, Tab 5, pages 58-59, para. 53.

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

34. While the Court of Appeal noted the availability of an application to the Consent and Capacity Board, it also (correctly) observed that:

> Recourse to the Board may not be a perfect solution from the appellants' prospective. If a substitute decision-maker has acted under s. 21(1) 1. on a wish that incapable person [sic] expressed when capable, after attaining sixteen 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.

Reference: Court of Appeal Decision, Record, Vol. 1, Tab 5, page 61, para. 59.

35. As a result of the decisions below, the physicians have continued to provide life-support to Mr. Rasouli, as they have for over fifteen months, because his substitute decision-maker has not provided her consent to withdrawal of that treatment.

PART II—QUESTIONS IN ISSUE

36. This appeal raises the following questions:

(a) As a general proposition, is patient consent required to the withholding or withdrawal of non-indicated treatment?

(b) Is consent required to the withdrawal of non-indicated treatment if other positive treatment is to be administrated upon the withdrawal of the non-indicated treatment?

(c) Is there a category of life-sustaining medical treatments that cannot be withdrawn or withheld without patient or substitute decision-maker consent even if the treatment is a non-indicated treatment?

(d) In the event a physician concludes that a current treatment has become a non-indicated treatment, despite prolonging life, what steps is a physician obliged to take before withdrawing the non-indicated treatment?

PART III—ARGUMENT

A. PATIENT CONSENT CANNOT CREATE A POSITIVE OBLIGATION TO PROVIDE NON-INDICATED TREATMENT UNDER THE COMMON LAW

37. The requirement for patient consent to the administration of medical treatment prior to its administration, absent extraordinary circumstances, has been a recognized feature of the common law for centuries. This principle has been codified by statute in many jurisdictions in Canada.

Reference: *Slater v. Baker* (1767), 2 Wils. K.B. 359, cited with approval in *Parmley v. Parmley*, [1945] S.C.R. 635 at 645-646, Appellants' Authorities, Tab 1.

Act, s. 10.

Health Care (Consent) and Care Facility (Admission) Act, R.S.B.C. 1996, c. 181, ss. 4-5.

Care and Consent Act, S.Y. 2003, c. 21, Sch. B, ss. 3-4.

Civil Code of Québec, S.Q. 1991, c. 64, art. 10-11.

Consent to Treatment and Heath Care Directives Act, R.S.P.E.I. 1988, c. C-17.2, ss. 4-5.

38. The common law and many statutes in Canada require that a physician who proposes to administer a treatment to a patient explain to the patient or, in the case of an incapable patient, the patient's substitute decision-maker the expected benefits and risks associated with the treatment. This information is intended to secure not only consent to treatment prior to its administration but also a consent that is informed.

Reference: Act, ss. 10-11.

Reibl v. Hughes, [1980] 2 S.C.R. 880 at 884-885, Appellants' Authorities, Tab 2.

Hopp v. Lepp, [1980] 2 S.C.R. 192 at 210, Appellants' Authorities, Tab 3.

Videto v. Kennedy, 1981 CarswellOnt 580 at para. 11 (C.A.), Appellants' Authorities, Tab 4.

39. A failure to obtain consent to a treatment prior to its administration may result in a finding that a physician has committed an assault or battery on a patient whereas a failure to obtain informed consent to a treatment prior to its administration may result in a finding that a physician was negligent in treating the patient.

Reference: *Reibl v. Hughes,* [1980] 2 S.C.R. 880 at 890, Appellants' Authorities, Tab 2.

40. The rationale for requiring informed consent is rooted in the notion of patient autonomy:

> The right to determine what shall, or shall not, be done with one's own body, and to be **free from** non-consensual medical treatment, is a right deeply rooted in our common law. This right underlies the doctrine of informed consent. With very limited exceptions, every person's body is considered inviolate, and, accordingly, every competent adult has the right to be free from unwanted medical treatment. The fact that serious risks or consequences may result from a refusal of medical treatment does not vitiate the right of medical self-determination. The doctrine of informed consent ensures the freedom of individuals to make choices about their medical care. It is the patient, not the doctor, who ultimately must decide if treatment — any treatment — is to be administered. [Emphasis added.]

Reference: *Fleming v. Reid,* 1991 CarswellOnt 1501 at para. 33 (C.A.), Appellants' Authorities, Tab 5.

41. But it does not follow that an individual's right to refuse the positive administration of medical treatment creates or implies a corollary right to require the provision of medical treatment. As was succinctly set out by the English Court of Appeal in *Re R*:

> It is trite law that in general a doctor is not entitled to treat a patient without the consent of someone who is authorised to give that consent... **However consent by itself creates no obligation to treat**. It is merely a key which unlocks a door
>
> ...
>
> No doctor can be required to treat a child, whether by the court in the exercise of its wardship jurisdiction, by the parents, by the child or anyone else. The decision whether to treat is dependent upon an exercise of his own professional judgment, subject only to the threshold requirement that, save in exceptional cases usually of emergency, he has the consent of someone who has authority to give that consent. [Emphasis added.]

Reference: *Re R,* [1991] 3 W.L.R. 592 at 599, 603 (per Lord Donaldson, M.R.) (Eng. C.A.), Appellants' Authorities, Tab 6.

42. A patient's undoubted right of self-determination does not entitle him or her to insist on receiving a particular medical treatment of his or her choosing. Instead, the physician, exercising professional clinical judgment, decides what treatment options are medically indicated, i.e., will provide a medical benefit to the patient. The physician offers that treatment or those treatment options to the patient, together with a description of the risks and benefits associated with them, and the patient decides which treatment or treatments to accept, if any. If the patient requests or demands a form of treatment that the physician concludes is not medically indicated, the physician has no legal obligation to provide it unless it can be demonstrated by expert evidence that the standard of care **requires** the care to be offered. To the contrary, a physician who provides a non-indicated treatment may be held liable for any injury that patient suffers arising from that treatment despite the consent.

Reference: *R.. on the application of Burke v. The General Medical Council*, 2005 WL 1860209 at paras. 31, 50, 55 (Eng. C.A.), Appellants' Authorities, Tab 7.

Airedale NHS Trust v. Bland, [1993] A.C. 789 at 818, 858, 866, 870 (per Butler-Sloss L.J., Lord Keith of Kinkel, and Lord Goff of Chieveley) (Eng. H.L.), Appellants' Authorities, Tab 8.

See also: Ellen Picard and Gerald Robinson, *Legal Liability of Doctors and Hospitals in Canada* (4th ed.), (Toronto, ON: Thomson Carswell, 2007) at 345-6, Appellants' Authorities, Tab 9.

43. Such a standard is appropriate. Where a treatment offers **no** medical benefit to a patient, there can be no legal justification for **requiring** the treatment to be offered to the patient. Similarly, where a treatment had previously provided a medical benefit (or the potential for a medical benefit) but because of a change in the patient's clinical condition or prognosis that treatment no longer provides a medical benefit, there can be no justification for requiring the treatment to be continued.

Reference: *R.. on the application of Burke v. The General Medical Council*, 2005 WL 1860209 at paras. 32-33 (Eng. C.A.), Appellants' Authorities, Tab 7.

44. Whether a treatment offers a medical benefit to a patient can only be based on the clinical judgment of a medical professional taking into account the patient's underlying medical condition and prognosis, the expected result of the administration of any given treatment, and the risks the patient will or may undergo if the treatment is administered. The patient's beliefs are irrelevant to the question of whether a treatment offers a medical benefit.

45. The clinical judgment as to whether a treatment offers a medical benefit may vary from physician to physician. Some physicians may be willing to offer particular treatment to a particular patient when others are not because of their varying views on the medical benefit. However, once a physician, in the good faith exercise of his or her clinical judgment, concludes that a treatment is not, or is no longer, medically indicated, he or she cannot be legally obliged to offer that treatment unless it can be demonstrated that a failure to provide it would result in a breach of the standard of care by that physician. Where no such breach can be demonstrated, the court should not make an order requiring the administration of the treatment by that physician, no matter what the wishes of the patient or substitute decision-maker.

Reference: *R.. on the application of Burke v. The General Medical Council,* 2005 WL 1860209 at paras. 9-13, 23, 29-33, 50-63 (Eng. C.A.), Appellants' Authorities, Tab 7.

Children's Aid Society of Ottawa-Carleton v. M.C., [2008] O.J. No. 3795 at para. 33 (S.C.J.) (QL), Appellant's Authorities, Tab 11.

Re G., [1995] 2 FCR 46 at 3 (Fam. Div. Eng. H.C.J.) (Lexis), Appellants' Authorities, Tab 12.

Re J (a minor), [1992] 4 All E.R. 614 at 619, 625-626 (Eng. C.A.), Appellants' Authorities, Tab 13.

AVS v. A NHS Foundation Trust & Anor, 2011 WL 2748112 at paras. 35, 38 (Eng. C.A.), Appellants' Authorities, Tab 14.

Airedale NHS Trust v. Bland, [1993] A.C. 789 at 884 (per Lord Brown-Wilkinson) (Eng. H.L.), Appellants' Authorities, Tab 8.

