

“End-of-life Decision Making: Rasouli appeal to be heard by Supreme Court of Canada”

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The Supreme Court of Canada has granted leave to appeal in the case of *Rasouli (Litigation Guardian of) v. Sunnybrook Health Sciences Centre*.¹ At issue is the appellants' proposition that Ontario doctors have the right to unilaterally withdraw and/or refuse to provide treatment to patients in end-of-life situations. The respondent and substitute decision maker (“SDM”), Dr. Parichehr Salasel,² argues that the *Health Care Consent Act, 1996*³ (“HCCA”) provides for a process requiring doctors to first seek the SDM's consent to withdraw treatment. She argues a doctor's unilateral withdrawal of treatment is not contemplated by the HCCA. If the SDM consent is not provided, the HCCA then provides the doctors with the option to apply to the Consent and Capacity Board (“Board”) and let it decide whether the proposed course of action is in Mr. Rasouli's best interests. The appellants disagree. In their view, Mr. Rasouli is in a permanent vegetative state (“PVS”) with no realistic hope of medical recovery. He is not receiving any medical benefit from being

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¹*Rasouli (Litigation Guardian of) v. Sunnybrook Health Sciences Centre* (2011), 105 O.R. (3d) 761 (Ont. S.C.J.), affirmed (2011), 107 O.R. (3d) 9 (Ont. C.A.), leave to appeal allowed 2011 CarswellOnt 14172 (S.C.C. Dec. 22, 2011) (“*Rasouli*”).

²Dr. Salasel was a physician in Iran until the family moved to Canada in April, 2010.

³*Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A.

kept alive artificially and it's in his best interests that he be taken off life support. In these circumstances, the appellants maintain that health practitioners need no one's consent to withdraw the life-sustaining measures if such measures are not medically warranted. If accepted, the appellant's submissions will reflect an erosion of the principles of patient autonomy.

The appellants' submissions in the *Rasouli* case are perceived by some to reflect legal efforts to effectively reduce patient autonomy. The contrasting results in the *Scardoni v. Hawryluck*⁴ and *Grover v. Grover*⁵ cases reflect the difficulties of the argument. At issue in both cases was to what degree the expressed wishes of a patient should be adhered to in end-of-life circumstances. The HCCA provides that a health practitioner shall not administer a treatment if the patient, while capable, expressed a wish applicable to the circumstances to refuse consent to the treatment.⁶ If it is not clear whether the wish is applicable to the circumstances, the HCCA provides that either the SDM or health practitioner who proposed a treatment may apply to the Board for directions.⁷ In both cases:

1. The person in question expressed such a wish.
2. The doctors applied to the Board for a declaration that incapable person's wishes were unknown and that the SDM's refusal to consent to a withdrawal of treatment was contrary to the patient's best interests. Furthermore, the doctors sought, in determining whether the SDM complied with s. 21, that the Board substitute its opinion for that of the SDM, and withdraw life support.⁸

⁴*Scardoni v. Hawryluck* (2004), 69 O.R. (3d) 700, 5 E.T.R. (3d) 226 (Ont. S.C.J.) (“*Scardoni*”).

⁵*Grover v. Grover*, 2009 CarswellOnt 1944 (Ont. S.C.J.) (“*Grover*”).

⁶HCCA, *supra* note 3, s. 26.

⁷HCCA, *supra* note 3, s. 35(1)(b).

⁸Pursuant to HCCA, *supra* note, s. 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.” HCCA, s. 37(3) empowers the Board to substitute its own decision for that of the SDM.

3. The health practitioners made the argument that the patient could not have envisioned the type of end-of-life situation she was facing and regardless of any stated wishes, life-sustaining measures should be withdrawn; and

4. The Board agreed with the doctors and the SDM appealed the decision to the Ontario Superior Court of Justice.

In *Scardoni*, Cullity J. allowed the appeal and rejected the doctors' argument. In contrast, Hockin J. in *Grover*⁹ rejected the appeal and upheld the Board's decision. Hockin J. was persuaded that the general statement of wishes did not envision the particular situation faced by the incapable patient and that the "best interests" of the patient should prevail. Given that the quality of life was so diminished and chances of recovery so low, in His Honour's view, those interests were best served by the withholding or withdrawal of treatment.¹⁰ If the precedent set by *Grover* is accepted and or the appellants succeed in *Rasouli*, patients' rights to have their wishes followed in end-of-life situations may effectively be ceded to unilateral decisions by doctors or the Board. Patients' views of what is in their "best interests" may be replaced by parties who do not share the primacy either of patients' values or their right to make their own end-of-life decisions.

What follows is an analysis of these issues and the *HCCA* through a review of four selected cases. The three Ontario cases — *Rasouli*, *Grover* and *Scardoni* — and a case that went before the Supreme Court of Israel called *Shefer v. State of Israel*.¹¹ The Israeli case provides a glimpse of how another jurisdiction deals with end-of-life issues and the primacy and weight it places on sanctity of life over the principles of patient autonomy and the best interests of the patient. What makes all these cases so very difficult for all parties involved is the balancing of the laudable goals of patient autonomy and the sanctity of life against the doctors' genuine concern for what they perceive to be in the best interests of their patients.

⁹*Grover*, *supra* note 4 at para. 17.

¹⁰*Scardoni*, *supra* note 3 at paras. 74 and 75; *Grover* at para. 20.

¹¹*Shefer v. State of Israel*, CA 506/88, PD 48(1) 87, 167 (1994).

