S.C.C. File 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

Respondent

- and -

THE CONSENT AND CAPACITY BOARD

Intervener

FACTUM OF THE RESPONDENT

HASSAN RASOULI, by his Litigation Guardian and substitute decision maker, PARICHEHR SALASEL

(Rules 36 and 42 of the *Rules of the Supreme Court of Canada*)

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PART I – OVERVIEW

1. On December 22, 2011, the appellant physicians ("the Appellants") were granted leave to appeal to this Court from the decision of the Court of Appeal for Ontario ("the Court of Appeal") dated June 29, 2011.

2. The Court of Appeal held that the Appellants' proposal to withdraw the respondent, Hassan Rasouli ("the Respondent"), from life support and provide end-of-life palliative care constitutes "treatment" under the *Health Care Consent Act, 1996*[1] ("the Act"). Therefore, the proposal requires the consent of the Respondent's substitute decision-maker ("SDM") and litigation guardian, Parichehr Salasel ("Parichehr").[2]

3. In making this ruling, the Court of Appeal upheld the decision of March 9, 2011 of the lower court judge, Justice Himel.[3]

4. In both courts below, the Appellants advanced an extreme argument, namely that a physician has the legal right to unilaterally terminate treatment he or she considers to provide no medical benefit to the patient, even if this results imminently in the patient's preventable death, without any need for patient/SDM consent or a determination by the Ontario Consent and Capacity Board ("CCB") or the court.[4]

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[1] R.S.O. 1996, Ch. 2, Sch. A. All sections of the Act relied upon are reproduced at Schedule "B" herein.

[2] Reasons of the Court of Appeal for Ontario dated June 29, 2011, para. 65 ("Reasons of the Court of Appeal"), Record of the Appellants, Vol. 1 of 4, Tab 5, p. 63.

[3] Reasons for decision of Justice Himel of the Superior Court of Justice dated March 9, 2011 ("Reasons of Justice Himel"), Record of the Appellants, Vol. 1 of 4, Tab 2.

[4] Reasons of Justice Himel, para. 36, Record of the Appellants, Vol. 1 of 4, Tab 2. See also Reasons of the Court of Appeal, paras. 4, 45, Record of the Appellants, Vol. 1 of 4, Tab 5, p. 63.

5. Before this Court, for the first time, the Appellants admit that there is a role *for the court*, at least, to play.[5] Although it is not clear, one interpretation of paras. 104-10 of the Appellants' factum (dated February 8, 2012), and para. 108, in particular, is that the Appellants now recognize that they should not act unilaterally. If so, the Appellants have capitulated on the Respondent's main argument.[6]

6. The Appellants continue to deny that the CCB is the proper forum to determine the issue of what should be done next for/to the Respondent, in his best interests. The Appellants deny the CCB's jurisdiction.[7]

7. The Respondent submits that both lower courts ruled correctly that consent is required for end-of-life treatment decisions and that, in Ontario, the proper forum to seek review of patient/SDM withholding of consent to physician-proposed end-of-life treatment is the CCB.[8]

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[5] The Appellants ask that this Court remit "to the Superior Court 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"; see Factum of the Appellants, sub-para. 112(c), p. 40. The appellant Dr. Brian Cuthbertson in a supplementary affidavit has sworn that the Respondent's physicians will continue mechanical ventilation pending determination of this appeal "and pending a further hearing by the Ontario Superior Court of Justice which the appellants have requested as part of the relief on this appeal"; see Affidavit of Brian Cuthbertson sworn March, 2012 ("New Cuthbertson Affidavit"), para. 7, Supplementary Record of the Appellants, Tab 2A, p. 4. Presumably, the Appellants do not maintain that it would be an *abuse of power* for the Superior Court to disagree with the Appellants and to hold that mechanical ventilation should be continued, as that argument should be made to, and be resolved by, this Court.

[6] All the Respondent seeks is an impartial ruling as to his best interests. (Parichehr does not assert that there exists an applicable prior capable wish under para. 21(1)1. of the Act.) See Affidavit of Parichehr Salasel sworn February 10, 2011 ("Parichehr Affidavit"), paras. 23, 91, Record of the Appellants, Vol. 3 of 4, Tab 16, pp. 173, 182-83.

[7] The Appellants added the Ontario Consent and Capacity Board ("CCB") as an intervener to the style of cause herein, pursuant to R. 22(2)(c)(iii) of the *Rules of the Supreme Court of Canada* (SOR/2002-156). The CCB was not a party to the proceedings below and to date has not taken a position on this appeal.

[8] Yet, the momentous issue is whether physicians can terminate life-sustaining treatment unilaterally and whether the Appellants intend to do so; or whether the Appellants must persuade a neutral decision-maker (either the CCB or the court, depending on whether the Act applies) of the correctness of their proposed course of action—hastening the Respondent's preventable death—before acting.

8. In the alternative, if the Act does not apply, the Appellants must obtain the court's consent or approval to withdraw life-sustaining treatment from the Respondent.

PART II – STATEMENT OF FACTS

9. On April 29, 2010, the Respondent and his family permanently immigrated to Canada from Iran. The Respondent is a 60 year old retired mechanical engineer and a devout Shia Muslim. Parichehr is a physician qualified to practice in Iran. They have two children. The family was and remains full of hope for their new life in Canada. Without many relatives in Canada, the family bond is especially strong.[9]

10. In August, 2010, the Respondent complained of dizziness and numbness of the right ear. Physicians found a benign tumour in his head and recommended non-emergency surgery.[10]

11. On October 7, 2010, the Respondent was admitted to Sunnybrook Hospital for surgery that day. In the days following surgery, the Respondent suffered an infection (bacterial meningitis), which caused severe brain damage.[11]

12. On October 8, 2010, the Respondent developed respiratory distress and a reduced level of consciousness. Therefore, he received mechanical ventilation ("MV"). On October 14, 2010, the Respondent underwent a tracheostomy, which allowed taking him off MV.[12]

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[9] Parichehr Affidavit, paras. 2, 4-7, 10-12, 21, Record of the Appellants, Vol. 3 of 4, Tab 16, pp. 171-73.

[10] Parichehr Affidavit, para. 20, Record of the Appellants, Vol. 3 of 4, Tab 16, p. 173.

[11] Affidavit of Brian Cuthbertson sworn February 14, 2011 ("Cuthbertson Affidavit"), para. 14, Record of the Appellants, Vol. 1 of 4, Tab 11, p. 87.

[12] Cuthbertson Affidavit, paras. 11-12, Record of the Appellants, Vol. 1 of 4, Tab 11, pp. 86-87.

13. Over October 16 and 17, 2010, the Respondent appeared to his physicians to have permanently lost consciousness. According to a neurologist who assessed the Respondent on October 17, Dr. Richard Swartz, the Respondent satisfied all criteria for being in permanent vegetative state ("PVS") then, except for the criterium that total loss of consciousness last at least three months (*i.e.*, the element of "permanence"), which criterium was met on January 15, 2011.[13]

14. Yet, by November, 2010, *i.e.*, even before a PVS diagnosis could be made, the Appellants had concluded that the Respondent had lost consciousness irreversibly and could receive no medical benefit from continued MV, which the Respondent had been receiving on an as-needed basis.[14] Therefore, Dr. Cuthbertson and others met with the Respondent's family members (including his wife and SDM, Parichehr) to explain the Appellants' views on prognosis and their wish to withdraw MV permanently and start "high quality palliative care".[15]

15. Dr. Cuthbertson states that he sought Parichehr's "acquiescence only, not her consent".[16] Parichehr states that, on or about December 1, 2010, the Appellants proposed, and asked for her consent, to withdraw MV and to transfer the Respondent from the critical care unit to Sunnybrook's palliative care unit to see to his comfort until his certain death (the "Proposed

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[13] Affidaivit of Richard Swartz sworn February 14, 2011 ("Swartz Affidavit"), paras. 6-7, Record of the Appellants, Vol. 3 of 4, Tab 12, p. 63.

[14] For instance, on October 29, 2010, the Respondent was transferred to Sunnybrook Hospital's step-down intensive care unit and on November 2, 2010, he was transferred to the ward. There, he sustained "intermittent apnea" (failure to breathe) and on November 3, 2010 he was re-admitted to the critical care unit and given MV. On November 9, 2010, the Respondent was sufficiently stable to be transferred again to the ward; see Cuthbertson Affidavit, paras. 21-23, Record of the Appellants, Vol. 1 of 4, Tab 11, pp. 88-89. See also Parichehr Affidavit, para. 62, Record of the Appellants, Vol. 3 of 4, Tab 16, p. 178.

[15] Cuthbertson Affidavit, paras. 30, 34, Record of the Appellants, Vol. 1 of 4, Tab 11, pp. 90-91.

[16] Cuthbertson Affidavit, para. 56, Record of the Appellants, Vol. 1 of 4, Tab 11, p. 96.

Treatment Plan").[17] In any event, Parichehr objected to the Proposed Treatment Plan.[18]

16. The Proposed Treatment Plan contravenes the Respondent's religious beliefs. In the view of Shia Muslims, life is sacred. A person is entitled to remain alive until all signs of life are gone. Preventable death must be prevented.[19]

17. Eventually, the Appellants told Parichehr that they did not need her consent.[20]

18. On January 24, 2011, the Appellants' lawyers wrote to the Respondent's lawyers, saying that the Appellants would withdraw MV, unless the Respondent applied immediately for an injunction to require its continuation.[21] Effectively, the Appellants gave their unconscious patient and his wife an ultimatum.

19. On an emergency basis, on January 27, 2011, the Respondent issued an application for an injunction to restrain the Appellants from implementing the Proposed Treatment Plan. The Respondent sought:

(a) a declaration that the Appellants must obtain the consent of the Respondent's authorized representative (Parichehr) to implement the Proposed Treatment Plan; and

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[17] Parichehr Affidavit, paras. 65-68, Record of the Appellants, Vol. 3 of 4, Tab 16, p. 179.

[18] Parichehr Affidavit, paras. 70, 88, Record of the Appellants, Vol. 3 of 4, Tab 16, pp. 180, 182.

[19] Affidavit of Religious Minister of Imam Mahdi Islamic Center, Ayatollah Seyed Reza Hosseini Nassab affirmed February 7, 2011, paras. 6, 9, 11-15, Record of the Appellants, Vol. 4 of 4, Tab 19, p. 13.

[20] Parichehr Affidavit, para. 86, Record of the Appellants, Vol. 3 of 4, Tab 16, p. 182.

[21] Letter from Harry Underwood to Guillermo Schible dated January 24, 2011, Exhibit "D" to the Parichehr Affidavit, Record of the Appellants, Vol. 3 of 4, Tab 16, p. 193. In taking this position, the Appellants declined to make use of s. 37 of the Act to have the CCB determine whether, in not consenting to the withdrawal of MV and the start of palliative care, Parichehr was acting in the Respondent's best interests.

(b) an order staying the balance of the application, in view of the statutory first-instance jurisdiction of the CCB to determine the underlying case herein as to what is, in fact, in the Respondent's best interests.[22]

20. On February 4, 2011, the Appellants issued a counter-application seeking an order:

(a) declaring that the Respondent is in PVS;

(b) declaring that the Appellants may lawfully withdraw and/or withhold life-sustaining treatment from the Respondent and provide palliative care only;

(c) declaring that the decision to withdraw and/or withhold life-sustaining treatment from a patient in PVS is a medical decision to which the consent of the patient's SDM is not required, either at common law or under the provisions of the Act;

(d) declaring that the *Canadian Charter of Rights and Freedoms* ("the *Charter*") does not apply to the attending physicians' decision to withdraw life-sustaining treatment in the Respondent's case;

(e) declaring that the CCB is without jurisdiction to determine the question of whether the attending physicians may withdraw and/or withhold life-sustaining treatment in the Respondent's case and provide palliative care only; and

(f) declaring that a decision to withhold life-sustaining treatment in the Respondent's case will not constitute an offence under the *Criminal Code*.[23]

21. Dr. Swartz gave affidavit evidence for the Appellants on the application as follows:

(a) the Respondent is in PVS, which is an irreversible loss of awareness due to traumatic or non-traumatic brain injury;

(b) it is overwhelmingly unlikely that the Respondent has any degree of awareness and overwhelmingly likely that the Respondent will never recover any degree of awareness — this is "as certain as one can be in medicine";

(c) the prognosis is that the Respondent will die, either from a persisting or

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[22] Notice of Application issued January 27, 2011, para. 1, Record of the Appellants, Vol. 1 of 4, Tab 7, p. 68.