Application of Justice Health; re a patient, 2011 WL 6288115 at paras. 6-7 (N.S.W.S.C.), Appellants' Authorities, Tab 15.

Frenchay Healthcare National Health Service Trust v. S., [1994] 1 W.L.R. 601 at 609 (per Sir Thomas Bingham, M.R.) (Eng. C.A.), Appellants' Authorities, Tab 16.

Auckland Area Health Board v. Attorney General, 1992 NZLR LEXIS 730 at paras. 51-52, 56 (H.C.), Appellants' Authorities, Tab 17.

46. For instance, in *Shortland v. Northland Health Ltd.*, the Court of Appeal of New Zealand considered whether a patient could be lawfully refused kidney dialysis notwithstanding his family's objections and notwithstanding the fact that he would likely die as a result of the refusal. The Court of Appeal upheld the decision of the lower court refusing to order administration of dialysis:

> ...it was simply not arguable on the evidence that there had been a failure to statisfy the requirement of conformity with prevailing medical standards and with practices, procedures and traditions commanding general approval within the medical profession. There were contrary expressions of opinion from overseas physicians, but the fact that people who had no direct knowledge of the case may have reached a different conclusion (in one case, a heavily-qualified different conclusion) does not provide a sufficient criterion.
>
> ... When decisions are difficult or even controversial, it is not unusual to find well-qualified experts expressing a contrary view. ...
>
> Thomas J's fourth criterion was that the decision at issue should have the fully informed consent of the patient's family. There are real difficulties in applying such a requirement to the circumstances of this case. It is not a requirement which should be regarded as applying to medical decisions irrespective of the circumstances. To require consent of the patient's family to the cessation of a particular form of treatment, or to a decision not to give the patient a particular form of treatment, gives the family the power to require the treatment to e given or continued irrespective of the clinical judgment of the doctors involved. The law cannot countenance such a general proposition. While the criterion **may** have been appropriate in the context of the proposed removal of a life-support system, as in the Auckland case, it cannot apply to a decision not to put a patient on long-term dialysis, following a period of assessment which demonstrated that long-term dialysis was clinically inappropriate. [Emphasis added].

Reference: *Shortland v. Northland Health Ltd.*, 1997 NZLR LEXIS 637 at paras. 28-31 (C.A.), Appellants' Authorities, Tab 10.[3]

[3] The appeal was heard and decided on the same day as the decision from the court below and the patient died the next morning.

47. Instead, as with any case involving the legal obligations of physicians owed to patients, the physician must be judged on whether there has been compliance with the applicable standard of care – that is a physician's only obligation known to law.

Reference: *Wilson v. Swanson*, [1956] S.C.R. 804 at 817, Appellants' Authorities, Tab 18.

Ter Neuzen v. Korn, [1995] 3 S.C.R. 674 at paras. 33, 38, Appellants' Authorities, Tab 19.

Airedale NHS Trust v. Bland, [1993] A.C. 789 at 818 (per Butler-Sloss L.J.) (Eng. H.L.), Appellants' Authorities, Tab 8.

B. THE STANDARD OF CARE AS IT APPLIES AT THE END OF LIFE

48. No authority supports the conclusion that the common law recognizes a duty of care to obtain consent to the withdrawal or withholding of non-indicated treatment, regardless of whether death will result or another treatment requiring consent is proposed to be administered. There is a wealth of authority that holds or implies that no such duty of care exists.

Reference: *Child and Family Services of Central Manitoba v. L.(R.)*, [1997] M.J. No. 563 at paras. 14 and 17 (C.A.), Appellants' Authorities, Tab 20.

Rotaru v. Vancouver General Hospital Intensive Care Unit, [2008] B.C.J. No. 456 at para. 16 (S.C.), Appellants' Authorities, Tab 21.

Re L.I.C., 2006 ABQB 130 (QL), Appellants' Authorities, Tab 22.

Re I.H.V. Estate, 2008 ABQB 250 at para. 33 (QL), Appellants' Authorities, Tab 23.

Children's Aid Society of Ottawa–Carleton v. M.C., [2008] O.J. No. 3795 (S.C.J.) (QL), Appellants' Authorities, Tab 11.

Re J (a minor), [1992] 4 All E.R. 614 at 622-623 and 626 (Eng. C.A.), Appellants' Authorities, Tab 13.

AVS v. A NHS Foundation Trust & Anor, 2011 WL 2748112 at para. 38 (Eng. C.A.), Appellants' Authorities, Tab 14.

Auckland Area Health Board v. Attorney General, 1992 NZLR LEXIS 730 (H.C.), Appellants' Authorities, Tab 17.

Clarke v. Hurst (1992), (4) SA 630 at 658, Appellants' Authorities, Tab 24.

Thaddeus Mason Pope, "Involuntary Passive Euthanasia in U.S. Courts: Reassessing the

Judicial Treatment of Medical Futility Cases", (2008) 9 Marquette Elder's Advisor 229 at 260-263, Appellants' Authorities, Tab 25.

Ellen Picard and Gerald Robinson, *Legal Liability of Doctors and Hospitals in Canada* (4th ed.), (Toronto, ON: Thomson Carswell, 2007) at 345-6, Appellants' Authorities, Tab 9.

49. In Ontario, the College of Physicians and Surgeons of Ontario (the CPSO) has established a standard of practice concerning end of life care. The CPSO established this policy as the regulating body for physicians and pursuant to an express statutory power to establish standards of practice for the profession. The policy, adopted in 2006, stipulates that physicians are not obliged to provide treatments that will almost certainly not benefit the patient, either because the patient's condition is such that recovery or improvement is virtually unprecedented or because the patient will be unable to experience any permanent benefit from the treatment.

Reference: Policy Statement #1-06 of the College of Physicians and Surgeons of Ontario, "Decision-making for the End of Life" (July, 2006) at 5, Appellants' Authorities, Tab 26.

Regulated Health Professions Act, 1991, S.O. 1991, c. 18, Schedule 2 (Health Procedural Code), s. 3(1).

See also: Policy Statement No. 1602 of the College of Physicians and Surgeons of Manitoba, "Withholding and Withdrawing Life-sustaining Treatment" (September, 2007) at 15-S11, Appellants' Authorities, Tab 27.

50. Compliance with the CPSO's standard of practice must entail compliance with the applicable standard of care.

51. A similar policy has been adopted by the Canadian Medical Association, a body devoted to serving and uniting the physicians of Canada and the national advocate, in partnership with the people of Canada, for the highest standards of health and health care. Its Joint Statement on Resuscitative Interventions, made, *inter alia*, with the Canadian Bar Association, provides:

> There is no obligation to offer a person futile or nonbeneficial treatment. ... In some situations a physician can determine that a treatment is "medically" futile or nonbeneficial because it offers no reasonable hope of recovery or

improvement or because the person is permanently unable to experience any benefit.

Reference: Joint Statement of Resuscitative Interventions of the Canadian Medical Association (1995) at 2, Appellants' Authorities, Tab 28.

Canadian Medical Association, "History, Mission, Vision and Values", online: The Canadian Medical Association <http://www.cma.ca/aboutcma/history-mission-vision-values>, Appellants' Authorities, Tab 29.

52. Also instructive are similar policies from the United Kingdom, Australasia, and South Africa, which are all to the same effect – no physician can be obliged to provide treatment that the physician concludes is non-indicated treatment.

Reference: General Medical Council (United Kingdom), "Treatment and care towards the end of life: good practice in decision making", (2010) at paras. 16, 141, 146, Appellants' Authorities, Tab 30.

Office of the Public Advocate (Australia), "Not for Resuscitation (NFR)", (March 2004) at 5, Appellants' Authorities, Tab 31.

The Royal Australasian College of Physicians, "Decision-Making at the End of Life in Infants, Children and Adolescents", (2008) at 15-17, Appellants' Authorities, Tab 32.

Health Professions Council of South Africa Guidelines for the Withholding and Withdrawing of Treatment (29 May 2007) at sections 2.6 and 5, Appellants' Authorities, Tab 33.

53. Moreover, as discussed in further detail below, there is no statutory provision overriding this standard of care in Ontario or elsewhere in Canada.

54. There is no evidence that the standard of care is different when death is imminent or when other care is to be offered at the same time as, or even as a result of, the withdrawal of the non-indicated treatment.

55. There is no public policy rationale to justify overriding this standard of care generally, or in the context of end of life care. For the Court of Appeal to have concluded otherwise, in particular without the benefit of any expert medical evidence to that effect, was an error.

56. In summary, at common law, prior to any medical treatment being administered two conditions must be met, in the following order:

(a) A physician must conclude, in the exercise of his or her clinical judgment, that the treatment is medically indicated and he or she must be willing to offer it to the patient; and

(b) Consent must be given to the administration of the treatment.

57. If the first condition is not met, the patient cannot force the physician to provide the treatment absent a court order that the standard of care requires the doctor to offer the treatment to the patient.