Ontario's Statutory Regime

In Ontario, the legislation governing the decision-making process on behalf of incapable patients in end-of-life matters is the *Substitute Decisions Act* ("SDA")¹² and the *HCCA*. The purpose or mission statement of the *HCCA* is set out in s. 1, which provides rules surrounding the primacy of a patient's right to consent to treatment. The *HCCA* contemplates a consistent application of the regime in all settings, to enhance the autonomy of persons for whom treatment is proposed, and requires that wishes with respect to treatment, expressed by persons while capable be adhered to. When interpreting the *HCCA*, one must keep an eye on these stated purposes to ensure that the interpretation of the legislation is consistent with the goals outlined in s. 1.¹³

Under subs. 46(1) of the *SDA*, a person may give a written power of attorney for personal care, authorizing the person or persons named as attorneys to make, on the grantor's behalf, decisions concerning the grantor's personal care. The *HCCA* sets out a process to deal with situations where the SDM and doctor disagree on treatment. Section 10(1)(b) provides that health practitioners shall not administer a proposed treatment unless he or she believes the person is incapable and the person's SDM has given consent on the person's behalf in accordance with the *HCCA*.

Key to the application of para. 10(1)(b) is the definition of treatment, which is defined in subs. 2(1) as:

[A]nything 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

...

¹²*Substitute Decisions Act*, 1992, S.O. 1992, c. 30.

¹³See Himel J.'s decision in *Rasouli*, *supra* note 1, at paras. 25–32, where she reviews case law and academic authorities for the proposition that the proper approach to the interpretation of legislative language is to read the *HCCA* words in the ordinary context of the text having in mind the goals, purpose and scheme of the legislation.

The definition of a "plan of treatment" includes: "for the withholding or withdrawal of treatment in light of the person's current health condition." In paragraph 21 of his endorsement in *Scardoni*, Cullity J. concluded:

Arguably, it is only by virtue of that definition that a decision to withdraw, or withhold, treatment would be a "treatment" for the purpose of s. 10 and would require a consent.

So what happens when doctors propose a treatment and the SDM refuses to consent? The *HCCA* provides that the SDM is authorized to give or refuse treatment "if the power of attorney confers authority to give or refuse consent to the treatment." For the purposes of this discussion, it is very important to set out the principles that govern the SDM's decision making process and to that end I include s. 21 in full.

21. (1) A person who gives or refuses consent to 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 . . . , 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 . . . , or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.

(Emphasis added)

So let us assume that the doctors feel that the wishes of the patient are unknown or if known, it is impossible to comply with them. The doctors recommend a treatment and the SDM refuses. The *HCCA* provides¹⁴ that the doctors may apply to the Board for a determination as to whether the SDM complied with s. 21. The Board may substitute its opinion for that of the SDM. For those looking to a fuller explanation of the process plays out, I refer the reader to Cullity J.'s decision in *Scardoni*.¹⁵

¹⁴*HCCA*, *supra* note 3, s. 37.

¹⁵*Scardoni*, *supra* note 3 at paras. 17–28.

Grover v. Grover

While capable, Mary Grover appointed her daughter Marjorie Grover as her attorney for personal care. She was also interviewed by her doctor at the nursing home and was asked what level of care she expected in the event of a serious illness. The evidence before the court was that Mary wanted everything medically and surgically possible to save and prolong her life, including heroic measures.¹⁶

Mary suffered from a number of strokes. After the third stroke she became non-communicative and a quadriplegic. Mary was placed on life support measures to sustain her. The doctors recommended that the patient be taken off the ventilator and that the endotracheal tube be removed. In their opinion, the likelihood was that Mary's life expectancy would be short were her life support to be removed. To the doctors, the other medical treatment was not in the patient's best interest. It involved surgery to ensure nutrition and hydration, but increased life expectancy to less than a year and risked complications.¹⁷ The doctors asked Marjorie to consent to the withdrawal of life support. She refused. The matter was referred to the Board, which ordered her to consent. The reasoning of the Board, in part, was set out in para. 17 of the court decision:

We found that G. [Mary] had not previously expressed a wish applicable to her circumstances [. . .] there was absolutely no evidence of her prior consideration of the effects of a devastating third stroke. MG [Margorie]'s statement that her mother would want to live "because of the way she was" extremely vague. Not one of her children, not even the SDM, MG was aware of a prior wish that could consider applicable to the circumstances.

As Sharpe J.A. said at para. 31 in *Conway v. Jacques*,¹⁸ cited above,

However, I agree with the appeal judge that prior capable wishes are not to be applied mechanically or literally without regard to relevant changes in circumstances. Even wishes expressed in categorical or absolute terms must be interpreted in light of the circumstances prevailing at the time the wish was expressed.

¹⁶*Grover*, *supra* note 4 at paras. 8–9.

¹⁷*Supra* at paras. 4–7.

¹⁸See *Conway v. Jacques* (2002), 214 D.L.R. (4th) 67 (Ont. C.A.), leave to appeal refused 2003 CarswellOnt 265 (S.C.C.) ("*Conway*").

The comments attributable to G were not precise and lacked particularity. There was no evidence of statements meant that she should be kept alive despite any levels of pain, loss of autonomy or personal dignity [...]

We therefore found that MG did not know of a wish applicable to the circumstances that G expressed while capable and after attaining sixteen years of age. MG was obliged to act in G's best interests as defined in s. 21(2) of the *Health Care Consent Act*. That meant that in deciding what G's best interests are, MG as the person who gives or refuses consent on her behalf shall take into consideration the factors set out in s. 21(2).