[23] Notice of Application issued February 4, 2011, para. 1, Record of the Appellants, Vol. 1 of 4, Tab 8, p. 76.

recurring infection of the same type that caused him brain injury or from other complications arising from the fact that he is confined to a hospital bed, is unresponsive and is under MV;

(d) on reassessments between October 17, 2010 and the date of the Swartz Affidavit (February 14, 2011), the Respondent showed improvements such as blinking when his eyes are touched, occasionally blinking in response to a threat, turning his head when stimulated, grimacing to painful stimulus, opening his eyes to stimulus, and reacting with his left pupil; yet according to Dr. Swartz, this "progression" is "in no way inconsistent with a diagnosis of PVS"; and

(e) the Respondent should receive "purely palliative care and [be] allowed to die peacefully," as there is no benefit to him from continued MV.[24]

22. Under cross-examination on February 14, 2011, Dr. Swartz accepted that:

(a) locked-in state can be misdiagnosed as PVS;[25]

(b) also, minimally conscious state ("MCS") can be misdiagnosed as PVS;[26]

(c) Dr. Bryan Jennett (whom Dr. Swartz recognized as one of the leading authorities in the world in this area; see Swartz Transcript, Q. 12, Record of the Appellants, Tab 22, p. 51) states in his text titled, *The Vegetative State*, that the rate of misdiagnosis of MCS as PVS is 27% for non-traumatic brain injury patients (and 41% in traumatic brain injury cases);[27]

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[24] Swartz Affidavit, paras. 5, 8, 11-13, 24, 31, Record of the Appellants, Vol. 3 of 4, Tab 12, pp. 63-65, 67.

[25] The authoritative article relied upon by the Appellants, "Medical Aspects of the Persistent Vegetative State, The Multi-Society Task Force on PVS" (the "Task Force Report"), *New England Journal of Medicine* 330:21, 1499-1508 (Part 1) and 330:22, 1572-79 (Part II), Exhibit "C" to the Swartz Affidavit, Record of the Appellants, Vol. 3 of 4, Tab 12C, states at p. 1501, p. 103 of the record: "[O]ne should be extremely cautious in making a diagnosis of vegetative state when there is any degree of sustained visual pursuit, consistent and reproducible visual fixation, or response to threatening gestures." Dr. Swartz said he was familiar with the possibility of a false positive diagnosis, on which the Task Force Report stated (p. 1501): "A false positive diagnosis ... could occur if it was concluded that a person lacked awareness when, in fact, he or she was aware. Such an error might occur if a patient in a locked-in state (i.e., conscious yet unable to communicate because of severe paralysis) was wrongly judged to be unaware"; see Swartz Transcript, Q. 21, Record of the Appellants, Vol. 4 of 4, Tab 22, p. 54. Indeed, that possibility was recognized by Dr. Swartz in the Swartz Affidavit, paras. 11-12, Record of the Appellants, Vol. 3 of 4, pp. 64-65.

[26] Dr. Swartz said he was aware of studies on the relative rate of misdiagnosis of MCS as PVS, as he had read some such studies "several years ago"; see Swartz Transcript, Record of the Appellants, Vol. 4 of 4, Tab 22, p. 66.

[27] Bryan Jennett, *The Vegetative State*, Cambridge University Press, p. 21, marked as Exhibit 1 in the cross-examination, Record of the Appellants, Vol. 4 of 4, Tab 22A, p. 109. Dr. Swartz noted that Dr. Jennett's figures were from a pre-1994 study, which meant that the assessors did not have the benefit of the 1994 Task Force Report's "recommendations" which served to create consensus in diagnosis and perhaps to lower rates of misdiagnosis. But Dr. Swartz did not know for sure whether rates of misdiagnosis decreased after 1994, nor by

(d) authors of a 2010 paper published in the American Academy of Neurology's official journal, *Neurology* ("a well-respected publication, absolutely") found that in clinical practice erroneous diagnosis of MCS as PVS may reach 40%;[28]

(e) a patient in MCS has a higher chance of making a marked recovery than a patient in PVS;[29]

(f) the conclusion by the authors of the 2010 paper above (Luauté *et al.*), following their study of 12 persons in (P)VS and 39 in MCS, that "a third of patients in MCS improved more than one year after coma onset," was (based on the abstract in their paper) a reasonable/accurate conclusion;[30] and

(g) the Task Force Report supports the (statistically significant) possibility that the Respondent may regain consciousness *even if he is in PVS*.[31] In other words, PVS is not, in fact, irreversible.

23. The Appellants declined an invitation to produce any medical literature showing that

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how much; indeed, he had not read any articles supporting the hypothesis that they had decreased. See Swartz Transcript, Qs. 58-65, Record of the Appellants, Vol. 4 of 4, Tab 22, pp. 66-68.

[28] J. Luauté, *et al.*, "Long-term outcomes of chronic minimally conscious and vegetative states," *Neurology* (2010) 75; 246-52 ("Long-term outcomes"), p. 246, marked as Exhibit 2 in the cross-examination, Record of the Appellants, Tab 22B, p. 135. This paper is referred to at para. 47 of *W (brought by her litigation friend B)* v. *M* ("*W* v. *M*"), [2011] EWHC 2443 (Fam), Respondent's Authorities, Tab 2. Dr. Swartz noted that the authors cited a 1993 and a 1996 paper, so one of these was before the 1994 Task Force Report's "recommendations"; but see footnote above. See Swartz Transcript, Qs. 63-65, 83-87, Record of the Appellants, Tab 22, pp. 68, 75-77.

[29] Swartz Transcript, Q. 7, Record of the Appellants, Vol. 4 of 4, Tab 22, p. 50. Later, Dr. Swartz could not provide figures on the recovery rates of patients in MCS vs. patients in PVS, but he again accepted that the former group's recovery rate was potentially better (although it still would not be high), as "Generally in medicine, the better you are the better the outcome"; see Swartz Transcript, Qs. 41-43, Record of the Appellants, Tab 22, pp. 61-62.

[30] J. Luauté, *et al.*, note 28, "Long-term outcomes," p. 246, Record of the Appellants, Vol. 4 of 4, Tab 22B, p. 135; and Swartz Transcript, Q. 92, Record of the Appellants, Vol. 4 of 4, Tab 22, p. 78. (The same paper states at p. 249, Record of the Appellants, Vol. 4 of 4, Tab 22B, p. 138: "Among the 39 patients in MCS, 3 were lost to follow up. Five years after coma onset, the outcomes of the other 36 patients were as follows: 13 severe disabilities (33.3%), 9 MCS (23.1%), and 14 deaths (35.9%). ... [N]o patient became vegetative during the follow up period.")

[31] Swartz Transcript, Qs. 27-28, Record of the Appellants, Vol. 4 of 4, Tab 22, pp. 57-58. In answering here, Dr. Swartz was looking at p. 1573 of the Task Force Report, Record of the Appellants, Tab 12C, Vol. 3 of 4, p. 112, stating that, in one study, "Of the 169 patients with [non-traumatic brain] injuries, only 11 percent had recovered consciousness three months after injury ..." and "One year after injury, 15 percent of the 169 patients had recovered consciousness ...", meaning that 4% of the 169 patients recovered consciousness *between months 4 and 12*. This measure (4%) is consistent with Dr. Swartz's stated view that patients' chances of recovering consciousness after the three-month mark (which is when, in his and the study's terminology, patients with non-traumatic brain injury qualify as being in PVS) are: "Far less than ten percent" and "less than ten percent"; see Swartz Transcript, Qs. 32-36, Record of the Appellants, Vol. 4 of 4, Tab 22, pp. 59-60. Indeed, Dr. Swartz's affidavit acknowledges that recovery of awareness in PVS cases "does occur"; see Swartz Affidavit, paras. 11-12, Record of the Appellants, Vol. 3 of 4, pp. 64-65. The Respondent submits that 4% is statistically significant. It should not be thought that PVS is "irreversible"; and no case should turn on the assumption that it is.

the above rate(s) of misdiagnosis is inaccurate.[32]

24. Before Justice Himel, the Appellants argued that they are not required to continue MV that is of no medical benefit to the Respondent and falls outside the standard of care or is inhumane, such that the Appellants are *obliged* to withdraw MV.[33]

25. On March 9, 2011, Justice Himel ordered that:

(a) the Appellants' proposal to end life-sustaining treatment to the Respondent must be referred to the CCB;

(b) pending the decision of the CCB, the Appellants are not permitted to withdraw MV and transfer the Respondent to palliative care;

(c) should the circumstances change, the parties may return to court; and

(d) the *Charter* does not apply to the Appellants' proposed decision to withdraw MV.[34]

26. On March 17, 2011, the Appellants appealed Justice Himel's order to the Court of Appeal. The appeal was heard on May 18, 2011.

27. On June 29, 2011, the Court of Appeal dismissed the appeal, unanimously.[35]

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[32] Swartz Transcript, Qs. 39-40, Record of the Appellants, Vol. 4 of 4, Tab 22, p. 61.

[33] Reasons of Justice Himel, para. 9, Record of the Appellants, Vol. 1 of 4, Tab 2, p. 4. The "no medical benefit" and "standard of care" questions—and what, consequently, the Appellants say they are obliged or have a "duty" to do—remain the Appellants' main arguments, although it is only in this Court that the Appellants say that a court should inquire into and answer these two questions before they act.

[34] Order of Madam Justice Himel dated March 9, 2011, Record of the Appellants, Vol. 1 of 4, Tab 3, pp. 29-31.

[35] Reasons of the Court of Appeal dated June 29, 2011, Record of the Appellants, Vol. 1 of 4, Tab 5, pp. 35-63. Order of the Court of Appeal entered September 8, 2011, Record of the Appellants, Vol. 1 of 4, Tab 6, pp. 64-65. As mentioned above, this Court granted leave to appeal to this Court on December 22, 2011; see Judgment of the Supreme Court of Canada dated December 22, 2011, Record of the Appellants, Tab 9, pp. 79-80.

New Diagnosis of MCS and Motion to Adduce Fresh Evidence

28. On January 23, 2012, Dr. Andrew Lim ("Dr. Lim"), a neurologist at Sunnybrook, examined the Respondent; and on January 28, 2012, Dr. Swartz examined the Respondent again. As a result of these assessments, the Respondent's diagnosis was changed from PVS to MCS.[36]

29. On March 13, 2012, the Appellants brought a motion (on consent) for an order to adduce fresh evidence of the new MCS diagnosis for this appeal. The fresh evidence sought to be adduced was the affidavit of Dr. Cuthbertson sworn March 7, 2012, which:

(a) attaches the written assessment reports of Dr. Lim on January 23, 2012 and Dr. Swartz on January 28, 2012, as Exhibits "A" and "B", respectively;[37]

(b) states that, as a result of this change in diagnosis, the Appellants and the Respondent's other treating physicians are pursuing investigations (which would take approximately two to three months to complete) to determine whether or not the Respondent may be capable of communication;

(c) states that, the current treatment plan (*i.e.*, the provision of MV and resort to Sunnybrook's critical care unit if necessary) has not changed as a result of the new diagnosis other than to conduct the tests above; and

(d) *if the Respondent is not capable of communication*, the Appellants and the Respondent's other treating physicians remain of the view that the standard of care does not require continuation of MV given the Respondent's current medical condition, including MCS.[38]

30. Notably, Dr. Swartz's assessment report dated January 28, 2012 states (pp. 2-3):

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[36] That the Respondent demonstrated some level of awareness is what the Respondent's family has been saying all along. See, for example, Parichehr Affidavit, paras. 46-49, 53-60, 78-81, Record of the Appellants, Vol. 3 of 4, Tab 16, pp. 176-78, 181; see Affidavit of Mojgan Rasouli sworn February 13, 2011, paras. 13, 18-22, 25-28, Record of the Appellants, Vol. 4 of 4, Tab 17, pp. 3-5; see Responding Affidavit of Parichehr Salasel sworn February 13, 2011, paras. 27-28, Record of the Appellants, Vol. 4 of 4, Tab 20, p. 25.

[37] Assessment Report of Andrew Lim, Supplementary Record of the Appellants, Tab 2A, pp. 6-8; and Assessment Report of Richard Swartz, Supplementary Record of the Appellants, Tab 2B, pp. 9-11.