C. THE STANDARD OF CARE AS IT APPLIES TO THIS CASE

58. In *Airedale NHS Trust v. Bland*, the House of Lords considered whether physicians have a legal duty to keep a patient alive in a PVS. This required an examination of duties arising under the criminal law and under the medical standard of care. In the result, it was held lawful for physicians to cease providing medical treatment to a PVS patient although it was known that shortly thereafter the patient would die.

Reference: *Airedale NHS Trust v. Bland*, [1993] A.C. 789 at 866, 868-869 (per Lord Goff of Chieveley) (Eng. H.L.), Appellants' Authorities, Tab 8.

59. The Law Lords held that a physician's duty is to treat a patient as long as it is in the patient's best interests to have the treatment. But if that ceases to be the case, because the treatment can provide no medical benefit, there is no duty on the physician to continue to provide it. Where a patient is totally unconscious and there is no prospect for improvement, life-prolonging treatment is properly regarded as being, in medical terms, useless. The

discontinuance of life-support in these circumstances is the same as the decision not to commence such treatment – in each case the doctor is simply allowing patient to die of his pre-existing condition.

60. It is clear that the application of the authoritative policies of the CPSO and other professional bodies, as addressed above, must have the same effect.

61. The purpose of critical care medicine, including life-support measures, is to support the patient long enough to allow recovery from a reversible illness. Where, as in Mr. Rasouli's case, there is no reversible illness from which he can or will recover, life-support serves no medical purpose. Moreover, he cannot experience any personal benefit from life-support measures in prolonging a life of which he is now unaware. At its highest, life-support in this case serves an emotional or credal purpose for Mr. Rasouli's family. This is not a medical benefit obliging a physician to offer or continue care.

Reference: Superior Court Decision, Record, Tab 2, pages 8-9, para. 31.

D. ONTARIO'S *HEALTH CARE CONSENT ACT* DOES NOT ALTER THE COMMON LAW APPLICABLE TO THIS CASE

62. In both decisions below, the courts rejected any application of the common law and purported to rely solely on the application of the Act.

63. However, nothing in the Act suggests that it was intended to change the common law as it relates to informed consent and the circumstances in which consent is required. The Act merely codifies the common law and provides a mechanism for determining who makes decisions on treatment for an incapable patient and how such decisions are to be made. It does

not create, in any circumstances, an obligation on physicians to administer non-indicated treatment on the request of a patient or substitute decision-maker.

64. Key provisions of the Act, such as section 10, which requires consent to "treatment", as well as the definition of "treatment" itself, demonstrate that the obligation to obtain consent is predicated upon the offer of treatment by a physician and that the Act presupposes that the proposed treatment has a therapeutic purpose. The Court of Appeal accepted this to be the correct interpretation (although its disposition incongruously ignores it).

Reference: Act, sections 2(1) and 10(1).

65. Section 10(1) of the Act provides as follows:

> 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. [Emphasis added.]

66. "Treatment" is defined in section 2(1) as:

> Anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan.

67. On its face, the definition of treatment does not appear to extend to the withdrawal or withholding of treatment. Indeed, when non-indicated treatment is withdrawn or withheld it is precisely **because** it cannot fulfil any of the purposes contained in the definition of treatment.

68. It must however be noted that included in the definition of treatment is a further defined term, "plan of treatment", which is 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. [Emphasis added.]

Reference: Act, s. 2(1).

69. It was in reliance on this definition that the applications judge concluded that the withdrawal of life-support in Mr. Rasouli's case required consent since the proposed withdrawal formed part of a plan of treatment. This was an erroneous interpretation of the Act.

70. The words "withholding or withdrawal of treatment" in the definition of plan of treatment are intended to convey that a physician may propose a plan of treatment that expressly contemplates that a certain treatment will be provided but that it will or may be withdrawn or withheld in specified circumstances, or alternatively that a certain treatment will in the first instance be withheld but may be provided in the event of a future change in condition or prognosis. For instance, a doctor might propose a trial of a certain drug with the proviso that if no results are seen within a week, the drug will be discontinued, or propose a trial of treatment without drugs with the proviso that drugs will be administered if there is a clinically significant change in condition.

71. The applications judge essentially converted the physician's **authority** to propose plans of treatment that incorporate an anticipated withholding or withdrawal of treatments into an **obligation** on the part of physicians to anticipate potentially unknowable events when developing a plan of treatment for a current condition and to incorporate all such eventualities into the plan, at peril otherwise of being required to continue the treatment despite a relevant change in circumstances.

72. In the case of Mr. Rasouli, who was intubated and placed on mechanical ventilation at a time when it was expected to sustain his life during recovery from a reversible illness (surgery for a benign brain tumour), the expectation was that he would be extubated once he had recovered from surgery and was able to breathe on his own. Instead, Mr. Rasouli suffered an unexpected post-surgical infection that transformed his underlying condition from a reversible illness to an irreversible illness which also rendered him unable to breathe on his own. It cannot have been the intention of the Act that the physicians are obliged to continue Mr. Rasouli's life-support regardless of any continuing indications merely because it was indicated under circumstances that no longer prevail and consent was not obtained in advance for its withdrawal.

73. If the Act were to have that effect, it would override a fundamental precept of medicine. Physicians regard every form of treatment as a "trial of treatment", which is to say one that is abandoned when the indications for it have ceased to exist. Only this approach can ensure that the patient's best interests are secured.

Reference: See, for example, *Shortland v. Northland Health Ltd.*, 1997 NZLR LEXIS 637 (C.A.), Appellants' Authorities, Tab 10.

E. THE REQUIREMENT FOR CONSENT TO AN ALTERNATIVE TREATMENT CANNOT CREATE AN OBLIGATION TO CONTINUE A NON-INDICATED TREATMENT

74. As has been discussed, the Court of Appeal adopted a different interpretation of the definition of "treatment" under the Act than did the applications judge. It accepted that a withholding of non-indicated treatment does not require consent. It also accepted that a withdrawal of treatment, without the institution of alternative treatment itself requiring consent, does not require consent. It held, however, that in the narrow case where a treatment is to be withdrawn and another treatment given upon the withdrawal which itself requires consent, then

consent must also be obtained to the withdrawal of the non-indicated treatment so long as death is imminent.

75. It is respectfully submitted that the rule laid down by the Court of Appeal, including its qualifications, are not grounded in the provisions of the Act.

76. The Act does not distinguish between the effect to be given to a withholding and to a withdrawal of treatment in any circumstances. Its only reference to these concepts is within the definition of "plan of treatment", as previously addressed.

77. The Act contains no concept of treatments being "integrally linked" such that the proposed substitution of one treatment for another requires consent to the withdrawal of the existing treatment.

78. It is also submitted that the Court of Appeal's approach creates incongruities and practical difficulties for its future application.

79. It leads to an incongruity where, for instance, a patient is on mechanical ventilation and is already receiving palliative care and the patient's physicians conclude that mechanical ventilation is no longer medically indicated. For it appears that in that case, following the Court of Appeal's approach, mechanical ventilation could be withdrawn without consent since there is to be no new treatment requiring consent. Similarly, if physicians do not propose to initiate palliative care upon withdrawal of mechanical ventilation, the requirement for consent would also not arise. Following the reasoning of the Court of Appeal, it is only where palliative care has not yet been instituted but will be offered when mechanical ventilation is withdrawn that the family, by withholding consent to palliative care, can require the continuation of mechanical

ventilation. The decision below wrongly allows families to compel treatment indirectly, which they do not have the right to do directly. But the right to do this will be confined to families whose loved ones are not already receiving alternative care and who qualify for it. Such a distinction is perplexing given that the result of the withdrawal of treatment is the same in each case.

80. The Court of Appeal's approach also leads to impracticalities. For whether an act on the part of a physician constitutes a withdrawal or a withholding will be challenging or impossible to determine in practice. For example, if a patient has previously been weaned from mechanical ventilation due to an improved ability to breathe spontaneously and then suffers a relapse or deterioration (for instance, because of the development of pneumonia), it is unclear whether physicians are at liberty to refuse to reinstitute mechanical ventilation.[4] It could be argued that, in those circumstances, a decision not to reinstitute treatment amounts to a withdrawal of a previously offered treatment rather than a withholding. Similarly, it has been argued in past cases that a "No-CPR" order amounts to a withdrawal of treatment because all patients are presumptively "Full Code" (required to be resuscitated) absent an order to the contrary. If this is correct, then a No-CPR order written together with an order for palliative care would appear to require consent.

Reference: *Cheah et. al. v. Sunnybrook Health Sciences Centre et. al.* (22 October 2010), Toronto 03-102/10 (Ont. S.C.J.), Endorsement of Conway, J. and Notice of Application at paras. 9, 32, Appellants' Authorities, Tab 34.

81. These practical difficulties demonstrate why a practical distinction between withholding and withdrawing treatment cannot be made easily, and thus why courts in other jurisdictions have refused to distinguish between them at law. Instead, whether a treatment will be offered or

[4] Indeed, Mr. Rasouli has previously been weaned off the ventilator for days at a time. Affidavit of Dr. Cuthbertson, Sworn February 14, 2011, Record, Vol. I, Tab 11, pages 88-89, paras. 21-23.

continued must be assessed based on a single question – the same question that applies to doctors whenever they provide care – namely, whether the standard of care requires the treatment to be offered or continued in the clinical circumstances of that case.