Marjorie appealed to the Ontario Superior Court of Justice.

At issue was the interpretation of ss. 35, 37 and 21 of the *HCCA*. Section 37 enables the health practitioner who proposed the treatment that was rejected by the SDM to apply to the Board for a determination as to whether the SDM complied with s. 21 in rejecting the treatment proposed. In other words, did Marjorie know of a wish of her mother *applicable to the circumstances* that her mother expressed while capable? If so was Marjorie's rejection of the doctor's proposed treatment plan in accordance with that wish. Moreover, was it clear whether the patient's previously expressed wishes were applicable to the circumstances she now faced?

Hockin J. reviewed the evidence and based his decision, in part, on the fact that Mary's expressed wishes were made prior to the devastating brain-stem stroke and that there was never any discussion with respect to paralysis or what should take place if Mrs. Grover would become a quadriplegic. At para. 27, His Honour agreed with the *dictum* of Sharpe J.A. in *Conway*:

... I agree with the appeal judge that prior capable wishes are not to be applied mechanically or literally without regard to relevant change in circumstances. Even wishes expressed in categorical or absolute terms must be interpreted in light of the circumstances prevailing at the time the wish was expressed.¹⁹

Hockin J. rejected the appellant's argument that the Board failed to take into account her mother's wish for full resuscitation and heroic measures.

¹⁹*Supra* at para. 31.

Apparently, another important factor taken into account was the prospects for recovery. In para. 32 of his decision, the judge stated:

This is a difficult case and particularly so because the prior wish was one made so close in time to Mrs. Grover's third stroke. I view this case as different, however, from *Scardoni v. Hawryluck*, the decision of Cullity J. Here the evidence is clear that there is no chance of any appreciable recovery. Mrs. Grover is functionally a quadriplegic and lacks the ability to communicate beyond blinking. There is no evidence of cognition.

Hockin J.'s conclusion in *Grover* that there were insufficient details in the patient's wishes therefore moved the process to the next step. Where it is unknown what the wish of the incapable person is, the SDM/doctor/court shall act in the incapable person's best interest which is determined, in accordance with para. 21(1)2 of the *HCCA*. In accordance with para. 21(2)(c), the decision maker assessing the best interests of the patient must consider whether or not the treatment is likely to "improve the incapable person's condition or well-being." As evident in his reasons, the prospects of recovery were a primary reason given by Hockin J. for upholding the Board's decision. Query whether a decision based primarily on "prospects of recovery" can be correct in law given the *HCCA*'s goals set out in s. 1 and the other factors set out in subs. 21(2) that must be taken into account when determining "best interests." One such factor includes any wish expressed by the incapable person with respect to the treatment, even where such wish is not required to be followed under para. 21(1)1.²⁰ Arguably, Hockin J.'s failure to take Mary's wishes into account overlooked the necessity to consider the *HCCA*'s mandate to enhance the autonomy of a patient to make her own decisions. If there is any doubt as to whether the expressed wishes of the patient should apply, should not the purpose of the *HCCA* — patient autonomy — inform the determination of "best interests"? Hockin J. apparently did not think so. As set out in para. 32 of this case the decision of Hockin J. differed from Cullity J. in *Scardoni*.

Scardoni v. Hawryluck

In *Scardoni*, two religious Roman Catholics were the designated attorneys for their mother, Joyce Holland, under a power of attorney for per-

²⁰See *HCCA*, *supra* note 3, s. 21(2)(b).

sonal care. In her power of attorney for personal care, Joyce authorized her two daughters:

[T]o make decisions concerning my personal care in accordance with the *Substitute Decisions Act* and any conditions, restrictions, specific instructions or special powers contained herein [...] specifically, on my behalf to give or refuse to consent to treatment to which the *Health Care Consent Act, 1996* applies.

The two daughters were intent on complying with their mother's wishes, for she had always told them "where there is life there is hope." They insisted that all efforts be expended to prolong their mother's life. They knew their mother's wishes and believed that it was in her best interests to use any means at their disposal to keep her alive.

The doctor in *Scardoni* was opposed to the use of a ventilator and inotropic drugs because, while such measures would sustain the patient's life, they would not improve the underlying disease. The doctor believed that there was no chance to prevent further deterioration from Alzheimer's. Ultimately, the doctor felt that prolongation of the patient's life was not in her best interests in that the benefit and quality of such an existence did not outweigh the resulting pain, discomfort and loss of dignity, resulting in a lower quality of life.

Pursuant to s. 37 of the *HCCA*, the doctor applied to the Board for direction on the basis that the SDM did not comply with s. 21 of the *HCCA* in coming to the decision not to consent to the treatment plan suggested by the doctor. The Board directed the daughters to follow the advice of the doctor. The daughters appealed. Cullity J. allowed the appeal and set aside the decision of the Board.

Based on his analysis of the legislation, Cullity J. came to several conclusions relevant to the issues before us:

1. — *Obligation by doctor to obtain consent to treatment*

By virtue of s. 10 of the *HCCA*, a doctor 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, he or she is of the opinion that the person is incapable with respect to the treatment, and the person's SDM has given consent on the person's behalf in accordance with the *HCCA*.