[38] Affidavit of Brian Cuthbertson sworn March 7, 2012 ("New Cuthbertson Affidavit"), paras. 9-10, Supplementary Record of the Appellants, Tab 2A, pp. 4-5.

"Mr. Rasouli has diffuse and severe limitations of voluntary and reflexive movements of his limbs and eyes which may limit the range of behavioral responses he can exhibit."[39] This means that the Respondent's level of consciousness is not clear from medical observation; it could well be higher than the Respondent is physically able to demonstrate.[40]

31. On April 17, 2012, Justice Karakatsanis of this Court granted the Appellants leave, on consent, to file the New Cuthbertson Affidavit as fresh evidence for this appeal.

32. The Appellants say that the continuation of MV depends on whether the Respondent can communicate; that they will test the Respondent's ability to communicate; and that the testing will take two to three months. It is unknown if this testing has taken place, or what has been its result. The Appellants have declined to confirm that they still wish to withdraw MV.

33. An adverse inference should be drawn.

PART III – STATEMENT OF POSITION WITH RESPECT TO QUESTIONS IN ISSUE

Questions Raised by the Parties to this Appeal

34. The Appellants state that this appeal raises four questions:

(a) Is patient consent required for 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;

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[39] Assessment Report of Richard Swartz, Supplementary Record of the Appellants, Tab 2B, pp. 9-10.

[40] See also Swartz Affidavit, paras. 11-12, Record of the Appellants, Vol. 3 of 4, pp. 64-65.

(b) Is consent required to the withdrawal of non-indicated treatment if other positive treatment is to be administered 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 SDM consent even if the treatment is 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 SDM; (ii) if requested by the SDM, obtain a second opinion from a suitably qualified physician who has not been involved in the patient's care; and (iii) allow the SDM to arrange his or her own independent medical opinion within a reasonable period of time in the circumstances of the case.[41] It is unclear whether the Appellants add a fourth requirement: to seek and obtain court approval to the withdrawal before acting.[42]

35. The Respondent rejects the relevance of the "no medical benefit" and "standard of care" questions. This appeal raises two questions:

(a) Is the CCB the proper forum, in Ontario, for determining disputes between physicians and SDMs regarding end-of-life treatment, in non-emergency situations? The Respondent submits that the answer is yes. Further, terminating life support is a "treatment" decision under the Act.

(b) In the alternative, *i.e.*, if the Act does not apply, does the common law prohibit unilateral withdrawal of life-sustaining treatment? The Respondent submits that the answer is yes. If the Act does not apply and resort to the CCB is not available, physicians must obtain court approval before terminating life support without consent in non-emergency situations.

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[41] Factum of the Appellants, paras. 36, 104-07, pp. 14, 37-39.

[42] Factum of the Appellants, para. 108, p. 39.

PART IV – STATEMENT OF ARGUMENT

36. A key question is whether the withdrawal of life support constitutes "treatment" under the Act. The Court of Appeal held that the withdrawal of MV followed by the administration of palliative care constitutes "treatment" under the Act, thus requiring consent.[43]

37. The Appellants have never said that palliative care is not part of their plan. They say that the Respondent would not benefit medically from continued MV; but the Proposed Treatment Plan is not limited to withdrawing MV. The Appellants do *not* say that it is within the standard of care and in the Respondent's best medical interest to withdraw MV and do nothing else. The Court of Appeal noted that the Appellants propose, as being in the Respondent's best interests, a treatment plan, being palliative care, the first step of which is to withdraw MV.[44]

38. Also, the Respondent goes further than the Court of Appeal did and submits that, without or without palliative care, withdrawing life-sustaining treatment such as MV for health-related reasons, ostensibly in the patient's best interests, constitutes "treatment" under the Act.

Reference to "Standard of Care" is Misguided – *In re S* (Eng. C.A.)

39. The Appellants refer to the standard of care and suggest that the Respondent is distorting the principle of informed consent. The Appellants argue, essentially, that the common

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[43] Reasons of the Court of Appeal, paras. 47, 52, 65, Record of the Appellants, Vol. 1 of 4, Tab 5, pp. 57-58, 63.

[44] Cuthbertson Affidavit, paras. 8, 34, Record of the Appellants, Vol. 1 of 4, Tab 11, pp. 86, 91. Swartz Affidavit, para. 31, Record of the Appellants, Vol. 3 of 4, Tab 12, p. 69. Affidavit of Jon Ween sworn February 13, 2011, para. 10, Record of the Appellants, Vol. 3 of 4, Tab 13, p. 120. Reasons of the Court of Appeal, paras. 49-50, Record of Appellants, Vol. 1 of 4, Tab 5, pp. 57-58. In asking the restricted question of whether physicians can withdraw life-sustaining treatment without consent, the Appellants seek to establish a legal right to do something that (1) they have never said they intend to do only and (2) could not be in the Respondent's best interest(s) to do only.

law principle of informed consent can only be used as a "shield" (*i.e.*, to prevent the application of care without consent) but that it cannot be used as a "sword" (to force a physician to do something he or she does not think is medically indicated). They say that the Act merely codified the common law principle of informed consent and that this principle cannot be used to force physicians to act contrary to the standard of care.

40. However, where life-sustaining treatment is already being provided, the principle of informed consent as a "shield" must extend to its withdrawal, as this involves significant interference with a person's bodily integrity[45] and right to/interest in life.[46] No one is ever more in need of a shield than when his physician wishes to hasten his preventable death.

41. The notion of "standard of care," being part of the vocabulary of tort law, has no place here. Tort law is retrospective; it considers civil liability for past acts. This case considers the proper procedure, prospectively, for determining next steps in treating a completely vulnerable patient. This case is not about what physicians can do without being successfully sued. It is about the disposition of a human life and what process should be engaged.

42. The Ontario legislature has established a neutral, expert tribunal to decide the difficult questions involved in cases like this one. But even if the Act does not apply and continued MV is medically "non-indicated," that would not resolve the issue of whether physicians

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[45] *Golubchuk (Committee of)* v. *Salvation Army Grace General Hospital* (2008), 55 C.P.C. (6th) 78, [2008] 8 W.W.R. 299, 227 Man. R. (2d) 274 (Man. Q.B.) at paras. 22-23 ("*Golubchuk*"), Respondent's Authorities, Tab 1.

[46] *W (brought by her litigation friend B)* v. *M* ("*W* v. *M*"), [2011] EWHC 2443 (Fam) at paras. 220-22, 249, 252, Respondent's Authorities, Tab 2.

can unilaterally terminate same and, thereby, end the life of a patient in stable condition.

43. *In re S (Adult Patient: Sterilisation)*, a decision of the English Court of Appeal, confirms that a physician's obligation to do what is in an incapable patient's best interests is distinct from the obligation to meet the standard of care. The latter duty, known as the "*Bolam* test" in England, merely sets out a minimum level of medical competence. Several medical alternatives may come within the standard of care. But there is only one option that is best for the patient and a physician cannot choose unilaterally from within the range of medically supportable options. Rather (in the absence of a statutory SDM regime and consent), the court must come to its own assessment. In this regard, the court should not defer to the physician.[47]

44. As confirmed in a legal text relied upon by the Appellants, "the doctor's overriding duty [is] to act in the patient's best interests".[48]

45. The "standard of care," then, misframes the issue. The Appellants assume that they

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[47] See *In re S (Adult Patient: Sterilisation)*, [2001] Fam. 15 (Eng. C.A.), Respondent's Authorities, Tab 3, wherein Justice Butler-Sloss, President of the Family Division of the High Court of Justice, stated: "[T]he judge, not the doctor, has the duty to decide whether such treatment *is* in the best interests of the patient. The judicial decision ought to provide the best answer not a range of alternative answers" (emphasis in original; pp. 27-28). In holding thus, Butler-Sloss P expressly disagreed with Lord Browne-Wilkinson's dicta to the contrary in *Bland*, a decision discussed below. According to Butler-Sloss P, the judge must determine "who is deciding the best interests of the patient from making a choice between the available options. ... [T]he principle of best interests as applied by the court extends beyond the considerations set out in the *Bolam* test [1957] 1 WLR 582. The judicial decision will incorporate broader ethical, social, moral and welfare considerations" (pp. 27-28). See also Thorpe LJ's reasons in the same case at p. 30. See also series of practice notes, [1994] 2 All ER 413, [1996] 4 All ER 766, [2001] 2 FLR 158, and [2006] 2 FLR 373 ("Series of Practice Notes"), p. 14, paras. 17-18, Respondent's Authorities, Tab 4. To similar effect is the early decision of *Frenchay Healthcare National Health Service Trust* v. *S.* [1994] 1 W.L.R. 601 (Eng. C.A.), Appellants' Authorities, Tab 16 (pp. 607F, 609C).

[48] Ellen I. Picard and Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed., p. 345, Appellants' Authorities, Tab 9. This is consistent with the Appellants' arguments in the courts below; see Reasons of the Court of Appeal, paras. 4, 12, 43, 57 and Reasons of Justice Himel, paras. 97, 103.

are right about the fundamental question of what is in the Respondent's best interests. If *dying imminently* is not in Hassan Rasouli's best interests, avoiding that result must be *within* the standard of care, even if securing that result is *also* within the standard of care.[49]

46. The Appellants also argue that the medical standard of care in Ontario mirrors what they advance as the common law position. Their evidence is that the medical standard of care is set out in a policy statement of the College of Physicians and Surgeons of Ontario (CPSO).[50]

47. Yet, this document states that the requirements of informed consent at the end of life are the same as the requirements in other situations and that when a patient is not capable, an SDM makes the decisions.[51] It specifies that patients have the "right to receive life-sustaining treatments that *may be* of benefit to them and that take into account their goals, values and beliefs. When it is not clear whether treatment might be of benefit, the choice should be made on the side of providing life-sustaining treatment" (emphasis added).[52] The same policy states that the Act "provides a structure for managing conflicts about treatment decisions for incapable patients that cannot be resolved in other ways."[53]

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[49] This was envisaged by Justice Cullity in *Scardoni* v. *Hawryluck* (2004), 69 O.R. (3d) 700, 12 Admin. L.R. (4th) 67, 5 E.T.R. (3d) 226 (S.C.J.), Respondent's Authorities, Tab 5, when he spoke about the "element of choice" (para. 40) that is present when one seeks continuation of previously indicated treatment that would be continued but for the physician's (re)consideration of best interests (para. 42); in such circumstances the CCB has the jurisdiction (para. 44) to consider which option is in the patient's "best interests" and incidentally to determine whether or not the SDM has been refusing consent in accordance with the patient's "best interests".

[50] Factum of the Appellants, paras. 49-50, p. 21. See Cuthbertson Affidavit, para. 50, Record of the Appellants, Vol. 1 of 4, Tab 11, p. 95; and Exhibit "B" to the Cuthbertson Affidavit, Record of the Appellants, Vol. 3 of 4, Tab 11B, pp. 33-40.

[51] College of Physicians and Surgeons of Ontario policy, *Decision Making for the End of Life* ("CPSO Policy"), Part 1.1, p. 3, right column, Exhibit "B" to the Cuthbertson Affidavit, Record of Appellants, Tab 11B, p. 35.

[52] CPSO Policy, Part 3.2, p. 5, left column, Record of Appellants, Tab 11B, p. 37.

[53] CPSO Policy, Part 4.1, p. 7, left column, Record of Appellants, Tab 11B, p. 39.

48. If this is the standard of care, then the Appellants must either continue MV or go to the CCB, on that basis, as well.[54]

49. The Discipline Committee of the CPSO has found that it is an act of professional misconduct and a "very serious issue" for a physician to sign a do not resuscitate ("DNR") order without communicating with a patient's family and receiving "proper authorization".[55]

50. The other policies the Appellants have produced are inconclusive. In any event, physicians cannot, by writing policies, flout the Act or avoid the court's *parens patriae* jurisdiction.

Reference to "No Benefit" is Misguided – MV is Effective & Non-clinical Considerations

51. The Appellants' reference to "no (medical) benefit," or to the "(medical) futility" of the treatment in question, is misguided and ultimately assumes that they are right about what is in the Respondent's best interests.[56]

52. The Appellants cannot say that the treatment in question (MV) will not work. MV

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[54] Reasons of Justice Himel, para. 51, Record of the Appellants, Vol. 1 of 4, Tab 2, p. 14.

[55] *Findlay (Re)*, Reasons for Decision of the Discipline Committee of the College of Physicians and Surgeons of Ontario, dated November 4, 2002, Respondent's Authorities, Tab 6.