Reference: *Airedale NHS Trust v. Bland*, [1993] A.C. 789 at 818, 866 (per Butler-Sloss L.J., and Lord Goff Chieveley) (Eng. H.L.), Appellants' Authorities, Tab 8.

Shortland v. Northland Health Ltd., 1997 NZLR LEXIS 637 at paras. 28-31 (C.A.), Appellants' Authorities, Tab 10.

Clarke v. Hurst (1992), (4) SA 630 at 658, Appellants' Authorities, Tab 24.

F. IMMINENCE OF DEATH SHOULD NOT AFFECT WHETHER CONSENT IS REQUIRED TO WITHDRAW TREATMENT

82. The Court of Appeal appeared to place a further restriction on the circumstances where consent is required to withdraw non-indicated treatment, namely, that consent is required only where death is imminent. It did so to distinguish this case from other (non-end of life) cases where one treatment is withdrawn as no longer medically indicated at the same time as a new treatment is proposed which does require consent.

Reference: Court of Appeal Decision, Record, Vol. 1, Tab 5, pages 58-59, para. 53.

83. The Court of Appeal was driven to attach the pre-condition it did to avoid the obvious implication its decision would otherwise have, which is that treatment must, in circumstances that commonly arise, be made available on demand. It is commonly the case that when one form of treatment is withdrawn, another form of treatment is offered in its place. To require consent to the withdrawal in those circumstances, because of the obligation to secure consent to the new treatment, would be to allow patients to insist on the continuation of treatment in circumstances where it has become non-indicated and its continued administration might even breach the applicable standard of care. The Court of Appeal accepted that it would be absurd (for example)

to allow patients to insist on a continuation of chemotherapy where no longer indicated simply by refusing to consent to radiation, or surgery, or any other recommended form of treatment.

Reference: Court of Appeal Decision, Record, Vol. 1, Tab 5, pages 58-59, para. 53.

84. In reaching its conclusion, the Court of Appeal did so without any evidence that it is only in this type of case that providing palliative care "necessarily recognizes that death is imminent". This conclusion was not one that could be reached without the benefit of evidence. The court could not be certain that Mr. Rasouli is not already receiving palliative care or that, even if he is not, it is medically appropriate to provide such care only when death is imminent.

Reference: Court of Appeal Decision, Record, Vol. 1, Tab 5, pages 58-59, paras. 51-53.

85. The Court of Appeal implicitly attributed to the legislature an intention to distinguish end of life cases (of a certain sort) from all other cases engaging a right to informed consent (which, as the court accepts, require that a physician first offer treatment). This is contrary to an express purpose of the Act, which is "to provide rules that apply consistently in all settings".

Reference: Act, s. 1(a).

86. There is nothing in the Act that treats a withholding or withdrawal of treatment that would result in a patient's imminent death any differently than any other decision to withhold or withdraw medical treatment. Accordingly, a requirement to obtain consent in such circumstances could only arise from the common law. Since physicians' legal obligations can only arise from the applicable standard of care, to conclude there is a requirement to secure consent to withdrawal of treatment in the circumstances requires a finding that the standard of care requires such consent to be obtained. There was no such finding in the decisions below.

87. Finally, there is a practical objection to the Court of Appeal's approach. The requirement for death to be imminent is exceedingly difficult to apply. Is death imminent if it will occur in hours, days, weeks or months? What if it is unknown when death will occur? It is also unclear from the decision whether that assessment is to be made by a physician or the family. The "imminence of death" requirement imposed by the Court of Appeal will simply result in further uncertainty as to when consent is required to withdraw treatment and when it is not.

G. THE ROLE OF THE CONSENT AND CAPACITY BOARD IN ONTARIO

88. The Act establishes the Consent and Capacity Board (the "Board"), an administrative tribunal which has the jurisdiction, *inter alia*,

(a) To determine whether a patient is incapable to give or refuse consent to treatment; and

(b) Where a patient has been found incapable, to determine whether the patient's substitute decision-maker has given or refused consent on behalf of that incapable person in compliance with the requirements of the Act.

Reference: Act, ss. 37 and 37.1.

89. Both the applications judge and the Court of Appeal held that the Board should determine whether Mr. Rasouli's substitute decision-maker was complying with her obligations pursuant to the Act. While the appellants accept that the Board plays an important role in the administration of health care in Ontario, the appellants submit that it is not the appropriate body to determine the questions raised by the facts of this case. That is because the jurisdiction of the Board **presupposes** that a health practitioner has proposed a certain treatment requiring consent.

90. The Act provides that when a physician believes a patient is incapable, the physician may seek consent from the patient's substitute decision-maker to a treatment that the physician proposes to administer. If the patient wishes to challenge the physician's assessment that he or she is incapable, the Board has jurisdiction to determine this issue. If the Board finds the patient to be capable, the Board has no further role to play in the matter as the patient is then free to consent or refuse to consent to the proposed treatment.

Reference: Act, s. 32.

91. If the patient is found incapable, the Board also has the jurisdiction to determine on an application by a physician whether a substitute decision-maker is giving or refusing consent to proposed treatments in accordance with the patient's prior expressed wishes or, if none, the patient's best interests.

Reference: Act, ss. 37 and 21.

92. In both these cases, the Board considers who is entitled to give or refuse consent to a proposed treatment, and assuming that it is a substitute decision-maker, whether the consent is given or refused in accordance with principles that reflect the wishes and interests of the incapable person. However, until consent to treatment is required, the Board's jurisdiction is not engaged.

93. In an application by a physician under section 37 for a determination of whether a substitute decision-maker has properly given or refused consent, the Board must apply the same criteria as bind the decision of the substitute decision-maker (those stated in section 21(1) of the Act). The Board cannot substitute its own view of the patient's best interests for the previously expressed wish of the patient. Section 21(1) provides:

> 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.

Reference: Act, s. 21(1).

94. The Board does not have jurisdiction to determine what medical treatments will be offered to a patient or to determine any questions related to the standard of care applicable to physicians.

95. In the context of a positive treatment that a physician believes is appropriate to offer to an incapable patient and is willing to administer, an oversight mechanism, whether by a tribunal or a court, is wholly appropriate. Incapacity does not render irrelevant a patient's wishes. The patient's right of autonomy remains intact – treatment that the person did not or would not want to receive should not be administered. If, prior to incapacity, a patient had expressed a wish not to receive a particular treatment, none of the physician, a substitute decision-maker, the Board, or the court should be allowed to override that wish. Appropriately, the Board has no ability to require a substitute decision-maker to act contrary to that wish unless the substitution decision-maker requests it **and** the Board is satisfied that the incapable person, if capable, would probably consent. The Act does not permit a treating physician to apply to the Board to depart from the patient's prior expressed, applicable, capable wishes under any circumstances.

Reference: Act, s. 36.

96. In the result, if consent were required to the withholding or withdrawal of any treatment, and a patient has expressed a wish to have all treatment, no matter the circumstances, then,

absent an application by the substitute decision-maker **and** a finding by the Board that the patient would probably consent to the withdrawal, the physician would be obliged to provide the treatment, no matter how futile.

Reference: *Cheah et. al. v. Sunnybrook Health Sciences Centre et. al.* (22 October 2010), Toronto 03-102/10 (Ont. S.C.J.), Endorsement of Conway, J. and Notice of Application at para. 32, Appellants' Authorities, Tab 34.

S.S. (Re), 2011 CanLII 5000 (Ont. C.C.B.), Appellants' Authorities, Tab 35.

97. Even where there is a no prior expressed wish binding the substitute decision-maker and the Board, and the Board is to apply the best interests test under section 21(2) of the Act, the Board is required to consider factors that are not medical in nature and to weigh them against medical benefits and harm:

> (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.

Reference: Act, s. 21(2).

98. In the context of giving or refusing consent to a treatment a physician is willing to administer, this is wholly appropriate since the test is meant to capture the analysis a patient would undertake in determining whether to give or refuse consent to a particular treatment. Where, however, the patient is permanently unconscious and unable to currently appreciate the harm or benefit of treatment and will never recover to experience any long term benefit, the "best interests" test is exceedingly difficult to apply because of the requirement to weigh the patient's wishes together with other considerations.

Reference: *S.S. (Re)*, 2011 CanLII 5000 (Ont. C.C.B.), Appellants' Authorities, Tab 35.

99. In any event, as has been submitted, it was never intended that the "best interests" test should be applied in circumstances where a health care practitioner is not proposing treatment.

100. The composition of the Board reflects the nature of the cases it properly has jurisdiction to decide. The current members of the Board are, almost without exception, lawyers, psychiatrists and lay members. There is currently one health practitioner from a field of medicine other than psychiatry. Contrary to the assertion by the applications judge, the Board lacks the expertise, as it lacks the mandate, to determine what types of medical treatments are indicated for a patient with complex disease processes, whether in the context of critical care medicine or otherwise.