2. — *Withdrawal or withholding treatment constitutes treatment*

In a prelude to the argument in the *Rasouli* case, Harry Underwood,²¹ the lawyer for the doctors, argued that the correct interpretation of s. 10 might well be that implementation of a proposal to withdraw, or withhold, treatment is not to be considered an administration of treatment within the meaning of s. 10. By contrast, Joyce Chan, the lawyer for the daughters, argued that all references to "treatment" in subs. 10(1) include a plan of treatment where there is a withholding or withdrawing of a particular treatment. If Mr. Underwood was correct, then subs. 10(1) does not require a SDM's consent to withhold treatment and consequently, regardless of what is written in any power of attorney, a doctor can decide to withdraw or withhold treatment no matter what the patient or SDM wish. In *Scardoni*, this question was merely hypothetical because the doctors asked for the daughters' consent to withhold treatment and thereafter applied to the Board. Nonetheless, Cullity J.'s analysis is very helpful in assessing the argument in *Rasouli*.

The question before the court was whether para. 10(1)(b) imposes an obligation on a health practitioner to obtain the consent of the SDM to a decision to withdraw, or withhold, a particular treatment. Mr. Underwood argued that it did not. To help understand counsel's argument, it is helpful to have the wording of the section before us:

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

(Emphasis added)

Mr. Underwood argued²² that:

- Implementation of a proposal to withdraw, or withhold treatment is not "administration of treatment."
- "Not to administer treatment" would, on this interpretation, apply only to positive steps to be taken to treat the patient's condition.

²¹Harry Underwood of McCarthy Tétrault LLP represented the doctors in the *Scardoni* case as well as the doctors in the *Rasouli* case.

²²See *Scardoni*, *supra* note 3 at para. 39.

- On this line of reasoning, it would follow that the consent of a SDM and or capable patient to withholding of treatment is not required by subs. 10(1) because the *HCCA* does not address implementation.
- Given the silence of the *HCCA*, the common law applies and Mr. Underwood submitted that the common law does not require treatment not medically warranted.

The Attorney-General supported the doctor's proposition that the *HCCA* should not be understood as permitting patients or their SDMs to choose the health treatment to be administered. On this point Cullity J. opined:

I believe that, as a general proposition, this is correct. It does not, however, follow that there is no room for a distinction between treatments that should be considered to be withdrawn, or withheld, for the purposes of the statutory definition of a plan of treatment and other treatments that health practitioners would consider to be inappropriate for a patient's medical condition. If consent is required for the former, the statute does confer an important element of choice on a capable patient and requires a consideration of the factors in s. 21 when the patient is incapable.²³

While Cullity J. agreed to the common sense proposition that patients should not be able to choose their own treatment, he underscored that there is a big difference when it comes to those "treatments" or "treatment plans" for which the *HCCA* does confer a choice.

Ms. Chan pointed out that "all references to 'treatment' in s. 10(1) of *HCCA* include a plan of treatment and that the obligation imposed by the subs. relates to the plan as a whole, including the withholding or withdrawing of particular treatment."²⁴ Cullity J. agreed because that interpretation of "treatment" was more consistent with the definitions in s. 2 of the *HCCA*. His Honour also pointed out that at one point in time the doctors treated the patient in intensive care for her specific health problems, which they thought in the past to be medically appropriate. Cullity J. suggested that there may be a difference between withdrawing (a) this type of treatment; and (b) treatment that is rejected by health practitioners as inappropriate on health grounds.

²³*Supra* at para. 40.

²⁴*Supra* at para. 42.

The court acknowledged the difficulty of how things would work when doctors were faced with a patient or SDM wanting treatment in end-of-life situations that was not medically warranted. Cullity J. opined:

[P]ractical difficulties that may be created for health-care practitioners if they are forced to distinguish between decisions to withhold treatment and decisions to administer certain treatments and not others. . . . There would also be a question whether it is possible for decisions to withhold, or withdraw, treatment to be made independently of a plan or a proposal.²⁵

On this issue, Cullity J. concluded:

In view of the desirability that health practitioners should be able to obtain a determination from the Board on the question whether a decision to withhold, or withdraw, treatment is in a patient's best interests — and the likelihood that this was reflected in the legislative intention — I believe each of the alternative interpretations supported by Mr. Underwood and Ms. Chan is more likely to be correct than a finding that the Board has no jurisdiction where the issue of consent relates to that question. In these circumstances, I intend to accept Mr. Underwood's invitation to leave the choice between the competing alternatives to be dealt with if and when a case ever arises in which the correct interpretation of the section is directly in issue.²⁶

The *Rasouli* case is one where the "correct interpretation of the section" is directly an issue. In summary, Cullity J. left the door open for Mr. Underwood's interpretation to be correct in some circumstances. In other words, the consent of the capable patient or the SDM may not be needed and doctors may be able to withhold treatment if health practitioners consider such treatment to be inappropriate for a patient's medical condition.²⁷

²⁵*Supra* at para. 43.

²⁶*Supra* at para. 44.

²⁷*Supra* at para. 42, where Cullity J. writes:

The distinction between treatment that is rejected by health practitioners as appropriate on health grounds and treatment that is part of a plan of treatment is withheld may be difficult — and even very difficult — to apply in some cases, but not, I think, here where the application of the treatment in intensive care for specific health problems of Mrs. Holland has been found by her physicians in the past to be medically appropriate and would be administered in the

3. — *Were the expressed wishes outside HCCA, s. 21(1) and 21(2)(b)?*

Central to the *Scardoni* case was the question whether the wishes of Mrs. Holland were applicable to her circumstances. It may be helpful to first review the relevant provisions.