[56] The Appellants say that the Court of Appeal concluded that consent is not required to withhold life-sustaining treatment that is *medically* futile and that it made other determinations about what physicians can and cannot do (Factum of the Appellants, paras. 24, 33, 74, 79). This is not so; see note 113, below. Morever, the Court of Appeal did not resolve the "metaphysical debate" over the "medical value" of MV to the Respondent (para. 46). Indeed, saying more risked stepping on the CCB's toes in relation to the "best interests" question. The issue, then, of when, if ever, life-sustaining treatment *that works* can be said to be "futile" remains open.

"cures" the Respondent's "intermittent apnea".[57] It is a completely successful treatment.[58] Rather, the Appellants say that MV is not worth doing, considering the patient's best interests.[59]

53. This takes the concept of "futility" too far.[60]

54. Physicians can claim no expertise, nor right, to decide when treatment is not worth doing. At a minimum, this involves subjective, value-laden evaluations of anticipated medical benefits and medical harms. What constitutes a "successful" recovery?[61] What probability of success is a "small" probability?[62]

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[57] Cuthbertson Affidavit, para. 22, Record of the Appellants, Vol. 1 of 4, Tab 11, p. 88.

[58] Responding affidavit of Parichehr Salasel sworn February 13, 2011, para. 29, Record of the Appellants, Vol. 4 of 4, pp. 25-26. See also Parichehr Affidavit, paras. 89-90, Record of the Appellants, Vol. 3 of 4, p. 182.

[59] François Baylis, "Expert Testimony by Persons Trained in Ethical Reasoning: The Case of Andrew Sawatzky," *Journal of Law, Medicine & Ethics* (2000): 224-31 ("Expert Testimony"), Respondent's Authorities, Tab 7.

[60] Bernard M. Dickens, "Medically Assisted Death: Nancy B. v. Hôtel-Dieu de Québec" (1993), 38 *McGill L.J.* 1053 at 1066, Respondent's Authorities, Tab 8. The Appellants rely on Ellen I. Picard and Gerald B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed., Appellants' Authorities, Tab 9; but the authors warn that it is "essential" that the futility concept have "strict limits," and state that guidance is found in the report of the Special Senate Committee on Euthanasia and Assisted Suicide, *Of Life and Death* (Ottawa: 1995) at p. 45, which recommended that "futility ... be construed very narrowly to mean 'treatment that will, in the opinion of the health care team, be completely ineffective'" (p. 346). Similarly, the *Joint Statement on Resuscitative Interventions* (Update 1995) ("*Joint Statement*"), Appellants' Authorities, Tab 28, favours continued MV, not withdrawal. Page 2, para. 6 states that there is no obligation to provide futile treatment but, "Futile and nonbeneficial treatments are controversial concepts when applied to CPR". The *Joint Statement* uses a very narrow concept of futility: treatment offering "almost certainly no chance," in the case of CPR, of returning the patient to his pre-arrest condition (p. 3). The focus is on physiological effect. The *Joint Statement* continues (p. 4): "People for whom the benefit of CPR is uncertain or unlikely should be given this treatment if the need arises". This category includes patients (p. 3, para. 3) for whom, "There is little chance that CPR will restore cardiac and respiratory function; even if the function is restored, it is unlikely to be maintained. The likelihood of the patient's returning to his or her pre-arrest condition is low". The Respondent submits that it is only in extreme cases that it can be said with confidence that CPR has almost certainly no chance of working (*e.g.*, patient with ruptured aorta). Therefore, even if the *Joint Statement* did accurately set out the law, it would be of extremely limited application and would have no application here.

[61] Consider the following dismissive value judgment: "Even if [the patient] were to recover awareness, it is almost certain ... that he would be found to be permanently paralysed on one side and completely dependent on others for his care." Under cross-examination re: this statement (Swartz Affidavit, para. 13, Record of the Appellants, Vol. 3 of 4, p. 65), Dr. Swartz adopted his counsel's answer attempting to remove this statement from Dr. Swartz's reasoning; see Swartz Transcript, Qs. 112-14, Record of the Appellants, Vol. 4 of 4, pp. 84-85.

[62] François Baylis, "Expert Testimony," note 59, Respondent's Authorities, Tab 7, p. 228. It is reasonable to want treatment, even if it provides only a small chance of success, and it is a value judgment to refuse to offer that small chance. Logically, as against certain death, no chance is too small.

55. It is a value judgment to ignore non-medical positive effects of treatment.[63] Indeed, as discussed at paras. 118-21 below, it is inconsistent with the Act to ignore them. Non-medical benefits take the "metaphysical debate" over the value of continued life support to a higher plane.

56. It is not for physicians to decide, by way of "clinical definition," what the minimum benefit of life support is. This calls for a moral judgment.[64]

57. Assessing someone's best interests is not wholly a medical matter.[65] It requires understanding and weighing a patient's religious beliefs, values, goals, hopes and expectations.[66]

58. The Proposed Treatment Plan is based on the Appellants' perceived balance of medical benefits and medical risks of continued MV, *i.e.*, life.[67] This cannot avoid subjectivity.

59. In 1999, the Council of Ethical and Judicial Affairs (CEJA) of the American Medical Association concluded that "objectivity is unattainable" when defining futility, and that the best approach is to implement a "fair process".[68] This is what the Act is.

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[63] Paul R. Helft, Siegler M., Lantos J., "The Rise and Fall of the Futility Movement," 343 *New England Journal of Medicine* (2000) 293-96, Respondent's Authorities, Tab 9.

[64] Jocelyn Downie & Karen McEwen, "The Manitoba College of Physicians and Surgeons Position Statement of Withholding and Withdrawal of Life-Sustaining Treatment (2008): Three Problems and a Solution," *Health Law Journal*, Vol. 17 (2009): 116-37, p. 116, Respondent's Authorities, Tab 10.

[65] *Ibid.*, pp. 116-17.

[66] François Baylis, "Expert Testimony," note 59, Tab 7, pp. 228-29.

[67] Cuthbertson Affidavit, paras. 5-7, Record of the Appellants, Vol. 1 of 4, Tab 11, pp. 85-86; and Swartz Affidavit, paras. 13, 27-30, Record of the Appellants, Vol. 3 of 4, pp. 65, 69.

[68] Council on Ethical and Judicial Affairs, American Medical Association, "Medical Futility in End-of-Life Care," *Journal of the American Medical Association* (1999: 281: 10) 937-41, Respondent's Authorities, Tab 18.

60. Parichehr concluded, on behalf of her husband, that, even if he was properly diagnosed as being in PVS, the risk of slow deterioration as a result of being confined to a hospital bed was a risk worth taking for a further period of time to assess his condition, rule out the possibility that he would improve, and to respect his religious beliefs and personal values.[69] This was felt to be in his "best interests".

61. MV is not a heroic or invasive treatment, such as surgery. The Respondent's death is easily preventable through the continuance of the very "treatment" the Appellants recommended and, with consent, implemented.[70] Neither the cost of that treatment nor the rationing of medical resources are an issue in this appeal.[71]

62. This turned out to be, in fact, a risk worth taking. Had the Appellants been allowed to act unilaterally from the beginning, the diagnosis of MCS—with recognition of its higher chances of marked recovery—would never have been made.

The Related Question of the Appellants' Alleged "Duty" to Withdraw MV

63. Asserting a "duty" to withdraw MV assumes that the Act does not apply. Physicians have a duty to comply with the Act. They have a duty to respect the prior capable wishes of all their patients, and they must accept that their patients' best interests are to be considered in accordance with the statutory test, discussed below.

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[69] Parichehr Affidavit, paras. 16, 21-23, 46, 70-72, Record of the Appellants, Tab 16, Vol. 3 of 4, pp. 172-73, 176, 180.

[70] *Golubchuk,* note 45, para. 28, Respondent's Authorities, Tab 1. Parichehr Affidavit, paras. 38-39, Record of the Appellants, Vol. 3 of 4, Tab 16, p. 175.

[71] Reasons of the Court of Appeal, paras. 31-34, Record of the Appellants, Vol. 1 of 4, Tab 5, p. 51.

64. If the Act does not apply, the "duty" notion still assumes that the Appellants are right about the Respondent's best interests and that non-clinical considerations are irrelevant.

65. The question herein is not whether the Appellants have a legal duty to provide MV to the Respondent indefinitely. There are, rather, two questions: (1) is it in the Respondent's best interests to terminate MV now, *i.e.*, to *die now*;[72] and (2) who answers (1)?

66. That (1) above is the right question was understood in the English decision, *An NHS Trust* v. *MB*. There, Justice Holman went against the unanimous medical evidence that withdrawing MV was in the patient's best interests, to conclude that it was not, at that time.[73]

67. The Appellants were not obliged to accept the Respondent as a patient but they did. Now, they have a legal duty to do what is in his best interests.[74] There is a dispute about what that is. The CCB is the best forum, and the required forum, to answer this question.

68. The Act provides due process and oversight. It is a good process.[75]

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[72] The Appellants acknowledge that the Respondent would not survive very long at all without MV; see Swartz Affidavit, para. 14, Record of Appellants, Vol. 3 of 4, Tab 12, p. 65.

[73] *An NHS Trust* v. *MB* [2006] EWHC 507 (Fam), paras. 25-26, 29-30, 58, 62, 77-83, 87, 89-90, 94-95, 100-05, Respondent's Authorities, Tab 11.

[74] See note 47 and note 48.

[75] The Court of Appeal at para. 61 of its decision, Record of the Appellants, Vol. 1 of 4, Tab 5, p. 61, agreed with Himel J.'s observations at paras. 48-50 of her reasons, Record of the Appellants, Vol. 1 of 4, pp. 13-14, regarding the CCB regime's "many advantages ... the most noteworthy being an expeditious hearing before an expert Board". Commenting on the CCB regime, as it applies to end-of-life consent to treatment disputes, the Court of Appeal said (para. 62, Record of the Appellants, Vol. 1 of 4, p. 62): "... the process seems to have worked well since the Act came into existence, some 15 years ago." See also Reasons of Justice Himel, para. 103, Record of the Appellants, Vol. 1 of 1, p. 27.

69. Patients in PVS have a 4% or higher chance of regaining *some* awareness. Patients in MCS have a 33% chance of making a marked recovery. MCS is misdiagnosed as PVS in non-traumatic brain injury cases 27% of the time. On a medical basis alone, a PVS diagnosis should not lead automatically to the opinion that terminating life support is in the patient's best interests.[76]

70. At some point, if a person in PVS does not improve, it may well be in his or her best interests to be allowed to die. But this question will not be limited to clinical considerations. As discussed below, the Act does not limit the question of best interests to clinical considerations (and, the Respondent submits, neither does the common law[77]). Indeed, as mentioned at para. 47 above, the CPSO Policy on which the Appellants rely itself requires that goals, values and beliefs be taken into account in the Respondent's circumstances.[78]

This Case is Confined to the Interpretation of a Provincial Statute

71. The Appellants have not challenged the competence of the Ontario legislature to make rules about consent to treatment. The Act provides a comprehensive statutory regime for consent to treatment decisions in Ontario.

72. This Court should reject the Appellants' *in terrorem* argument that physicians will be required generally to provide non-medically indicated treatment. There is no evidence that this

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[76] See note 30, note 31 and note 118. Moreover, in most circumstances, prior capable wishes and values and beliefs must be allowed to play a role. Fundamental social values such as security of the person, autonomy and dignity, must also shape the analysis.

[77] *Sweiss* v. *Alberta* (2009), 314 D.L.R. (4th) 474, 15 Alta. L.R. (5th) 283 (Q.B.), paras. 63-65, 68, Respondent's Authorities, Tab 12. See *In re S (Adult Patient: Sterilisation)*, [2001] Fam. 15 (Eng. C.A.), p. 28, Respondent's Authorities, Tab 3. See Series of Practice Notes, note 47, p. 14, para. 18, Respondent's Authorities, Tab 4.

[78] CPSO Policy, Part 3.2, p. 5, left column, Record of Appellants, Tab 11B, p. 37.

is a problem. If it is a problem, then the legislature, not the court, should fix it.[79] The Respondent should not be compelled to die, just in case this issue is more than hypothetical.

73. The Appellants complain that the Court of Appeal created a "special category" of treatment not found in the Act. But as stated at para. 38 above, and for the reasons at paras. 78-87 below, with or without palliative care the proposed withdrawal of MV herein constitutes "treatment" under the Act. No special category is needed.