101. Moreover, despite the assertions that the Board provides an expeditious mechanism to resolve these disputes, frequently in end of life cases where the Board has directed the substitute decision-maker to consent to a withdrawal or withholding of treatment, an appeal has followed to

the Superior Court of Justice, resulting in an automatic stay of the Board's decision pending its determination. In the result, these cases routinely take months to resolve.

Reference: *Scardoni v. Hawryluck*, 2004 CanLII 34326 (Ont. S.C.J.), Appellants' Authorities, Tab 36.

Barbulov v. Cirone, [2009] O.J. No. 1439 (Ont. S.C.J.) (QL), Appellants' Authorities, Tab 37.

Estrela v. Demajo, (9 July 2009), Toronto 03-36/09 (Ont. S.C.J.) Appellants' Authorities, Tab 38.

AK (Re), 2011 CanLII 82907 (Ont. C.C.B), Appellants' Authorities, Tab 39.

Grover (Re), 2009 CanLII 16577 (Ont. S.C.), Appellants' Authorities, Tab 40.

Statutory Powers and Procedures Act, R.S.O. 1990, c. S. 22, s. 25.

102. Moreover, even when the Board orders the substitute decision-maker to consent, if that person then refuses to comply with the order, the physician is obliged to attempt to secure consent from alternative substitute decision-makers. That is so because the Board does not itself given consent but instead requires a substitute decision-maker to do so. Eventually, once the physician has exhausted the possibility of obtaining any family member's consent, the Public Guardian and Trustee is required to consent.

Reference: Act, ss. 37(4), (5), (6), (6.1), (6.2), (6.3) and (7).

Barbulov v. Cirone, (20 April, 2009), Toronto, 03-012/09 (Ont. S.C.J.), Appellants' Authorities, *supra* Tab 41.

103. Accordingly, any assertion that the Consent and Capacity Board provides an efficient mechanism to resolve these disputes is illusory.

H. THE APPROPRIATE PROCESS TO BE FOLLOWED WHEN NON-INDICATED TREATMENT IS TO BE WITHDRAWN

104. Despite the fact that physicians have no legal obligation to continue non-indicated treatment, a physician who has concluded that a treatment is no longer indicated should not

proceed to withdraw that care, if it is prolonging life, without following certain steps first. The process is described in the Sunnybrook Hospital policy, which was closely adhered to by the appellants in this case.

Reference: Sunnybrook Health Sciences Centre Policy, "Decisions about Life Support Interventions", (April 1, 2009), Appellants' Authorities, Tab 42.

See also: Policy Statement No. 1602 of the College of Physicians and Surgeons of Manitoba, "Withholding and Withdrawing Life-sustaining Treatment" (September, 2007), Appellants' Authorities, Tab 27.

General Medical Council (United Kingdom), "Treatment and care towards the end of life: good practice in decision making", (2010) at paras. 16, 23, Appellants' Authorities, Tab 30.

105. First, the physician should communicate to the patient or the patient's substitute decision-maker that a current treatment has been determined to be no longer medically indicated and the reasons for that conclusion. If the patient or substitute decision-maker accepts that conclusion, the physician may proceed to withdraw the care without further steps.

Reference: Act, s. 29(3).

106. If the patient or substitute decision-maker has concerns or questions the conclusion, the physician should offer to obtain a second opinion from another suitably qualified physician who has not previously been involved in the patient's care. If that opinion should differ from the treating physician's own conclusion, this will not create an obligation on the physician to treat, but the physician who holds the different opinion may be willing to assume care.

Reference: *AVS v. A NHS Foundation Trust & Anor*, 2011 WL 2748112 at paras. 37-38 (Eng. C.A.), Appellants' Authorities, Tab 14.

107. If the patient or substitute decision-maker wishes to arrange a second medical opinion, either in addition to or instead of the second opinion obtained by the physician, the physician

should accommodate that request, including allowing that person access to the patient's medical records and allowing that medical professional to assess the patient in person.

108. Finally, in the event the steps outlined above do not result in a resolution and there is disagreement about what the standard of care requires in the circumstances, either the patient, the substitute decision-maker, or the physician should be able to seek an immediate determination from the court as to whether the standard of care requires the physician to continue the disputed medical treatment. The court should undertake a summary trial of the issue on an expedited basis since the effect of granting an interim injunction is inevitably to decide the underlying issue (namely, whether the patient is to have the treatment in question).

Reference: *Sweiss v. Alberta Health Services*, 2009 ABQB 691 at paras. 51, 69 (QL), Appellants' Authorities, Tab 43.

Re I.H.V. Estate, 2008 ABQB 250 at paras. 31, 33 (QL), Appellants' Authorities, Tab 23.

109. For the reasons set out above, the Board has neither the jurisdiction nor the expertise to conduct a hearing into the applicable standard of care. Courts, on the other hand, regularly consider and assess, albeit retrospectively, whether a physician has met the applicable standard of care based on an assessment of expert evidence. In cases like this case, the court will be asked to assess, in advance, whether a proposed course of conduct by the physician meets the standard of care. This is an appropriate role for the courts to play.

110. In this case, neither of the courts below considered whether the treatment would offer any medical benefit to Mr. Rasouli given his neurological condition nor whether the standard of care requires life-sustaining treatments to be continued for Mr. Rasouli. As these are questions of fact or mixed fact and law, these matters will need to be remitted back to the Superior Court of Justice for consideration on the facts of this case.

PART IV—COSTS

111. The appellants do not seek costs of this appeal.

PART V—ORDER SOUGHT

112. The appellants seek an order:

(a) Declaring that consent is not required to withhold or withdraw any treatment that the treating physician has concluded does not provide, or no longer provides, any medical benefit to a patient;

(b) Declaring that consent is not required by a physician to withhold or withdraw any treatment unless it is demonstrated that the standard of care requires the physician to offer the treatment to patient; and

(c) Remitting to the Superior Court of Justice for determination the question of whether the medical treatment in issue in this case offers any medical benefit to Mr. Rasouli and/or whether the standard of care requires the appellants to continue to provide life-support to Mr. Rasouli.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

Dated at Toronto, this 8th day of February, 2012.

H. Underwood

Harry Underwood
Erica J. Baron
Andrew McCutcheon

Counsel for the Appellants

PART VI—TABLE OF AUTHORITIES

Authority	**Paragraphs Where Cited**
Airedale NHS Trust v. Bland, [1993] A.C. 789 (per Butler-Sloss L.J., Lord Keith of Kinkel, Lord Goff of Chieveley, and Lord Browne-Wilkinson) (Eng. H.L.).	42, 45, 47, 58, 81
AK (Re), 2011 CanLII 82907 (Ont. C.C.B).	101
Application of Justice Health; re a Patient, 2011 WL 6288115 (N.S.W.S.C.).	45
Auckland Area Health Board v. Attorney General, 1992 NZLR LEXIS 730 (H.C.).	45, 48
AVS v. A NHS Foundation Trust & Anor, 2011 WL 2748112 (Eng. C.A.).	45, 48, 106
Barbulov v. Cirone, (20 April, 2009), Toronto, 03-012/09 (Ont. S.C.J.).	102
Barbulov v. Cirone, [2009] O.J. No. 1439 (Ont. S.C.J.) (QL).	101
Canadian Medical Association, "History, Mission, Vision and Values", online: The Canadian Medical Association <http://www.cma.ca/aboutcma/history-mission-vision-values>.	51
Cheah et. al. v. Sunnybrook Health Sciences Centre et. al. (22 October 2010), Toronto 03-102/10 (Ont. S.C.J.), Endorsement of Conway, J. and Notice of Application.	80, 96
Child and Family Services of Central Manitoba v. L.(R.), [1997] M.J. No. 563 (C.A.).	48
Children's Aid Society of Ottawa-Carleton v. M.C., [2008] O.J. No. 3795 (S.C.J.) (QL).	45, 48
Clarke v. Hurst (1992), (4) SA 630.	48, 81
Ellen Picard and Gerald Robinson, *Legal Liability of Doctors and Hospitals in Canada* (4th ed.), (Toronto, ON: Thomson Carswell, 2007).	42, 48
Estrela v. Demajo, (9 July 2009), Toronto 03-36/09 (Ont. S.C.J.).	101
Fleming v. Reid, 1991 CarswellOnt 1501 (C.A.).	40
Frenchay Healthcare National Health Service Trust v. S., [1994] 1 W.L.R. 601 (per Sir Thomas Bingham, M.R.) (Eng. C.A.).	45
General Medical Council (United Kingdom), "Treatment and care towards the end of life: good practice in decision making", (2010).	52, 104