- Para. 21(1)1 If the person [*i.e.*, a substitute decision-maker] 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.
- Para. 21(1)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.
- Para. 21(2)(b) 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 any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under para. 1 of subs. (1).

If the wishes were not "applicable to the circumstances" then the decision to consent or refuse consent to the proposed treatment has to be made in the incapable person's best interest. The doctors argued that Joyce's insufficiently specific wishes were such that it was unknown

future but for their views of her best interests within the meaning of s. 21 of the Act and, specifically, s. 21(2)(c).

See also para. 44:

I believe each of the alternative interpretations supported by Mr. Underwood and Ms Chan is more likely to be correct than a finding that the Board has no jurisdiction where the issue of consent relates to that question.

whether or not her wishes were applicable to the circumstance, and that therefore it was in her best interests to withdraw the life-saving treatment.

It is in para. 54 of his *Scardoni* decision that Cullity J. diverged from Hockin J.'s reasoning in *Grover*. Cullity J. reviewed the comments of Sharpe J.A. in *Conway*²⁸ and based on that analysis concluded that even if the wishes expressed by an adult person do not fall within subs. 21(1) because they are insufficiently specific to the applicable circumstances, those wishes are relevant to the determination of the "best interests" of the patient in accordance with para. 21(2)(b).

One of Joyce's daughters testified that her mother had told her that she believed in "prolonging life and not to take it" and that she wanted to "continue and if necessary take all the precautions that were out there for her to continue." Her mother told her that she wanted every available treatment used to prolong her life in any circumstances.²⁹

The Board concluded that there was nothing in the patient's power of attorney to guide her daughters. Joyce never knew she had Alzheimer's disease and therefore could not have specifically directed her mind to that diagnosis. There were no conversations between Joyce and the SDMs she appointed regarding end-of-life decisions beyond "where there is life there is hope."³⁰ On that basis, the Board gave an order in accordance with what they viewed as the patient's best interests.

Cullity J. agreed with the Board that it:

is implicit in the reasons in *Conway* that a general statement of a person giving a power of attorney that she wished to be kept alive in all circumstances will not necessarily satisfy the requirements of s. 21(1)1, although whether this is so may depend on the circumstances existing when the wish was expressed, as well as those that subsequently occurred.

However, where Cullity J. disagreed with the Board was with their analysis of "Best Interests." He concluded that the Board erred in law in ignoring the patient's values, wishes, and beliefs on the basis that they did

²⁸*Conway*, *supra* note 17.

²⁹See *Scardoni*, *supra* note 3 at paras. 63 and 65.

³⁰*Supra* at para. 65.

not represent the official position of the Catholic Church and were irrelevant or incorrect.³¹ Paragraph 21(2)(a) of the *HCCA* provides:

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, 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.

In Cullity J.'s view, the Board's not giving proper consideration to Mrs. Holland's religious beliefs "ignored the legislative purpose of s. 21(2)(a) and misinterpreted its provisions. As such, it involved a mistake of law to which the standard of correctness applies."

Medical Futility v. Sanctity of Life

In *Scardoni*, Joyce was not in a vegetative state or brain-dead. She was medically stable with recurrent pneumonia and only cognitively impaired on account of her Alzheimer's disease. In short, the patient was very much alive when the physician proposed to withhold medically beneficial treatments for her pneumonia, namely the use of a ventilator and isotropic drugs that would require an admission to the intensive care unit. During the relevant times, Joyce was able to breathe spontaneously but not sufficiently, and therefore she was not totally dependent on the ventilator.

Assertions of medical futility invariably underpin proposals to withhold or withdraw life-sustaining and/or medically beneficial treatments. Medical futility generally means that the physicians have no obligation to offer treatments that do not benefit the patients, and assumes that futile interventions often increase the patient's pain and discomfort in the final days and weeks of life. Generally, the subjective notions of "loss of dignity" and "poor quality of life" are relied upon to buttress the arguments of medical futility, as opposed to values and beliefs in "sanctity of life."

While not specifically mentioned in the *HCCA*, the principle of "sanctity of life" is codified in the Canadian *Criminal Code*³² under s. 14 (cannot consent to death), s. 215 (duty to provide necessities of life), ss. 216-217 (duties of persons undertaking acts dangerous to life) and s. 219 (crimi-

³¹*Supra* at para. 84.

³²*Criminal Code*, R.S.C. 1985, c. C-46.

nal negligence), ss. 463, 464 and 465. Arguably, these sections when read all together impose the legal duties to provide and the legal liabilities for non-provision of necessities of life. The respect for "sanctity of life" is also entrenched in s. 7 of the *Canadian Charter of Rights and Freedoms*,³³ which provides:

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Ontario's legislation and jurisprudence reveal a tension between the prioritization of different Canadian values, including patient autonomy, the patient's best interests and the issue of "sanctity of life." In Ontario, when end-of-life decisions are made, "sanctity of life" is not a goal in and of itself. It is relevant in the context of a patient's personal religious beliefs, which are but one factor taken into account when the SDM or the Board or the Court must determine what is in the best interests of the incapable patient.

What follows is an analysis of a case that went before the Supreme Court of Israel called *Shefer*.³⁴ In Israel, "Sanctity of Life" is where the discussion of end-of-life issues starts. It may be helpful in seeing how that jurisdiction dealt with similar issues.