74. Having said that, the decision to terminate life support has special significance; and not all treatments are the same: some (*e.g.*, surgery or drugs) involve a physician's judgment as to their usefulness. It is not a matter of medical judgment that people need food, water and air.

75. Sometimes, a medical apparatus is required to assist a patient in receiving food, water or air. It takes no medical judgment to conclude that (1) the supply of these necessities will benefit the patient and (2) a withdrawal of these necessities by terminating mechanical assistance, as with MV or intravenous or feeding tubes, will affect the patient's health condition negatively by leading imminently to death.

76. Basic necessities of life are inherently good. The question is not whether such

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[79] Reasons of the Court of Appeal, paras. 29-32, 60-62, 64, Record of the Appellants, Vol. 1 of 4, pp. 50, 61-62. A particular form of non-indicated treatment withheld by physicians is not "treatment" withheld under a "plan of treatment", unless at one point it was "developed by one or more health practitioners"; see s. 2(1) of the Act. Moreover, a physician can obtain a quick determination from the CCB. It is the "legislature's will ... involv[ing] policy considerations that come within the legislature's purview" (para. 60) to have made patient autonomy and prior capable wishes paramount. If problems do arise, it is for the legislature to "review the situation" (para. 64). However, "the process seems to have worked well since the Act came into existence, some 15 years ago" (para. 62).

artificial supply is futile, if it is effective, but whether the patient's life is worth sustaining with those necessities. This is *not* a matter of medical judgment.

77. The Appellants' complaints about the CCB regime[80] are for the Ontario legislature's consideration.[81] If the statutory regime can be improved, it should be. Until then, a world of successful physician ultimatums on the one hand, and costly and lengthy court proceedings on the other, would harm patients.[82]

The *Health Care Consent Act, 1996* ("the Act")

78. The objectives of the Act are:

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[80] Factum of the Appellants, paras. 96, 100-03, pp. 34-37.

[81] Reasons of the Court of Appeal, paras. 60, 64, Record of the Appellants, Vol. 1 of 4, Tab 5, pp. 61-62.

[82] Patrick Moore, "An End-of-Life Quandary in Need of a Statutory Response: When Patients Demand Life-Sustaining Treatment That Physicians are Unwilling to Provide," 48 *Boston College Law Review* (2007) 433-69, pp. 446-47, 453-54, 457-60, 462-63, 466-76, Respondent's Authorities, Tab 13. There is another matter to consider. The Act both defines "treatment" and establishes the SDM hierarchy of persons with legal authority to consent to "treatment"; the SDM role is linked to the definition of "treatment". Holding that the withdrawal or withholding of life-sustaining treatment is not "treatment" under the Act should lead to the conclusion that physicians cannot obtain "consent" for such decisions through the Act. This would return physicians to the problems exemplified by, but not limited to, what has come to be known as the Daughter from California Syndrome. For all patients who did not sign a power of attorney for personal care, physicians will have to either treat each and every family member as having a veto or listen to none of them. The latter is the only safe course even when all family members agree, since none have legal authority to "consent" to treatment decisions, necessitating court applications of the kind seen in *Bland*. This Daughter from California Syndrome is one of the problems that the Act addressed. Section 1(b) of the Act states that one of the Act's objectives is to facilitate treatment for persons lacking capacity to make treatment decisions. The SDM hierarchy solves problems for physicians. Although the Appellants say they do not need patient/SDM "consent" to withdraw MV in the Respondent's case and evidently they do not care to obtain it, consideration must be had for all the physicians who would disagree and are glad that they know just who they have to obtain that consent from. The statutory regime also grants physicians who do not think like the Appellants the legal protection at s. 29(3) of the Act. If the withdrawal or withholding of life-sustaining treatment is outside of the Act, s. 29(3) of the Act will not be available to physicians for this step, since they cannot "in good faith" think that, in relation to that step, statutory SDMs exist at all. Appropriately cautious physicians will bring a court application, on notice to the Ontario Public Guardian and Trustee (PGT), in every case. Meanwhile, according to section 1(f), one of the Act's objectives is to permit the PGT's intervention "only as a last resort". Consideration must be given, too, to the fact that, most of the time, SDMs consent either readily or eventually to what physicians recommend. So the system is efficient. Physicians cannot have the benefits of the Act without the burdens. Even when consent is refused, many physicians gladly resort to the CCB to quickly determine the dispute (see para. 103 herein). The alternative is either court applications in every case or physicians acting unilaterally and without legal protection, thus undermining patient autonomy, which as per s. 1(c), the Act intends to enhance.

(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.[83]

79. The Act defines "plan of treatment" as a plan that deals with one or more of the health problems a person has or is likely to have in the future and 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.[84]

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[83] *Health Care Consent Act, 1996*, s. 1.

[84] *Health Care Consent Act, 1996*, s. 2(1).

80. The inclusion of "the withholding or withdrawal of treatment" is consistent with the Act's stated objective in s. 1 to cover all settings. It is also consistent with the common sense view that treatment is not limited to the application of care but is more broadly about the *management* of health conditions and can include medical restrictions.[85]

81. The Ontario *Legislation Act, 2006*, provides that a statute shall be interpreted as being remedial and shall be given such fair, large and liberal interpretation as best ensures the attainment of its objects.[86]

82. The Act should not be parsed as a taxation statute.

83. Any ambiguity should be resolved in favour of the wholly vulnerable person.

84. The Act defines "treatment" broadly and non-exclusively as "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" (italics added).[87]

85. As Justice Himel noted, the definition is circular.[88] This makes the definition as broad as possible. Effectively, "treatment" is statutorily defined as *what, for health-related reasons, a physician thinks should happen next.*

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[85] As such, it would include orders prohibiting treatment that would otherwise be provided by default or be implied. See, in this regard, Cuthbertson Affidavit, para. 54, Record of the Appellants, Vol. 1 of 4, Tab 11, p. 95.
[86] *Legislation Act, 2006*, S.O. 2006, c. 21, s. 64(1), Schedule "B" herein.
[87] *Health Care Consent Act, 1996*, s. 2(1).
[88] Reasons of Justice Himel, para. 29, Record of the Appellants, Vol. 1 of 4, Tab 2, p. 8.

86. The Appellants say that what should happen next is that MV should be withdrawn *and* "high quality" palliative care should start.[89]

87. It is in view of the Respondent's "current health condition," as it was before the MCS diagnosis, and in order to avoid the further slow deterioration that is anticipated, possible infections, *etc.*,[90] that the Appellants say it is in the Respondent's *medical* best interest that MV be withdrawn and palliative care start. It follows that the Appellants propose to withdraw MV and to start palliative care for a "health-related purpose". This qualifies as "treatment" under the Act.

88. Section 10(1)(b) of Act provides that a health practitioner who proposes a treatment for an incapable person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless he or she has obtained his or her statutory SDM's consent on the patient's behalf in accordance with the Act. The list of SDMs is found at s. 20 of the Act.[91]

89. *Significant changes* to ongoing treatment (and the changes proposed herein are significant) can only be implemented with patient/SDM consent.[92]

90. Sections 25 and 27 of the Act allow for treatment without consent if there is a medical emergency.

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[89] See note 44.

[90] Cuthbertson Affidavit, paras. 5-7, Record of the Appellants, Vol. 1 of 4, Tab 11, pp. 85-86; and Swartz Affidavit, paras. 13, 27-30, Record of the Appellants, Vol. 3 of 4, pp. 65, 69.

[91] *Health Care Consent Act, 1996*, ss. 10(1)(b) and 20.

[92] Section 12 of the Act deals with implied/presumed consent to minor/inconsequential changes.

91. Consistent with the fact that patient autonomy is paramount, the Act provides that statutory SDMs shall give or refuse consent to a treatment in accordance with any known prior capable wish and, only in the event that no prior capable wish is known, then, in accordance with the incapable person's best interests, as defined by the statute.[93]

92. With respect to "best interests," the Act requires statutory SDMs to consider:

(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.[94]

93. This is the proper language of end-of-life decision making.

94. This comprehensive matrix of considerations sets up a decision-making process that

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[93] *Health Care Consent Act, 1996*, s. 21(1). There is, however, limited authority for the CCB to permit consent to treatment that departs from a prior capable wish: s. 36(3) of the Act.

[94] *Health Care Consent Act, 1996,* s. 21(2).

is not static but rather is in constant flux as the patient's situation either changes or fails to change.

95. The Act demands consideration of the patient's values, beliefs and prior capable wishes in ascertaining a patient's "best interests". The equation is not limited to clinical matters.

96. The Act does not limit "treatment" to that which seeks to cure, improve or reverse the patient's underlying illness. SDMs must consider whether "treatment" might slow down a condition's deterioration. Without MV the Respondent would promptly die.[95]

97. The definition of "treatment" itself, at sub-paras. 2(1)(a)-(h), specifies the eight circumstances that are not included within the definition "treatment" despite said definition. Moreover, s. 3 of the Act contains the definition of an "excluded act".[96]

98. The legislature could have easily excluded from the Act the consent requirement where physicians propose to terminate life support. Instead, the definition of treatment in s. 2(1) expressly includes palliative care. Nothing indicates that the Act is not intended to cover patients in PVS, as if the legislature failed to consider that a patient may be incapable/unconscious for some time. There would be no merit to bouncing patients from the CCB upon injury and for some time after, to court when unconscious for "too long", then back to the CCB over palliative care.[97]

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[95] See Swartz Affidavit, para. 14, Record of Appellants, Vol. 3 of 4, Tab 12, p. 65.

[96] *Health Care Consent Act, 1996*, definition of "treatment" in s. 2(1) and s. 3.

[97] The Act survived a constitutional challenge in *M. (A.)* v. *Benes*, Appellants' Authorities, Tab 17, because counsel for the Attorney General for Ontario submitted that the government had delegated to physicians the task of ensuring that SDMs understood their role and the s. 21 criteria that ought to guide their decision to grant or refuse consent on behalf of a patient, and that said delegation was implied by s. 10(1)(b) of the Act. It would be odd if the legislature intended that such guidance/legal advice from physicians could go from pointing to s. 21 of the Act and the

99. The Act provides a comprehensive and quick mechanism for physicians to obtain a determination from the CCB as to whether an SDM is complying with s. 21(1) of the Act—*i.e.*, providing or refusing consent to proposed "treatment" in accordance with any known applicable prior capable wish, or if there is no such wish, then in accordance with the patient's "best interests". The CCB may substitute its opinion for that of the SDM and give directions which, if not followed by a set deadline, can result in the substitution of the SDM as statutory SDM.[98]

100. A party to a proceeding before the CCB may appeal the Board's decision to the Superior Court on a question of law or fact or both. That appeal is subject to strict timelines.[99]

101. Yet, the Superior Court of Ontario is to give deference to the CCB's findings of fact or mixed law and fact, including what is in a patient's best interests for the purposes of s. 21(2). The CCB is considered to have special expertise that is not possessed by a judge hearing an appeal. In consequence, the legislature has entrusted to the CCB, and not to the court, the task of deciding, at first instance, whether an SDM is complying with s. 21(1) of the Act. The court should not interfere with the CCB's decision unless it is unreasonable in light of the findings of fact on which it is based or dependent on an incorrect determination of a question of law.[100]

The Consent and Capacity Board ("CCB")

102. The CCB is the proper forum to decide what should be done in the Respondent's

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important role played by the CCB, to rejecting the SDM role and the CCB's jurisdiction, from one day to the next.

[98] *Health Care Consent Act, 1996,* ss. 37 and 75.

[99] *Health Care Consent Act, 1996*, s. 80.

[100] *Scardoni* v. *Hawryluck*, note 49, paras. 34-35, Respondent's Authorities, Tab 5.

best interests. As the Court of Appeal for Ontario stated in *M. (A.)* v. *Benes*:

> A case will come before the Board only when the health practitioner disagrees with the S.D.M.'s application of the best interests test under s. 21(2). The Board will then have before it two parties who disagree about the application of s. 21: the S.D.M., who may have better knowledge than the health practitioner about the incapable person's values, beliefs and non-binding wishes; and the health practitioner, who is the expert on the likely medical outcomes of the proposed treatment. The disagreement between the S.D.M. and the health practitioner potentially creates tension and the Act recognizes this by providing for a neutral expert Board to resolve the disagreement. Indeed, after hearing submissions from all parties, the Board is likely better placed than either the S.D.M. or the health practitioner to decide what is in the incapable person's best interests. Thus, the Board should not be required to accord any deference to the S.D.M.'s decision.[101]

103. Physicians have been going to the CCB with thorny end-of-life issues since the Act was instituted 16 years ago. Justice Himel set out six instances of physicians resorting to the CCB under s. 37 of the Act over SDM withholding of consent to their proposed termination of life support and DNR orders. Justice Himel called this step "the current practice of many doctors".[102] The Appellants' book of authorities contains another five such instances.[103] The Court of Appeal considers that the CCB regime "seems to have worked well".[104] There is no evidence that the CCB has not been dealing with the issues at play in this case satisfactorily, much less in a way that judicial review cannot resolve.