Authority	**Paragraphs Where Cited**
Grover (Re), 2009 CanLII 16577 (Ont. S.C.).	101
Health Professions Council of South Africa Guidelines for the Withholding and Withdrawing of Treatment (May 29, 2007).	52
Hopp v. Lepp, [1980] 2 S.C.R. 192.	38
Joint Statement of Resuscitative Interventions of the Canadian Medical Association (1995).	51
Office of the Public Advocate (Australia), "Not for Resuscitation (NFR)", (March 2004).	52
Policy Statement #1-06 of the College of Physicians and Surgeons of Ontario, "Decision-making for the End of Life" (July, 2006).	49
Policy Statement No. 1602 of the College of Physicians and Surgeons of Manitoba, "Withholding and Withdrawing Life-sustaining Treatment" (September, 2007).	49, 104
R. on the application of Burke v. The General Medical Council, 2005 WL 1860209 (Eng. C.A.).	42, 43, 45, 102
Re G., [1995] 2 FCR 46 (Fam. Div. Eng. H.C.J.) (Lexis).	45
Re I.H.V. Estate, 2008 ABQB 250 (QL).	48, 108
Re J (a minor), [1992] 4 All E.R. 614 (Eng. C.A.).	45, 48
Re L.I.C., 2006 ABQB 130 (QL).	48
Re R, [1991] 3 W.L.R. 592 (per Lord Donaldson, M.R.) (Eng. C.A.).	41
Reibl v. Hughes, [1980] 2 S.C.R. 880.	38, 39
Rotaru v. Vancouver General Hospital Intensive Care Unit, [2008] B.C.J. No. 456 (S.C.).	48
S.S. (Re), 2011 CanLII 5000 (Ont. C.C.B.).	96, 98
Scardoni v. Hawryluck, 2004 CanLII 34326 (Ont. S.C.J.).	101
Shortland v. Northland Health Ltd, 1997 NZLR LEXIS 637 (C.A.).	46, 73, 81
Slater v. Baker (1767), 2 Wils. K.B. 359, cited with approval in *Parmley v. Parmley*, [1945] S.C.R. 635.	37
Sunnybrook Health Sciences Centre Policy, "Decisions about Life Support	104

Authority	**Paragraphs Where Cited**
Interventions, (April 1, 2009).	
Sweiss v. Alberta Health Services, 2009 ABQB 691 (QL).	108
Ter Neuzen v. Korn, [1995] 3 S.C.R. 674.	47
Thaddeus Mason Pope, "Involuntary Passive Euthanasia in U.S. Courts: Reassessing the Judicial Treatment of Medical Futility Cases", (2008) 9 Marquette Elder's Advisor 229.	48
The Royal Australasian College of Physicians, "Decision-Making at the End of Life in Infants, Children and Adolescents", (2008).	52
Videto v. Kennedy, 1981 CarswellOnt 580 (C.A.).	38
Wilson v. Swanson, [1956] S.C.R. 804.	47

PART VII—STATUTES

Current to January 28, 2012

S.O. 1996, c. 2, Schedule A, s. 1

[eff since March 29, 1996](Current Version)

Health Care Consent Act, 1996

S.O. 1996, c. 2, Schedule A

Amended by: S.O. 1998, c. 26, s. 104; S.O. 2000, c. 9, ss. 31-48; S.O. 2002, c. 18, Sched. A, s. 10; S.O. 2004, c. 3, Sched. A, s. 84; S.O. 2006, c. 19, Sched. L, s. 2; S.O. 2006, c. 34, s. 34; S.O. 2006, c. 21, Sched. C, s. 111; S.O. 2006, c. 26, s. 14; S.O. 2006, c. 35, Sched. C, s. 52; S.O. 2009, c. 26, s. 10 (1), (3); S.O. 2009, c. 33, Sched. 18, s. 10; S.O. 2010, c. 1, Sched. 9, s. 1; S.O. 2007, c. 8, s. 207 (1), (9), (10), (15)-(17).

PART I GENERAL

SECTION 1

Purposes

1. The purposes of this Act are,

(a) to provide rules with respect to consent to treatment that apply consistently in all settings;

(b) to facilitate treatment, admission to care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters;

(c) to enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed and persons who are to receive personal assistance services by,

(i) allowing those who have been found to be incapable to apply to a tribunal for a review of the finding,

(ii) allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on

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

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

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

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

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

S.O. 1996, c. 2, Sched. A, s. 1, in force March 29, 1996 (O. Gaz. 1996 p. 729).

Current to January 28, 2012

S.O. 1996, c. 2, Schedule A, s. 2

[eff since July 1, 2010](Current Version)

Health Care Consent Act, 1996

S.O. 1996, c. 2, Schedule A

PART I
GENERAL

SECTION 2

Definitions

2. (1) In this Act,

"attorney for personal care" means an attorney under a power of attorney for personal care given under the Substitute Decisions Act, 1992; ("procureur au soin de la personne")

"Board" means the Consent and Capacity Board; ("Commission")

"capable" means mentally capable, and "capacity" has a corresponding meaning; ("capable", "capacité")

"care facility" means,

(a) a long-term care home as defined in the Long-Term Care Homes Act, 2007, or

(b) a facility prescribed by the regulations as a care facility; ("établissement de soins")

"community treatment plan" has the same meaning as in the Mental Health Act; ("plan de traitement en milieu communautaire")

"course of treatment" means a series or sequence of similar treatments administered to a person over a period of time for a particular health problem; ("série de traitements")

"evaluator" means, in the circumstances prescribed by the regulations,

(a) a member of the College of Audiologists and Speech-Language Pathologists of Ontario,

(b) a member of the College of Dietitians of Ontario,

(c) a member of the College of Nurses of Ontario,

(d) a member of the College of Occupational Therapists of Ontario,

(e) a member of the College of Physicians and Surgeons of Ontario,

(f) a member of the College of Physiotherapists of Ontario,

(g) a member of the College of Psychologists of Ontario, or

(h) a member of a category of persons prescribed by the regulations as evaluators; ("appréciateur")

"guardian of the person" means a guardian of the person appointed under the Substitute Decisions Act, 1992; ("tuteur à la personne")

"health practitioner" means a member of a College under the Regulated Health Professions Act, 1991, a naturopath registered as a drugless therapist under the Drugless Practitioners Act or a member of a category of persons prescribed by the regulations as health practitioners; ("praticien de la santé")

"hospital" means a private hospital as defined in the Private Hospitals Act or a hospital as defined in the Public Hospitals Act; ("hôpital")

"incapable" means mentally incapable, and "incapacity" has a corresponding meaning; ("incapable", "incapacité")

"mental disorder" has the same meaning as in the Mental Health Act; ("trouble mental")

"personal assistance service" means assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning or any other routine activity of living, and includes a group of personal assistance services or a plan setting out personal assistance services to be provided to a person, but does not include anything prescribed by the regulations as not constituting a personal assistance service; ("service d'aide personnelle")

"plan of treatment" means a plan that,

(a) is developed by one or more health practitioners,

(b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and

(c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition; ("plan de traitement")

"psychiatric facility" has the same meaning as the Mental Health Act; ("établissement psychiatrique")

"recipient" means a person who is to be provided with one or more personal assistance services,

(a) in a long-term care home as defined in the Long-Term Care Homes Act, 2007,

(b) in a place prescribed by the regulations in the circumstances prescribed by the regulations,

(c) under a program prescribed by the regulations in the circumstances prescribed by the regulations, or

(d) by a provider prescribed by the regulations in the circumstances prescribed by the regulations; ("bénéficiaire")

"regulations" means the regulations made under this Act; ("règlements")

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

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

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

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

(d) the communication of an assessment or diagnosis,

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

(f) a personal assistance service,

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

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

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

S.O. 1996, c. 2, Sched. A, s. 2, in force March 29, 1996 (O. Gaz. 1996 p. 729); S.O. 2000, c. 9, s. 31; S.O. 2009, c. 26, s. 10 (1); S.O. 2009, c. 33, Sched. 18, s. 10 (1); S.O. 2007, c. 8, s. 207 (1).

Current to January 28, 2012

S.O. 1996, c. 2, Schedule A, s. 10

[eff since March 29, 1996](Current Version)

Health Care Consent Act, 1996

S.O. 1996, c. 2, Schedule A

PART II
TREATMENT

CONSENT TO TREATMENT

SECTION 10

No treatment without consent

10. (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

(a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or

(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act.

Opinion of Board or court governs

(2) If the health practitioner is of the opinion that the person is incapable with respect to treatment, but the person is found to be capable with respect to the treatment by the Board on an application for review of the health practitioner's finding, or by a court on an appeal of the Board's decision, the health practitioner shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless the person has given consent.

S.O. 1996, c. 2, Sched. A, s. 10, in force March 29, 1996 (O. Gaz. 1996 p. 729).

Current to January 28, 2012

S.O. 1996, c. 2, Schedule A, s. 11

[eff since March 29, 1996](Current Version)

Health Care Consent Act, 1996

S.O. 1996, c. 2, Schedule A

PART II
TREATMENT

CONSENT TO TREATMENT

SECTION 11

Elements of consent

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

1. The consent must relate to the treatment.

2. The consent must be informed.

3. The consent must be given voluntarily.

4. The consent must not be obtained through misrepresentation or fraud.

Informed consent

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

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

(b) the person received responses to his or her requests for additional information about those matters.

Same

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

1. The nature of the treatment.
2. The expected benefits of the treatment.
3. The material risks of the treatment.
4. The material side effects of the treatment.
5. Alternative courses of action.
6. The likely consequences of not having the treatment.

Express or implied

(4) Consent to treatment may be express or implied.

S.O. 1996, c. 2, Sched. A, s. 11, in force March 29, 1996 (O. Gaz. 1996 p. 729).