Shefer v. State of Israel and Israeli Legislation dealing with End-of-life Issues

Reviewing this issue from the perspective of Israeli law might be of some assistance in the analysis of end-of-life issues in Ontario. The Israeli cases and statutory approach are complex given the incorporation of Jewish cultural and religious beliefs with the democratic values enshrined in the Basic Laws of Israel.³⁵

³³Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act, 1982* (U.K.), 1982, c. 11. ("Charter")

³⁴*Shefer*, *supra* note 11.

³⁵See Basic Law: Human Dignity and Liberty, Sec. 1:

The purpose of this Basic Law is to protect human dignity and liberty, in order to establish in a Basic Law the values of the State of Israel as a Jewish and democratic state.

Illustrative of the Israeli approach was a very difficult case called *Shefer*. Two year old Yael Shefer suffered from the incurable genetic disease Tay-Sachs. She was in a PVS and not under any apparent stress. Yael's mother wanted to prevent her daughter from being given medical treatment other than pain killing drugs.³⁶ In order to determine the appropriate policy with regard to euthanasia, Menahem Elon J. analyzed the *Halakhic*³⁷ attitude toward the issue,³⁸ as well as the variety of accepted approaches typical of democratic legal systems. His decision represents a synthesis between the two traditions. The Biblical tradition of human beings being created in the image of G-d is the inspiration for the *Halakhic*

³⁶The request to stop the medical treatment was raised by the infant's mother, while her father didn't express his opinion. During the judicial process the infant passed away. Nevertheless, due to the importance of the issue, the Supreme Court continued the judicial process and decided the case although it was completely theoretical.

³⁷*Halakha* is a Hebrew word from the root *halakch*, meaning "to go." For the context of this paper the one-line definitions found in most dictionaries does not accurately define it and we invite the reader to access the *Encyclopedia Judaica* (MacMillan, 1978) Vol. 8, p. 1155, for an appreciation of what this terms means in the context of Talmudic study, the middle ages and the 21st century. See also M. Elon, *Jewish Law: History, Sources, Principles*, trans. by B. Auerbach and M.J. Sykes (Philadelphia, Jerusalem: 1994), Vol. I, p. 93:

The term *Halakhah* [...] refers to the normative portion of the Oral Law [...]. The *Halakhah* includes all of the precepts in Judaism — those laws involving the commandments concerning the relationship between people and G-d as well as those laws applicable to relationships in human society.

In the context of this paper, *Halakha* describes the Legal Jewish Framework through which Orthodox Jews govern their lives. It is an all-consuming body of Jewish religious law that governs every aspect of life. *Halakha* is based on rabbinic analysis and interpretation of Biblical verses, Talmudic discourse and earlier rabbinic examination of those texts and questions. Orthodox Jews take upon themselves the observance of *Halakha* in all things including matters regarding end-of-life decisions.

³⁸According to Israel's *Foundations of the Law Act*, 1980, s. 1:

Where the court, faced with a legal question requiring decision, finds no answer to it in statute law or case law or by analogy, it shall decide it in the light of the principles of freedom, justice, equity and peace of Israel's heritage.

principle recognizing the sanctity of life. Moreover, it also imposes upon every person a duty to safeguard the divine gift of life.

The sanctity of life is a *Halakhic* foundation stone imposing on human beings obligations of a guardian as opposed to mere ownership rights over one's own life. In this context, the inappropriate ending of one's life breaches that obligation. *Halakha* balances the sanctity of life with the desire not to prolong human suffering. This is especially so for those suffering from terminal illness. The rabbinic authorities achieve this balance by only permitting euthanasia in a passive manner, but not in an active one, and only in cases of incurable terminal illnesses accompanied by great suffering. Therefore, the *Halakhic* approach does not permit one to be removed from the ventilator, but in appropriate cases, permission may be given to refrain from putting the terminally ill patient on the ventilator in the first place. After reviewing a variety of modern legal systems' approaches, Elon J. opined about the similarity between the *Halakhic* approach and the American one, and thus adopted the *Halakhic* solution as giving expression to Israel as being a "Jewish and democratic state."

The analysis in the *Shefer* case is a useful exercise in understanding how these principles were incorporated into Israeli legislation, the *Dying Patient Act*, 2005 (the "DPA").³⁹ The *DPA* addresses, in part, the questions raised in the *Rasouli* case, including under what circumstances, if any, a doctor may unilaterally withdraw or withhold treatment. The *DPA* balances the *Halakhic* reticence to withhold and or withdraw treatment with mechanisms to address patients' and families' desire to end unnecessary suffering. It was based on the aforementioned distinction between passive and active euthanasia.

Relevant to the comparison with Ontario's legislation is a fundamental distinction between the *HCCA* and the *DPA*. While in the absence of an

³⁹Israeli Book of Laws, 2006, p. 58. For an English translation of the legislation see: <http://www.medethics.org.il/articles/JME/JMEM12/JMEM.12.2.asp>.

For more details on the *DPA*, see the following publications:

<http://www.ima.org.il/imaj/ar07jul-12.pdf>

<http://www.wcjcs.org/QC2007/Materials/The%20dying%20patient%20new%20Israeli%20legislation%20-%20Charles%20Sprung.pdf>

<http://web2.ono.ac.il/ShauserPublish/files/16.pdf>

expressed wish the *HCCA* values "bests interests," s. 4 of the *DPA* provides as follows:

A person shall be presumed to wish to continue living, unless proven otherwise; if not proven otherwise beyond any reasonable doubt — the tendency should be to decide in favor of the wish to continue living.