104. The Appellants say that going to the CCB is, for physicians, purely optional. Justice Himel was correct to reject this.[105]

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[101] (1999), 46 O.R. (3d) 271, para. 46, 180 D.L.R. (4th) 72 (C.A.), Respondent's Authorities, Tab 17.

[102] Reasons of Justice Himel, para. 50, Record of the Appellants, Vol. 1 of 4, Tab 2, p. 14.

[103] See Tabs 35 and 39 (being CCB decisions) and Tabs 36, 37, 38 (being appeals of CCB decisions).

[104] Reasons of the Court of Appeal, para. 62, Record of the Appellants, Vol. 1 of 4, Tab 5, p. 62.

[105] Reasons of Justice Himel, paras. 36-37, Record of the Appellants, Vol. 1 of 4, Tab 2, p. 10.

105. Justice Cullity's *obiter* comments in the leading Ontario decision prior to this case, *Scardoni* v. *Hawryluck*, speak strongly in favour of concluding that the CCB has first-instance jurisdiction in these circumstances.[106]

106. There is a public interest aspect. Patients, patients' families and the public at large are entitled to reassurance that physicians are not hastening their patients' preventable death without consent or oversight.[107]

The *Bland* decision and the Common Law

107. If the Act does not apply, the Respondent is protected by the common law.

108. The Appellants argue that, at common law, they can unilaterally decide not to start MV, if it is futile, so they can withdraw MV unilaterally on the same basis. Further, although English courts established a practice to require that physicians bring a court application to withdraw life-sustaining treatment (even if the patient is in PVS and family members agree with the recommendation[108]), the court is to defer to the expert. The law of consent is not engaged. Physicians are accountable for breaches of the standard of care. The Appellants rely on the *Bland* decision and those cases that purport to follow it.

109. Respectfully, *Bland* does not stand for these propositions and the English authorities

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[106] *Scardoni* v. *Hawryluck,* note 49, paras. 40, 42, 44, Respondent's Authorities, Tab 5.

[107] *Sawatzky* v. *Riverview Health Centre Inc.* (1998), 167 D.L.R. (4th) 359 at 370-72, 26 C.P.C. (4th) 156, 132 Man. R. (2d) 222 (Q.B.), Respondent's Authorities, Tab 14.

[108] As was the case in *Airedale NHS Trust* v. *Bland*, [1993] A.C. 789 (H.L.) ("*Bland*"), Appellants' Authorities, Tab 8. See also Series of Practice Notes, note 47, p. 1, para. 1, Respondents' Authorities, Tab 4.

do not undermine the consent requirement. Rather, as a result of a peculiar situation in England, following the statutory elimination of the court's *parens patriae* jurisdiction over incapable adults, the court was unable to say in *Bland* that it could provide consent to the physicians' proposal to withdraw life-sustaining treatment on behalf of the incapable patient. Thus, in England, the incapable person was in a position where medical treatment that might be readily consented to could not be consented to by any authorized next of kin or even the court.[109]

110. As a result, the court held that physicians could rely on the principle of necessity to act unilaterally. This was done as a matter of public policy and in patients' best interests as the only way they could receive necessary treatment. This applied to incapable adults only.

111. With children, for whom the court's *parens patriae* jurisdiction had not been abrogated, the law remained that physicians (if they did not have consent from a parent/guardian) had to obtain the court's "consent" to treat.[110] This would have been the requirement with

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[109] Mr. Bland had been in PVS for almost four years and his family agreed with the physicians that life-sustaining treatment be withdrawn (see *Bland*, pp. 789D-E, Appellants' Authorities, Tab 8); but in the absence of an SDM statutory regime, it was not for any family member to "consent". In many of the cases on which the Appellants rely as representing the common law, the patient's family has not opposed withdrawal, which may explain the court's deferential language, in some decisions, to the medical profession. The seminal decision of Thomas J., in *Auckland Area Health Board* v. *Attorney General*, [1993] 1 NZLR 235, Appellants' Authorities, Tab 17, referred to favourably in *Bland* (pp. 867A, 896B, Appellants' Authorities, Tab 8) made it a *requirement* that, before life-sustaining treatment is withdrawn, "the patient's family or guardian must be fully informed and freely concur in what is proposed" (p. 15). Subsequently, *Shortland* v. *Northland Health Ltd.*, Appellants' Authorities, Tab 10, accepted that this "may [be] appropriate in the context of the proposed removal of a life-support system" (p. 8). The latter decision noted that the requirement presents difficulties "in deciding who should be included as members of the patient's family" (p. 8). That is not a significant problem where the legislature has established a consent hierarchy.

[110] See, for example, *Re J (a minor) (wardship: medical treatment)* [1992] 4 All ER 614, Appellants' Authorities, Tab 13. Thus, even prior to the *Mental Capacity Act, 2005*, in the absence of consent from either the child's parent(s) or the court, a physician could not treat a child. There was an impasse—and for better or worse, the *status quo* continued. The impasse is seen in Lord Donaldson's comments from prior cases, which he repeated in *Re J (a minor)* (p. 623B-F) to the effect that: doctors cannot "dictate" the treatment to be given to a child, since "[t]he court or parents ... can refuse to consent"; there are "checks and balances" leading to the "desirable result" that treatment is "in some measure a joint decision of the doctors and the court or parents"; doctors' function is "not limited to a

incapable adults also, but for the apparently unintended consequences of legislative action.

112. In *Bland*, Lord Goff stated that the House of Lords in *In re F. (Mental Patient Sterilisation)* [1990] 2 AC 1 "came reluctantly to the conclusion" that the court did not have jurisdiction over incapable adults.[111] But, a practice direction was established requiring physicians to apply to the court, not for "consent" but for a *declaration of lawfulness* regarding the proposed step. Lord Goff called this "the present requirement" (p. 874E).[112]

113. Also in *Bland*, Lord Lowry stated he "never heard a rational, or indeed any, explanation" regarding why the state/the court's *parens patriae* jurisdiction over incapable adults was abolished by statute, and stated he "sincerely hope[d]" that the jurisdiction would soon be restored, as the absence of that jurisdiction was "most unfortunate". Lord Lowry lamented that a physician proposing to withdraw treatment "will be judge in his own cause" (p. 875E-H).

114. Lord Brown-Wilkinson provided further detail as to how the statutory abolishment

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technical one of repairing or servicing a body", so the court or parents can contribute "towards reaching the best possible solution"; and a doctor cannot treat a child without the "threshold requirement" of consent (in the absence of an emergency). The impasse is clear in *In re R. (a minor) (wardship: consent to treatment)* [1991] 3 WLR 592, Appellants' Authorities, Tab 6, where Lord Donaldson stated: "There can be concurrent powers to consent. If more than one body or person has a power to consent, only a failure to, or refusal of, consent by all having that power will create a veto" (p. 603). Thus, normally, where neither parent consented, until the court consented, there was nothing the physician could do. Notably, *Re J (a minor)* at Appellants' Authorities, Tab 13, involved the potential withdrawal of mechanical ventilation. The appeal court set aside an overly broad order made below, but did not go as far as permitting (unilateral) withdrawal; the "threshold requirement" of consent remained in play. See also *Bland*, Appellants' Authorities, Tab 8, p. 883A-B.

[111] *Bland*, Appellants' Authorities, Tab 8, p. 862E.

[112] *Ibid.*, p. 794F-G. See also Series of Practice Notes, note 47, Respondent's Authorities, Tab 4. Later, in *In re S*, note 47, Respondent's Authorities, Tab 3, Thorpe LJ stated that there was no difference between the court exercising its (inadvertently lost) *parens patriae* jurisdiction to "consent" on behalf of the patient and its inherent jurisdiction to make declarations, since the court was to make the decision on the same basis, *i.e.*, the (required) declaration would be refused if the welfare or best interests of the patient did not require that it be granted (pp. 29-30).

occurred (p. 883A-C). He noted that this abolishment has been suggested to be an accident but the result was that the court had "no power on Anthony Bland's behalf either to consent or refuse consent" (p. 883D). Thus, it was the "lacuna in the law" (p. 883D) that forced the court's conclusion based on concepts of necessity (*i.e.*, because the court had to find a way to permit the physician to provide necessary care without committing battery, or worse) that the physician could act without anyone's consent, subject to the practice direction above. Lord Brown-Wilkinson (p. 885E) also stated that he hoped for Parliamentary review of the situation.

115. Hence, the common law has never seen the termination of life support as something that physicians can do unilaterally, based simply on the argument that to *withdraw* (futile) treatment is not "treatment" and therefore there is nothing requiring consent. *Bland* confirmed what was known: that a physician must treat when there is no possible way to obtain consent. *Bland* did not designate the termination of life support a physician's prerogative. To the contrary, physicians were required to obtain a court declaration that taking that step would be lawful.

116. In Canada, the court's *parens patriae* jurisdiction over incapable adults has not been abrogated by statue. Hastening the preventable death of a totally vulnerable citizen engages that jurisdiction, if the Act does not apply. And since the court is *able to* "consent" to treatment on behalf of incapable patients, it would follow that the court's consent *must* be obtained. In other words, because court approval can be obtained and the medical situation is not, truly, one of emergency, it is not necessary to conclude that, in the best interests of patients, physicians can

resort to the principle of necessity to act unilaterally.[113]

117. Further, in *Bland* Lord Goff stated that the "substituted judgment" test "adopted in most American courts"—pursuant to which the court determines, if it can, and follows the choice that the patient would have made as to whether or not life-sustaining treatment should be terminated, and which "generally involves a detailed inquiry into the patient's views and preferences"—is not "part of English law in relation to incompetent adults, on whose behalf nobody has power to give consent to medical treatment" (871H-872B). It seems Lord Goff rejected the "substituted judgment" test at least in part because the court was not consenting *on behalf of* Mr. Bland since, further to a legislative accident, the court had no jurisdiction to do so.

118. The substituted judgment doctrine that is prevalent in the United States is *a part* of Ontario's approach to thorny end-of-life issues. This is consistent with *Charter* values.

119. The Act makes patient autonomy and prior capable wishes paramount; and a patient's values, beliefs and non-applicable prior capable wishes must be considered, absent an

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[113] A leading decision from Australia, *Northridge* v. *Central Sydney Health Service*, [2000] NSWSC 1241, paras. 15, 20, 22, 24, 109, 112, 125, Respondent's Authorities, Tab 15, relying in part on *Re Eve* (1986) 31 DLR (4th) 1 at 34 (S.C.C.), is instructive. *Northridge* confirms the court's *parens patriae* jurisdiction to prevent the withdrawal of life-sustaining treatment and states that such a step "will in virtually all cases require the sanction of a High Court judge," which requirement is "a clear recognition of the right of unconscious patients to have their right to life protected by the full power of the law". Although the Court of Appeal below stated that it was prepared to accept for the purposes of its decision that *the Act* (para. 46) does not require consent to withhold or withdraw non-indicated treatment, all that follows from this is that such a proposal does not necessarily go to the CCB for review. The Court of Appeal did not hold that physicians can terminate life support unilaterally. The Court of Appeal explicitly expressed no views on the common law or the *Charter* (para. 36) or the court's *parens patriae* jurisdiction. The Reasons of the Court of Appeal therefore say little about how an Ontario court would receive a physician's proposal to terminate life support without patient/SDM consent (or rather, over the objection of any close family member; see note 82). The Court of Appeal below was confident that, pursuant to its "integrally linked" and "treatment package" analysis (paras. 49-52), this case had to go to the CCB.

applicable prior capable wish. *Sub-section 21(1) of the Act is a mix of the "substituted judgment" and "best interests" tests.* As per s. 1(c)(iii) of the Act, in this way, the autonomy of persons for whom treatment is proposed is enhanced.