Current to January 28, 2012

S.O. 1996, c. 2, Schedule A, s. 21

[eff since March 29, 1996](Current Version)

Health Care Consent Act, 1996

S.O. 1996, c. 2, Schedule A

PART II
TREATMENT

CONSENT ON INCAPABLE PERSON'S BEHALF

SECTION 21

Principles for giving or refusing consent

21. (1) A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles:

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.

2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.

Best interests

(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;

(b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and

(c) the following factors:

1. Whether the treatment is likely to,

i. improve the incapable person's condition or well-being,

ii. prevent the incapable person's condition or well-being from deteriorating, or

iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.

2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.

3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.

4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

S.O. 1996, c. 2, Sched. A, s. 21, in force March 29, 1996 (O. Gaz. 1996 p. 729).

Current to January 28, 2012

S.O. 1996, c. 2, Schedule A, s. 29

[eff since March 29, 1996](Current Version)

Health Care Consent Act, 1996

S.O. 1996, c. 2, Schedule A

PART II
TREATMENT

PROTECTION FROM LIABILITY

SECTION 29

Apparently valid consent to treatment

29. (1) If a treatment is administered to a person with a consent that a health practitioner believes, on reasonable grounds and in good to be sufficient for the purpose of this Act, the health practitioner is not liable for administering the treatment without consent.

Apparently valid refusal of treatment

(2) If a treatment is not administered to a person because of a refusal that a health practitioner believes, on reasonable grounds and in good faith, to be sufficient for the purpose of this Act, the health practitioner is not liable for failing to administer the treatment.

Apparently valid consent to withholding or withdrawal

(3) If a treatment is withheld or withdrawn in accordance with a plan of treatment and with a consent to the plan of treatment that a health practitioner believes, on reasonable grounds and in good faith, to be sufficient for the purpose of this Act, the health practitioner is not liable for withholding or withdrawing the treatment.

Emergency: treatment administered

(4) A health practitioner who, in good faith, administers a treatment to a person under section 25 or 27 is not liable for administering the treatment without consent.

Emergency: treatment not administered

(5) A health practitioner who, in good faith, refrains from administering a treatment in accordance with section 26 is not liable for failing to administer the treatment.

Reliance on assertion

(6) If a person who gives or refuses consent to a treatment on an incapable person's behalf asserts that he or she,

(a) is a person described in subsection 20(1) or clause 24(2)(a) or (b) or an attorney for personal care described in clause 32(2)(b);

(b) meets the requirement of clause 20(2)(b) or(c); or

(c) holds the opinions required under subsection 20(4),

a health practitioner is entitled to rely on the accuracy of the assertion, unless it is not reasonable to do so in the circumstances.

S.O. 1996, c. 2, Sched. A, s. 29, in force March 29, 1996 (O. Gaz. 1996 p. 729).

Current to January 28, 2012

S.O. 1996, c. 2, Schedule A, s. 32

[eff since December 1, 2000](Current Version)

Health Care Consent Act, 1996

S.O. 1996, c. 2, Schedule A

PART II
TREATMENT

APPLICATIONS TO BOARD

SECTION 32

Application for review of finding of incapacity

32. (1) A person who is the subject of a treatment may apply to the Board for a review of a health practitioner's finding that he or she is incapable with respect to the treatment.

Exception

(2) Subsection (1) does not apply to,

(a) a person who has a guardian of the person, if the guardian has authority to give or refuse consent to the treatment;

(b) a person who has an attorney for personal care, if the power of attorney contains a provision waiving the person's right to apply for the review and the provision is effective under subsection 50(1) of the Substitute Decisions Act, 1992.

Parties

(3) The parties to the application are:

1. The person applying for the review.

2. The health practitioner.

3. Any other person whom the Board specifies.

Powers of Board

(4) The Board may confirm the health practitioner's finding or may determine that the person is capable with respect to the treatment, and in doing so may substitute its opinion for that of the health practitioner.

Restriction on repeated applications

(5) If a health practitioner's finding that a person is incapable with respect to a treatment is confirmed on the final disposition of an application under this section, the person shall not make a new application for a review of a finding of incapacity with respect to the same or similar treatment within six months after the final disposition of the earlier application, unless the Board gives leave in advance.

Same

(6) The Board may give leave for the new application to be made if it is satisfied that there has been a material change in circumstances that justifies reconsideration of the person's capacity.

S.O. 1996, c. 2, Sched. A, s. 32(1-6), in force March 29, 1996 (O. Gaz. 1996 p. 729).

Decision effective while application for leave pending

(7) The Board's decision under subsection (5) remains in effect pending an application for leave under subsection (6).

S.O. 1996, c. 2, Sched. A, s. 32; S.O. 2000, c. 9, s. 32.

Current to January 28, 2012

S.O. 1996, c. 2, Schedule A, s. 36

[eff since December 1, 2000](Current Version)

Health Care Consent Act, 1996

S.O. 1996, c. 2, Schedule A

PART II
TREATMENT

APPLICATIONS TO BOARD

SECTION 36

Application to depart from wishes

36. (1) If a substitute decision-maker is required by paragraph 1 of subsection 21 (1) to refuse consent to a treatment because of a wish expressed by the incapable person while capable and after attaining 16 years of age,

(a) the substitute decision-maker may apply to the Board for permission to consent to the treatment despite the wish; or

(b) the health practitioner who proposed the treatment may apply to the Board to obtain permission for the substitute decision-maker to consent to the treatment despite the wish.

Notice to substitute decision-maker

(1.1) A health practitioner who intends to apply under clause (1) (b) shall inform the substitute decision-maker of his or her intention before doing so.

Parties

(2) The parties to the application are:

1. The substitute decision-maker.

2. The incapable person.

3. The health practitioner who proposed the treatment.

4. Any other person whom the Board specifies.

Criteria for permission

(3) The Board may give the substitute decision-maker permission to consent to the treatment despite the wish if it is satisfied that the incapable person, if capable, would probably give consent because the likely result of the treatment is significantly better than would have been anticipated in comparable circumstances at the time the wish was expressed.

S.O. 1996, c. 2, Sched. A, s. 36(2, 3), in force March 29, 1996 (O. Gaz. 1996 p. 729).

S.O. 1996, c. 2, Sched. A, s. 36; S.O. 2000, c. 9, s. 34.

Current to January 28, 2012

S.O. 1996, c. 2, Schedule A, s. 37

[eff since December 1, 2000](Current Version)

Health Care Consent Act, 1996

S.O. 1996, c. 2, Schedule A

PART II
TREATMENT

APPLICATIONS TO BOARD

SECTION 37

Application to determine compliance with s. 21

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

Parties

(2) The parties to the application are:

1. The health practitioner who proposed the treatment.

2. The incapable person.

3. The substitute decision-maker.

4. Any other person whom the Board specifies.

Power of Board

(3) In determining whether the substitute decision- maker complied with section 21, the Board may substitute its opinion for that of the substitute decision-maker.

Directions

(4) If the Board determines that the substitute decision-maker did not comply with section 21, it may give him or her directions and, in doing so, shall apply section 21.

Time for compliance

(5) The Board shall specify the time within which its directions must be complied with.

Deemed not authorized

(6) If the substitute decision-maker does not comply with the Board's directions within the time specified by the Board, he or she shall be deemed not to meet the requirements of subsection 20(2).

S.O. 1996, c. 2, Sched. A, s. 37(1-6), in force March 29, 1996 (O. Gaz. 1996 p. 729).

Subsequent substitute decision-maker

(6.1) If, under subsection (6), the substitute decision- maker is deemed not to meet the requirements of subsection 20(2), any subsequent substitute decision-maker shall, subject to subsections (6.2) and (6.3), comply with the directions given by the Board on the application within the time specified by the Board.

Application for directions

(6.2) If a subsequent substitute decision-maker knows of a wish expressed by the incapable person with respect to the treatment, the substitute decision-maker may, with leave of the Board, apply to the Board for directions under section 35.

Inconsistent directions

(6.3) Directions given by the Board under section 35 on a subsequent substitute decision-maker's application brought with leave under subsection (6.2) prevail over inconsistent directions given under subsection (4) to the extent of the inconsistency.

P.G.T.

(7) If the substitute decision-maker who is given directions is the Public Guardian and Trustee, he or she is required to comply with the directions, and subsection (6) does not apply to him or her.

S.O. 1996, c. 2, Sched. A, s. 37(7), in force March 29, 1996 (O. Gaz. 1996 p. 729).

S.O. 1996, c. 2, Sched. A, s. 37; S.O. 2000, c. 9, s. 35.

Current to January 28, 2012

S.O. 1996, c. 2, Schedule A, s. 37.1

[eff since December 1, 2000](Current Version)

Health Care Consent Act, 1996

S.O. 1996, c. 2, Schedule A

PART II
TREATMENT

APPLICATIONS TO BOARD

SECTION 37.1

Deemed application concerning capacity

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

S.O. 2000, c. 9, s. 36.