That presumption is consistent with Israel's culture and religious history of the Jewish faith. However, the presumption is rebuttable under three conditions set out in s. 5 of the *DPA*.⁴⁰

⁴⁰Section 5 of the *DPA* provides as follows:

A terminally ill patient shall not be excluded from the presumption that he wishes to continue living, and medical treatment shall not be withheld from him under the provisions of this Law, except in accordance with the conditions enumerated in this section, as the case may be.

(a) Where the terminally ill patient is competent — based on his explicitly expressed wish;

(b) Where the terminally ill patient is incompetent and is seventeen years old, based on one of the following:

(1) Advance medical directives that he gave and which that satisfy the provisions of sections 33 and 34(a);

(2) A decision of a representative in accordance with a power of attorney that satisfies the provisions of sections 38 and 39(a);

(3) A decision of an institutional committee or the National Committee rendered in accordance with the provisions of Chapter F.

(c) In the absence of directives or decisions as specified in subsection (b) — based on the decision of a responsible physician, provided that such decision is adopted having consideration for —

(1) An explicit declaration of a close person to the effect that the terminally ill patient does not wish to continue living;

(2) In the absence of such a declaration — having consideration for the position of the terminally ill pa-

There are three ways to rebut the presumption:

(a) The patient's "previously expressed wish,"

(b) The decision of his or her power of attorney, or

(c) The third possible rebuttal comes from the doctor. His or her role comes into play if and only if there is no previously expressed wish made by the incapable patient and only if there is no decision by the power of attorney for personal care. At that point, the *DPA* provides at s. 5:

A terminally ill patient shall not be excluded from the presumption that he wishes to continue living, and medical treatment shall not be withheld for him [...] except in accordance with the conditions enumerated in this section, as the case may be [...]

In the absence of directives or decisions [...] — based on the decision of a responsible physician, provided that such decision is adopted having consideration for —

(1) An explicit declaration of a close person to the effect that the terminally ill patient does not wish to continue living;

(2) In the absence of such a declaration — having consideration for the position of the terminally ill patient's guardian, who is a close person, to the extent that such exists, to the effect that the terminally ill patient's wish is that his life not be prolonged.

In contrast to the position taken by the doctors in the *Rasouli* and *Scardoni* cases, s. 5 of the *DPA* indicates that only when the presumption that the patient wants to live is rebutted may a doctor's decision to withdraw or withhold treatment be considered. Even at that point, the doctor

tient's guardian, who is a close person, to the extent that such exists, to the effect that the terminally ill patient's wish is that his life not be prolonged.

must take into account the guardian's perspective on the wishes of the patient.⁴¹

Yet, there is one case where the doctor's decision might overcome the patient's wish. Section 13 of the *DPA* provides:

Where a terminally ill patient who wishes to prolong his life and requests medical treatment that the responsible physician considers to be unjustified under the circumstances, his wish should be respected and the requested treatment should be provided in accordance with any other law and in accordance with the conditions and the arrangements prevailing from time to time in the Israeli medical system; *the provisions of this section will not apply to medical treatment that in the opinion of the responsible physician is not expected to prolong the life of the patient, or liable to significantly harm the patient or someone else.*

(Emphasis added)

The legislation as a whole permits a doctor to unilaterally withdraw or withhold treatment in only three instances. Each of these exceptions flow from the same basic principal rooted in *Halakha* — that being the sanctity of life balanced against the need to alleviate human suffering.

In summary, the Israeli law, influenced by Jewish cultural and religious heritage, recognizes the sanctity of life ("in the image of G-d He made

⁴¹This limited authority given to the responsible physician is consistent with another Israeli statute. The *Patient's Rights Act, 1996*, regulates, among other things, cases where medical treatment should be given without the patient's consent. Section 15(2) determines:

Should the patient be deemed to be in grave danger but reject medical treatment, which in the circumstances must be given soon, the clinician may perform the treatment against the patient's will, if an Ethics Committee has confirmed that all the following conditions obtain:

- (a) The patient has received information as required to make an informed choice;
- (b) The treatment is anticipated to significantly improve the patient's medical condition;
- (c) There are reasonable grounds to suppose that, after receiving treatment, the patient will give his retroactive consent.

the man")⁴² and derived from it the strong commitment to preserve human life which is imposed both on the health system and on the patient. Only in limited cases are patients and/or doctors permitted to bring human life to an end when there are any means of prolonging life. In these cases, precedence was given to the patient's express wishes and the decisions of his SDMs. Only in very rare scenarios, when the patient's expressed desires were rooted in a misconceived perception of the utility of the proposed treatment was the doctor's opinion permitted to override the patient's wishes. To date, we are unaware of a case brought before the Israeli courts where a doctor has challenged the patient's wishes.

It may be useful for the Supreme Court of Canada to see how Israel has balanced its view that the sanctity of life is primary with rights of patients to autonomy to make decisions in such matters. The Israeli law limits a doctor's ability to impose his or her view to only those circumstances where the proposed treatment "*is not expected to prolong the life of the patient, or liable to significantly harm the patient*" (emphasis added). Thus far, Ontario's cases have accepted the proposition that patient autonomy is subordinate to others' views of the patients' "best interests."