120. Normally, SDMs are in a better position than physicians to know, understand and weigh patients' values, beliefs and prior capable wishes—indeed, all non-medical considerations. The "substituted judgment" doctrine is incompatible with unilateral decisions by physicians.

121. The establishment of a mostly family-based SDM hierarchy inclines towards the substitute judgment doctrine. The "best interests" test in the Act is only applied when the "substitute judgment" test is not determinative; and when it is not, the patient's personality remains highly relevant. England has no such history with an SDM hierarchy; there, a paternalistic and impersonal "best interests" test has always been the only test.

122. It bears mention that Lords Lowry and Brown-Wilkinson got their wish. The *Mental Capacity Act, 2005* ("the *MCA*"), which came into force October 1, 2007, created the Court of Protection, with powers analogous to the CCB. Now, in England, by statute where there is any doubt or a dispute between physicians and family members as to whether withholding or withdrawing life-sustaining treatment is in a patient's best interests, an application must be made to the Court of Protection for a decision. There are no exceptions.[114]

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[114] See *W* v. *M*, note 46, para. 82, Respondent's Authorities, Tab 2. The Appellants rely on the General Medical Council's practice guideline, *Treatment and care towards the end of life: good practice in decision making*, Appellants' Authorities, Tab 30, where p. 19, sub-para. 16(i) and p. 65, para. 141, provide that a physician is "not obliged to" offer or provide medically non-indicated treatment. This means only that the physician is not obliged, on her own, to "cave in" and provide whatever a patient's proxy requests. It does not mean that, further, the physician

The Important Elements of Autonomy and Dignity

123. Clinical judgment is not an end in itself. The exercise of that judgment is geared towards the patient's best interests, while respecting his or her autonomy. A patient has the right to reject good medical advice. Even unquestionably sound clinical judgment is not a sufficient condition precedent for proceeding without consent.

124. Both the Act[115] and the common law should be interpreted in a manner that is consistent with *Charter* values. The Respondent's or his SDM's ability to make decisions and accept the consequences is central to autonomy, dignity and self-respect as a human being. There is no reason to suspect that the Act did not intend to protect patient autonomy and dignity near the end of life, as well as security of the person.

125. If the Act does not apply, the court's *parens patriae* jurisdiction necessarily engages in these circumstances to protect security of the person, autonomy and dignity.[116]

126. To withdraw MV without consent, or an order of a tribunal or court, is unlawful.

A Degree of Consciousness Can Be Sufficient To Make Preserving Life a "Decisive Factor"

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can proceed to do what *she* thinks is best without first getting an order from the Court of Protection. See that p. 66, para. 142 takes the physician back to p. 30, para. 48. Thus, in England, things are back to normal. After what was apparently a legislative accident (and correction), incapable adults (1) are, like children (see note 110), in a "checks and balances" impasse and (2) have a robust "shield" against unilateral physician termination of life support.

[115] Reasons of the Court of Appeal, para. 36, Record of the Appellants, Vol. 1 of 4, Tab 5.

[116] See note 113. See also Jocelyn Downie, "Unilateral Withholding and Withdrawal of Potentially Life-Sustaining Treatment: a Violation of Dignity Under the Law in Canada" (Autumn 2004) 20:3, *Journal of Palliative Care*, pp. 143-49, Respondent's Authorities, Tab 16.

127. In *W (brought by her litigation friend B)* v. *M*[117] ("*W* v. *M*"), the Court of Protection, *per* Justice Baker, considered an application under the *MCA*. *W* v. *M* considered whether life-sustaining treatment should be withdrawn from a patient who was in MCS, not (P)VS.

128. The Law Lords in *Bland* held that physicians could withdraw life-sustaining treatment from a patient in PVS. According to Lord Goff, the main principles at play were:

(a) the sanctity of life is fundamental;

(b) that principle is not, however, absolute and may yield in certain circumstances, for example, to the principle of self-determination;

(c) a decision whether life-sustaining treatment should be initiated or withdrawn must be determined by what is in the best interests of the patient;

(d) in the majority of cases the best interests of the patient were likely to require that treatment be given;

(e) there was a category of case in which the decision whether to withhold treatment would be made by weighing up relevant and competing considerations; but

(f) such an approach was inappropriate in the case of Anthony Bland as the treatment had no therapeutic purpose and was futile because he was unconscious and had no prospects of recovery.[118]

129. Justice Baker upheld the principles above but found "… no rationale for extending the approach … to non-VS cases".[119] MCS cases must undergo a "balance sheet" analysis: the (dis)advantages of withdrawing life-sustaining treatment must be weighed against the

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[117] [2011] EWHC 2443, Respondent's Authorities, Tab 2.

[118] As summarized by Justice Baker in *W* v. *M*, para. 65, Respondent's Authorities, Tab 2. As already seen, however, PVS is not irreversible; moreover, there is a high possibility of misdiagnosis. Indeed, in *W* v. *M* itself, the patient was in PVS for "several years". In the process of family members and physicians jointly seeking court approval to terminate life support, the patient was found to be in MCS (paras. 2-3, 47-48).

[119] *W* v. *M,* note 46, para. 102, Respondent's Authorities, Tab 2.

(dis)advantages of continuing same. The exercise is not limited to medical considerations.[120]

130. The standard "balance sheet" exercise[121] proves the irrelevance of medical negligence or "standard of care" as the test.

131. Justice Baker found that "the importance of preserving life is the *decisive factor* in this case" (emphasis added). In *W* v. *M*, withholding artificial nutrition and hydration ("ANH") was not in the patient's best interests.[122]

132. Hassan Rasouli is in MCS. To withdraw MV is contrary to his best interests, either under s. 21(2) of the Act or (if the Act does not apply) pursuant to the balancing of interests required at common law.

PART V – ORDER SOUGHT

133. Hassan Rasouli requests that this appeal be dismissed with costs.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

Date: July 10, 2012

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J. Gardner Hodder
Guillermo Schible
Stefan A. De Smit

Lawyers for the Respondent

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[120] See note 77.

[121] *An NHS Trust* v. *MB*, paras. 58, 62, note 73, Respondent's Authorities, Tab 11.

[122] *W* v. *M,* note 46, paras. 220-22, 249, 252, Respondent's Authorities, Tab 2.

SCHEDULE A – TABLE OF AUTHORITIES

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2. *W (brought by her litigation friend B)* v. *M.* [2011] EWHC 2443 (Fam), paras. 2-3, 47-48, 65, 71, 82, 102, 220-22, 249, 252.

3. *In re S (Adult Patient: Sterilisation)*, [2001] Fam. 15 (Eng. C.A.), pp. 27-30.

4. Series of Practice Notes, [1994] 2 All ER 413, [1996] 4 All ER 766, [2001] 2 FLR 158, and [2006] 2 FLR 373, p. 1, 12, 14.

5. *Scardoni* v. *Hawryluck* (2004), 69 O.R. (3d) 700, 12 Admin. L.R. (4th) 67, 5 E.T.R. (3d) 226 (S.C.J.), paras. 34-35, 40, 42, 44.

6. *Findlay (Re)*, Reasons for Decision of the Discipline Committee of the College of Physicians and Surgeons of Ontario, dated November 4, 2002.

7. François Baylis, "Expert Testimony by Persons Trained in Ethical Reasoning: The Case of Andrew Sawatzky," *Journal of Law, Medicine & Ethics* (2000): 224-31.

8. Bernard M. Dickens, "Medically Assisted Death: Nancy B. v. Hôtel-Dieu de Québec" (1993), 38 *McGill L.J.* 1053 at 1066.

9. Paul R. Helft, Siegler M., Lantos J., "The Rise and Fall of the Futility Movement," 343 *New England Journal of Medicine* (2000) 293-96.

10. Jocelyn Downie & Karen McEwen, "The Manitoba College of Physicians and Surgeons Position Statement of Withholding and Withdrawal of Life-Sustaining Treatment (2008): Three Problems and a Solution," *Health Law Journal*, Vol. 17 (2009): 116-37 at 116-17.

11. *An NHS Trust* v. *MB* [2006] EWHC 507 (Fam), paras. 25-26, 29-30, 58, 62, 77-83, 87, 89-90, 94-95, 100-05.

12. *Sweiss* v. *Alberta* (2009), 314 D.L.R. (4th) 474, 15 Alta. L.R. (5th) 283 (Q.B.), paras. 63-65, 68.

SCHEDULE A – TABLE OF AUTHORITIES

13. Patrick Moore, "An End-of-Life Quandary in Need of a Statutory Response: When Patients Demand Life-Sustaining Treatment That Physicians are Unwilling to Provide," 48 *Boston College Law Review* (2007) 433-69 at pp. 446-47, 453-54, 457-60, 462-63, 466-76.

14. *Sawatzky* v. *Riverview Health Centre Inc.* (1998), 167 D.L.R. (4th) 359 at 370-72, 26 C.P.C. (4th) 156, 132 Man. R. (2d) 222 (Q.B.).

15. *Northridge* v. *Central Sydney Health Service*, [2000] NSWSC 1241, paras. 15, 20, 22, 24, 109, 112, 125.

16. Jocelyn Downie, "Unilateral Withholding and Withdrawal of Potentially Life-Sustaining Treatment: a Violation of Dignity Under the Law in Canada" (Autumn 2004) 20:3, *Journal of Palliative Care*, pp. 143-49.

17. *M. (A.)* v. *Benes* (1999), 46 O.R. (3d) 271, 180 D.L.R. (4th) 72, paras. 18, 21-23, 46 (C.A.).

18. Council on Ethical and Judicial Affairs, American Medical Association, "Medical Futility in End-of-Life Care," *Journal of the American Medical Association* (1999: 281:10) 937-41.

SCHEDULE B - LEGISLATION

Legislation Act, 2006, S.O. 2006, c. 21, s. 64(1).

Rule of liberal interpretation
64. (1) An Act shall be interpreted as being remedial and shall be given such fair, large and liberal interpretation as best ensures the attainment of its objects. 2006, c. 21, Sched. F, s. 64 (1).

Health Care Consent Act, R.S.O. 1996, c. 2, Sch. A

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. 1996, c. 2, Sched. A, s. 1.

Interpretation
2. (1) In this Act,

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

"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") 1996, c. 2, Sched. A, s. 2 (1); 2000, c. 9, s. 31; 2007, c. 8, s. 207 (1); 2009, c. 26, s. 10 (1); 2009, c. 33, Sched. 18, s. 10 (1).

Meaning of "excluded act"
3. (1) In this section,

"excluded act" means,
(a) anything described in clause (b) or (g) of the definition of "treatment" in subsection 2 (1), or
(b) anything described in clause (h) of the definition of "treatment" in subsection 2 (1) and prescribed by the regulations as an excluded act. 1996, c. 2, Sched. A, s. 3 (1).

No treatment without consent
10. (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not

administered, unless,

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

(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).

Included consent

12. Unless it is not reasonable to do so in the circumstances, a health practitioner is entitled to presume that consent to a treatment includes,

(a) consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different from the nature, expected benefits, material risks and material side effects of the original treatment; and

(b) consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered. 1996, c. 2, Sched. A, s. 12.

Plan of treatment

13. If a plan of treatment is to be proposed for a person, one health practitioner may, on behalf of all the health practitioners involved in the plan of treatment,

(a) propose the plan of treatment;

(b) determine the person's capacity with respect to the treatments referred to in the plan of treatment; and

(c) obtain a consent or refusal of consent in accordance with this Act,

(i) from the person, concerning the treatments with respect to which the person is found to be capable, and

(ii) from the person's substitute decision-maker, concerning the treatments with respect to which the person is found to be incapable. 1996, c. 2, Sched. A, s. 13.

Order authorizing treatment pending appeal

19. (1) If an appeal is taken from a Board or court decision that has the effect of authorizing a person to consent to a treatment, the treatment may be administered before the final disposition of the appeal, despite section 18, if the court to which the appeal is taken so orders and the consent is given. 1996, c. 2, Sched. A, s. 19 (1).

Consent

List of persons who may give or refuse consent

20. (1) If a person is incapable with respect to a treatment, consent may be

given or refused on his or her behalf by a person described in one of the following paragraphs:

1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.
2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent to the treatment.
3. The incapable person's representative appointed by the Board under section 33, if the representative has authority to give or refuse consent to the treatment.
4. The incapable person's spouse or partner.
5. A child or parent of the incapable person, or a children's aid society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to the treatment in the place of the parent, this paragraph does not include the parent.
6. A parent of the incapable person who has only a right of access.
7. A brother or sister of the incapable person.
8. Any other relative of the incapable person. 1996, c. 2, Sched. A, s. 20 (1).