Current to January 10, 2012

R.S.B.C. 1996, c. 181, s. 5

[eff since February 28, 2000](Current Version)

HEALTH CARE (CONSENT) AND CARE FACILITY (ADMISSION) ACT

RSBC 1996, CHAPTER 181

Part 2 -- Consent to Health Care

SECTION 5

General rule -- consent needed

5 (1) A health care provider must not provide any health care to an adult without the adult's consent except under sections 11 to 15.

(2) A health care provider must not seek a decision about whether to give or refuse substitute consent to health care under section 11, 14 or 15 unless he or she has made every reasonable effort to obtain a decision from the adult.

RSBC 1996 (Supp) -181-5 [SBC 1993-48-5], effective February 28, 2000 (B.C. Reg. 200/99).

Current to January 10, 2012

R.S.B.C. 1996, c. 181, s. 4

[eff since February 28, 2000](Current Version)

HEALTH CARE (CONSENT) AND CARE FACILITY (ADMISSION) ACT

RSBC 1996, CHAPTER 181

Part 2 -- Consent to Health Care

SECTION 4

Consent rights

4 Every adult who is capable of giving or refusing consent to health care has

(a) the right to give consent or to refuse consent on any grounds, including moral or religious grounds, even if the refusal will result in death,

(b) the right to select a particular form of available health care on any grounds, including moral or religious grounds,

(c) the right to revoke consent,

(d) the right to expect that a decision to give, refuse or revoke consent will be respected, and

(e) the right to be involved to the greatest degree possible in all case planning and decision making.

RSBC 1996 (Supp) -181-4 [SBC 1993-48-4], effective February 28, 2000 (B.C. Reg. 200/99).

Current to January 15, 2012

S.Y. 2003, c. 21, Schedule B, s. 3

CARE CONSENT ACT

S.Y. 2003, c. 21, Schedule B

PART 1
CONSENT TO CARE - GENERAL RULES

Division 1 - General

SECTION 3

Consent Rights

3 Every person who is capable of giving or refusing consent to care has

(a) the right to give consent or to refuse consent on any grounds, including moral or religious grounds, even if the refusal will result in death;

(b) the right to select a particular form of available care on any grounds, including moral or religious grounds; and

(c) the right to revoke consent.

S.Y. 2003, c. 21, Sched. B, s. 3, effective May 2, 2005 (Act, s. 2).

Current to January 15, 2012

S.Y. 2003, c. 21, Schedule B, s. 4

CARE CONSENT ACT

S.Y. 2003, c. 21, Schedule B

PART 1
CONSENT TO CARE - GENERAL RULES

Division 1 - General

SECTION 4

General rule - consent needed

4 A care provider must not provide care to a person without the person's consent or substitute consent except under section 21, 22, or 23.

S.Y. 2003, c. 21, Sched. B, s. 4, effective May 2, 2005 (Act, s. 2).

Current to November 1, 2011

S.Q. 1991, c. 64, s. 10

Civil Code of Québec

S.Q. 1991, c. 64

BOOK ONE
PERSONS

CHAPTER I
INTEGRITY OF THE PERSON

TITLE TWO CERTAIN PERSONALITY RIGHTS

SECTION 10.

10. Every person is inviolable and is entitled to the integrity of his person.

Except in cases provided for by law, no one may interfere with his person without his free and enlightened consent.

1991, c. 64, a. 10.

Current to November 1, 2011

S.Q. 1991, c. 64, s. 11

Civil Code of Québec

S.Q. 1991, c. 64

BOOK ONE
PERSONS

TITLE TWO
CERTAIN PERSONALITY RIGHTS

CHAPTER I INTEGRITY OF THE PERSON

DIVISION I
CARE

SECTION 11.

11. No person may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent.

If the person concerned is incapable of giving or refusing his consent to care, a person authorized by law or by mandate given in anticipation of his incapacity may do so in his place.

1991, c. 64, a. 11.

À jour jusqu'au 1er novembre 2011

L.Q. 1991, ch. 64, art. 10

Code civil du Québec

L.Q. 1991, c. 64

LIVRE PREMIER
DES PERSONNES

CHAPITRE PREMIER
DE L'INTÉGRITÉ DE LA PERSONNE

TITRE DEUXIÈME DE CERTAINS DROITS DE LA PERSONNALITÉ

ARTICLE 10.

10. Toute personne est inviolable et a droit à son intégrité.

Sauf dans les cas prévus par la loi, nul ne peut lui porter atteinte sans son consentement libre et éclairé.

1991, c. 64, a. 10.

À jour jusqu'au 1er novembre 2011

L.Q. 1991, ch. 64, art. 11

Code civil du Québec

L.Q. 1991, c. 64

LIVRE PREMIER
DES PERSONNES

TITRE DEUXIÈME
DE CERTAINS DROITS DE LA PERSONNALITÉ

SECTION I
DES SOINS

CHAPITRE PREMIER DE L'INTÉGRITÉ DE LA PERSONNE

ARTICLE 11.

11. Nul ne peut être soumis sans son consentement à des soins, quelle qu'en soit la nature, qu'il s'agisse d'examens, de prélèvements, de traitements ou de toute autre intervention.

Si l'intéressé est inapte à donner ou à refuser son consentement à des soins, une personne autorisée par la loi ou par un mandat donné en prévision de son inaptitude peut le remplacer.

1991, c. 64, a. 11.

Current to January 28, 2012

R.S.P.E.I. 1988, c. C-17.2, s. 4

CONSENT TO TREATMENT AND HEALTH CARE DIRECTIVES ACT

R.S.P.E.I. 1988, c. C-17.2

PART II CONSENT TO TREATMENT

SECTION 4

Consent rights

4. Every patient who is capable of giving or refusing consent to treatment has the right

(a) to give consent or to refuse consent on any grounds, including moral or religious grounds, even if the refusal will result in death;

(b) to select a particular form of treatment from among those proposed by a health practitioner on any grounds, including moral or religious grounds;

(c) to be assisted by an associate; and

(d) to be involved to the greatest degree practicable in case planning and decision making.

1996, c.10, s.4.

Current to January 28, 2012

R.S.P.E.I. 1988, c. C-17.2, s. 5

CONSENT TO TREATMENT AND HEALTH CARE DIRECTIVES ACT

R.S.P.E.I. 1988, c. C-17.2

PART II
CONSENT TO TREATMENT

SECTION 5

No treatment without consent

5. A health practitioner shall not administer a treatment and shall take reasonable steps to ensure that it is not administered unless he or she is of the opinion that

(a) the patient, while capable with respect to the treatment, has given consent; or

(b) the patient is incapable with respect to the treatment, and another person has given consent in accordance with this Act.

1996, c.10, s.5.

Current to January 28, 2012

S.O. 1991, c. 18, s. 3

[eff since December 31, 1993](Current Version)

Regulated Health Professions Act, 1991

S.O. 1991, c. 18

SECTION 3

Duty of Minister

3. It is the duty of the Minister to ensure that the health professions are regulated and co-ordinated in the public interest, that appropriate standards of practice are developed and maintained and that individuals have access to services provided by the health professions of their choice and that they are treated with sensitivity and respect in their dealings with health professionals, the Colleges and the Board.

S.O. 1991, c. 18, s. 3.

Current to January 28, 2012

R.S.O. 1990, c. S.22, s. 25

[eff since November 28, 1997](Current Version)

Statutory Powers Procedure Act

R.S.O. 1990, c. S.22

SECTION 25

Appeal operates as stay, exception

25. (1) An appeal from a decision of a tribunal to a court or other appellate body operates as a stay in the matter unless,

(a) another Act or a regulation that applies to the proceeding expressly provides to the contrary; or

(b) the tribunal or the court or other appellate body orders otherwise.

Idem

(2) An application for judicial review under the Judicial Review Procedure Act, or the bringing of proceedings specified in subsection 2 (1) of that Act is not an appeal within the meaning of subsection (1).

R.S.O. 1990, c. S.22, s. 25(2).

R.S.O. 1990, c. S.22, s. 25; S.O. 1997, c. 23, s. 13.

S.C.C. No. 34362

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

B E T W E E N :

DR. BRIAN CUTHBERTSON and DR. GORDON RUBENFELD

Appellants

- and -

HASSAN RASOULI BY HIS LITIGATION GUARDIAN AND SUBSTITUTE DECISION MAKER, PARICHEHR SALASEL

Respondents

- and -

THE CONSENT AND CAPACITY BOARD

Intervener)

FACTUM OF THE APPELLANTS,
Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld

McCarthy Tétrault LLP
Suite 5300
Toronto Dominion Bank Tower
Toronto ON M5K 1E6

Harry Underwood
Erica J. Baron
Andrew McCutcheon
Tel: (416) 601-7911 Fax: (416) 868-0673
Counsel for the Appellants,
Dr. Brian Cuthbertson and Dr. Gordon Rubenfeld

****

Cavanagh Williams Conway Baxter LLP
Barristers and Solicitors
401 – 111 Prince of Wales Drive
Ottawa, ON K2C 3T2

Colin S. Baxter
Tel: (613) 780-2012
Fax: (613) 569-8668
Email: cbaxter@cwcb-law.com

Agent for the Appellants
#11108071