Requirements

(2) A person described in subsection (1) may give or refuse consent only if he or she,

(a) is capable with respect to the treatment;

(b) is at least 16 years old, unless he or she is the incapable person's parent;

(c) is not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf;

(d) is available; and

(e) is willing to assume the responsibility of giving or refusing consent. 1996, c. 2, Sched. A, s. 20 (2).

Ranking

(3) A person described in a paragraph of subsection (1) may give or refuse consent only if no person described in an earlier paragraph meets the requirements of subsection (2). 1996, c. 2, Sched. A, s. 20 (3).

Same

(4) Despite subsection (3), a person described in a paragraph of subsection (1) who is present or has otherwise been contacted may give or refuse consent if he or she believes that no other person described in an earlier paragraph or the

same paragraph exists, or that although such a person exists, the person is not a person described in paragraph 1, 2 or 3 and would not object to him or her making the decision. 1996, c. 2, Sched. A, s. 20 (4).

No person in subs. (1) to make decision
(5) If no person described in subsection (1) meets the requirements of subsection (2), the Public Guardian and Trustee shall make the decision to give or refuse consent. 1996, c. 2, Sched. A, s. 20 (5).

Conflict between persons in same paragraph
(6) If two or more persons who are described in the same paragraph of subsection (1) and who meet the requirements of subsection (2) disagree about whether to give or refuse consent, and if their claims rank ahead of all others, the Public Guardian and Trustee shall make the decision in their stead. 1996, c. 2, Sched. A, s. 20 (6).

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. 1996, c. 2, Sched. A, s. 21 (1).

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. 1996, c. 2, Sched. A, s. 21 (2).

Emergency treatment

Meaning of "emergency"

25. (1) For the purpose of this section and section 27, there is an emergency if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm. 1996, c. 2, Sched. A, s. 25 (1).

Emergency treatment without consent: incapable person

(2) Despite section 10, a treatment may be administered without consent to a person who is incapable with respect to the treatment, if, in the opinion of the health practitioner proposing the treatment,

(a) there is an emergency; and

(b) the delay required to obtain a consent or refusal on the person's behalf will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm. 1996, c. 2, Sched. A, s. 25 (2).

Continuing treatment

(6) Treatment under subsection (2) may be continued only for as long as is reasonably necessary to find the incapable person's substitute decision-maker and to obtain from him or her a consent, or refusal of consent, to the continuation of the treatment. 1996, c. 2, Sched. A, s. 25 (6).

Return of capacity

(9) If, after a treatment is begun under subsection (2), the person becomes capable with respect to the treatment in the opinion of the health practitioner, the person's own decision to give or refuse consent to the continuation of the treatment governs. 1996, c. 2, Sched. A, s. 25 (9).

No treatment contrary to wishes

26. A health practitioner shall not administer a treatment under section 25 if the health practitioner has reasonable grounds to believe that the person, while capable and after attaining 16 years of age, expressed a wish applicable to the circumstances to refuse consent to the treatment. 1996, c. 2, Sched. A, s. 26.

Emergency treatment despite refusal

27. If consent to a treatment is refused on an incapable person's behalf by his or her substitute decision-maker, the treatment may be administered despite the refusal if, in the opinion of the health practitioner proposing the treatment,

(a) there is an emergency; and

(b) the substitute decision-maker did not comply with section 21. 1996, c. 2, Sched. A, s. 27.

Protection from liability

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 faith, to be sufficient for the purpose of this Act, the health practitioner is not liable for administering the treatment without consent. 1996, c. 2, Sched. A, s. 29 (1).

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. 1996, c. 2, Sched. A, s. 29 (2).

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. 1996, c. 2, Sched. A, s. 29 (3).

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. 1996, c. 2, Sched. A, s. 29 (4).

Person making decision on another's behalf

30. A person who gives or refuses consent to a treatment on another person's behalf, acting in good faith and in accordance with this Act, is not liable for giving or refusing consent. 1996, c. 2, Sched. A, s. 30.

Application for directions

35. (1) A substitute decision-maker or a health practitioner who proposed a treatment may apply to the Board for directions if the incapable person expressed a wish with respect to the treatment, but,

(a) the wish is not clear;
(b) it is not clear whether the wish is applicable to the circumstances;
(c) it is not clear whether the wish was expressed while the incapable person was capable; or
(d) it is not clear whether the wish was expressed after the incapable person attained 16 years of age. 1996, c. 2, Sched. A, s. 35 (1); 2000, c. 9, s. 33 (1).

Notice to substitute decision-maker
(1.1) A health practitioner who intends to apply for directions shall inform the substitute decision-maker of his or her intention before doing so. 2000, c. 9, s. 33 (2).

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. 1996, c. 2, Sched. A, s. 35 (2).

Directions
(3) The Board may give directions and, in doing so, shall apply section 21. 2000, c. 9, s. 33 (3).

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. 2000, c. 9, s. 34 (1).

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. 2000, c. 9, s. 34 (2).

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. 1996, c. 2, Sched. A, s. 36 (2).

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. 1996, c. 2, Sched. A, s. 36 (3).

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. 1996, c. 2, Sched. A, s. 37 (1).

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. 1996, c. 2, Sched. A, s. 37 (2).

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. 1996, c. 2, Sched. A, s. 37 (3).

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. 1996, c. 2, Sched. A, s. 37 (4).

Time for compliance
(5) The Board shall specify the time within which its directions must be complied with. 1996, c. 2, Sched. A, s. 37 (5).

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). 1996, c. 2, Sched. A, s. 37 (6).

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. 2000, c. 9, s. 35.

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. 2000, c. 9, s. 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. 2000, c. 9, s. 35.

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. 1996, c. 2, Sched. A, s. 37 (7).

Consent and Capacity Board
70. (1) The board known as the Consent and Capacity Review Board in English and as Commission de révision du consentement et de la capacité in French is continued under the name Consent and Capacity Board in English and Commission du consentement et de la capacité in French. 1996, c. 2, Sched. A, s. 70 (1).

Composition
(2) The members of the Board shall be appointed by the Lieutenant Governor in Council. 1996, c. 2, Sched. A, s. 70 (2).

Assignment of Board members to deal with applications
73. (1) The chair shall assign the members of the Board to sit alone or in panels of three or five members to deal with particular applications. 1996, c. 2, Sched. A, s. 73 (1).

Qualifications of member sitting alone
(2) A member of the Board may be assigned to sit alone to deal with an application only if,
(a) throughout the two-year period immediately preceding the assignment, he or she has been a member of the Board or of the review board established by section 37 of the *Mental Health Act*, as it read before the day subsection 20 (23) of the *Consent and Capacity Statute Law Amendment Act, 1992* came into force;
(b) he or she is a person licensed under the *Law Society Act* to practise law in Ontario as a barrister and solicitor and, throughout the 10-year period immediately preceding the assignment, he or she has been,
(i) a person licensed under the *Law Society Act* to practise law in Ontario as a barrister and solicitor, or
(ii) a member of the Law Society of Upper Canada and, subsequently, a person licensed under the *Law Society Act* to practise law in Ontario as a barrister and solicitor;
(c) in the case of an application for a review of a finding of incapacity, he or she has experience that, in the opinion of the chair, is relevant to adjudicating capacity; and
(d) he or she meets all of the other qualifications specified by the chair under subsection 71 (3). 1996, c. 2, Sched. A, s. 73 (2); 2006, c. 21, Sched. C, s. 111 (1).

Application hearings
Board to fix time and place of hearing
75. (1) When the Board receives an application, it shall promptly fix a time and place for a hearing. 1996, c. 2, Sched. A, s. 75 (1).
Hearing to begin within seven days
(2) The hearing shall begin within seven days after the day the Board receives the application, unless the parties agree to a postponement. 1996, c. 2, Sched. A, s. 75 (2).

Decision
(3) The Board shall render its decision and provide a copy of the decision to each party or the person who represented the party within one day after the day the hearing ends. 2006, c. 21, Sched. C, s. 111 (2).

Reasons
(4) If, within 30 days after the day the hearing ends, the Board receives a request from any of the parties for reasons for its decision, the Board shall, within four business days after the day the request is received,
(a) issue written reasons for its decision; and

(b) provide a copy of the reasons to each person who received a copy of the decision under subsection (3). 2006, c. 21, Sched. C, s. 111 (2); 2009, c. 33, Sched. 18, s. 10 (2).

Appeal
80. (1) A party to a proceeding before the Board may appeal the Board's decision to the Superior Court of Justice on a question of law or fact or both. 1996, c. 2, Sched. A, s. 80 (1); 2000, c. 9, s. 48.

Time for filing notice of appeal
(2) The appellant shall serve his or her notice of appeal on the other parties and shall file it with the court, with proof of service, within seven days after he or she receives the Board's decision. 1996, c. 2, Sched. A, s. 80 (2).

Notice to Board
(3) The appellant shall give a copy of the notice of appeal to the Board. 1996, c. 2, Sched. A, s. 80 (3).

Record
(4) On receipt of the copy of the notice of appeal, the Board shall promptly serve the parties with the record of the proceeding before the Board, including a transcript of the oral evidence given at the hearing, and shall promptly file the record and transcript, with proof of service, with the court. 1996, c. 2, Sched. A, s. 80 (4).

Time for filing appellant's factum
(5) Within 14 days after being served with the record and transcript, the appellant shall serve his or her factum on the other parties and shall file it, with proof of service, with the court. 1996, c. 2, Sched. A, s. 80 (5).

Time for filing respondent's factum
(6) Within 14 days after being served with the appellant's factum, the respondent shall serve his or her factum on the other parties and shall file it, with proof of service, with the court. 1996, c. 2, Sched. A, s. 80 (6).

Extension of time
(7) The court may extend the time for filing the notice of appeal, the appellant's factum or the respondent's factum, even after the time has expired. 1996, c. 2, Sched. A, s. 80 (7).

Early date for appeal
(8) The court shall fix for the hearing of the appeal the earliest date that is compatible with its just disposition. 1996, c. 2, Sched. A, s. 80 (8).

Appeal on the record, exception
(9) The court shall hear the appeal on the record, including the transcript, but may receive new or additional evidence as it considers just. 1996, c. 2, Sched. A, s. 80 (9).

Powers of court on appeal
(10) On the appeal, the court may,
(a) exercise all the powers of the Board;
(b) substitute its opinion for that of a health practitioner, an evaluator, a substitute decision-maker or the Board;
(c) refer the matter back to the Board, with directions, for rehearing in whole or in part. 1996, c. 2, Sched. A, s. 80 (10).

Counsel for incapable person
81. (1) If a person who is or may be incapable with respect to a treatment, managing property, admission to a care facility or a personal assistance service is a party to a proceeding before the Board and does not have legal representation,
(a) the Board may direct Legal Aid Ontario to arrange for legal representation to be provided for the person; and
(b) the person shall be deemed to have capacity to retain and instruct counsel. 1996, c. 2, Sched. A, s. 81 (1); 2009, c. 33, Sched. 18, ss. 10 (3, 4).

Responsibility for legal fees
(2) If legal representation is provided for a person in accordance with clause (1) (a) and no certificate is issued under the *Legal Aid Services Act, 1998* in connection with the proceeding, the person is responsible for the legal fees. 1996, c. 2, Sched. A, s. 81 (2); 1998, c. 26, s. 104.

Regulations
85. (1)The Lieutenant Governor in Council may make regulations,
…
(f) prescribing things that do not constitute treatment for the purpose of the definition of “treatment” in subsection 2 (1);
(g) prescribing excluded acts for the purpose of clause 3 (1) (b);
… 1996, c. 2, Sched. A, s. 85 (1); 2007, c. 8, s. 207 (17); 2009, c. 26, s. 10 (3).

DR. BRIAN CUTHBERTSON, *et al*. - and - HASSAN RASOULI, *etc*. S.C.C. File No. 34362

IN THE SUPREME COURT
OF CANADA

(ON APPEAL FROM THE COURT
OF APPEAL FOR ONTARIO)

Proceeding commenced at:
TORONTO

FACTUM OF THE RESPONDENT

HASSAN RASOULI, by his Litigation Guardian and substitute decision maker, PARICHEHR SALASEL

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