Rasouli

Hassan Rasouli developed bacterial meningitis and ventriculitis. Unresponsive, he was kept alive by a mechanical ventilator and fed through a tube. His doctors asserted that Hassan was in a PVS, with no realistic hope of medical recovery. His doctors took the position that unless the current course of treatment ends, Hassan will die slowly with virtually no chance of recovery. In their view, it's in Hassan's best interest to be taken off life support and discontinue the mechanical intervention.

Dr. Parichehr Salasel is Hassan's wife, SDM and litigation guardian. She was trained as a doctor in Iran, and she and her family are Muslims. Parichehr disagrees with her husband's doctors. While her husband's end-of-life wishes were unknown, Parichehr felt that her husband had a chance of recovery and would have wanted to continue on the ventilator.

The physicians and the hospital were prepared to unilaterally withdraw Hassan from the mechanical ventilator and took the position that they did not need Parichehr's permission to do so nor did they have to refer the

⁴²Genesis 1, 27. See also Mishnah, *Avot* 3, 14; Tosefta, *Sanhedrin* 9, 7.

question to the Board. However, they agreed to postpone their plans until the court could deal with the matter.

Dr. Parichehr sought an order directing the matter to the Board while the doctors brought a cross-application seeking a declaratory relief that the patient is in a PVS and absolving the physicians of civil and criminal responsibility concerning the proposed withdrawal of treatment.

Before addressing the case in detail, it may be helpful to review the conclusions of both the Ontario Superior Court and the Ontario Court of Appeal.

Issue	Ontario Superior Court	Court of Appeal for Ontario
Is consent required from a patient or his SDM for the withholding or withdrawal of treatment in end-of-life situations?	Consent is required from the SDM or Board when withdrawing life support in Ontario. ⁴³ Doctors may not unilaterally decide to end life support. ⁴⁴	The <i>HCCA</i> does not require doctors to obtain consent from a patient or SDM to withhold or withdraw "treatment" that they view as medically ineffective or inappropriate. ⁴⁵

⁴³See *Rasouli* (Ont. S.C.J.), *supra* note 1 at paras. 18 and 103.

⁴⁴*Supra* at paras. 36-37.

⁴⁵See *Rasouli* (Ont. C.A.), *supra* note 1 at paras. 42 and 46.

Is there a distinction between stopping medical treatment that has already started and not initiating treatment from the onset because doctors feel it is medically inappropriate?	Yes. A plan of treatment is by definition a plan that is "developed by one or more health practitioners," patients themselves cannot develop it. In other words, treatment cannot be included in a plan of treatment for the purposes of the <i>HCCA</i> until it is proposed by a health practitioner. ⁴⁶	Yes. But doctors must act in their patients' best interests, and if they fall below the standard in withholding treatment from the outset they can be held accountable. ⁴⁷
What is the common law duty of doctors in end-of-life situations and does it have any application in this case?	The court opined that the common law continues to apply to any matters that fall outside the purview of the <i>HCCA</i> and the SDA, but found that the statutory scheme for consent under the <i>HCCA</i> applies to the withdrawal of life support. ⁴⁸	Common law duty, if any, is not relevant because the <i>HCCA</i> provides a complete answer. ⁴⁹

⁴⁶See *Rasouli* (Ont. S.C.J.), *supra* note 1 at paras. 43-44; Cf: Cullity J.'s discussion of this question in paras. 40-42 of *Scardoni*.

⁴⁷See *Rasouli* (Ont. C.A.), *supra* note 1 at para. 57.

⁴⁸See *Rasouli* (Ont. S.C.J.), *supra* note 1 at paras. 53-55.

⁴⁹See *Rasouli* (Ont. C.A.), *supra* note 1 at para. 36.

Does withdrawal of treatment or withholding treatment constitute treatment under the <i>HCCA</i> ?	"Treatment" under the <i>HCCA</i> includes the withdrawal of life support. ⁵⁰	The doctors' plan of care for Hassan does amount to "treatment" as defined in the <i>HCCA</i> . ⁵¹ Removal from the mechanical ventilator must be accompanied with palliative care which is "treatment" and requires consent. Here, given there was not consent to palliative care, the doctors cannot withdraw life support without first turning to the Board. ⁵²
Is the decision to terminate treatment a breach of Mr. Rasouli's <i>Charter</i> s. 7 rights to "life, liberty and security of the person"?	The <i>Charter</i> does not apply to the proposed decision of the physicians to withdraw mechanical ventilation. ⁵³	The Court of Appeal made no comment on the respondent's s. 7 arguments save and except to say that the <i>HCCA</i> must be interpreted consistent with the <i>Charter</i> . ⁵⁴

⁵⁰*Supra* at paras. 24, 33, 52 and 103. Herman J.'s decision here is consistent with Cullity J.'s *obiter dictum* in para. 42 of *Scardoni*

⁵¹See *Rasouli* (Ont. C.A.), *supra* note 1 at para. 17.

⁵²*Supra* at paras. 45–58.

⁵³See *Rasouli* (Ont. S.C.J.), *supra* note 1 at paras. 93 and 106.

⁵⁴See *Rasouli* (Ont. C.A.), *supra* note 1 at para. 36.

Are doctors permitted to withdraw treatment that has been started without referring the matter to the Board?	No. The physicians were not permitted to withdraw mechanical ventilation and were ordered to transfer Mr. Rasouli to palliative care. ⁵⁵	Doctors cannot act unilaterally. ⁵⁶ If the SDM refuses to consent to withdrawal of life support, they must refer the matter to the Board.
Would there be criminal sanctions against the doctors if they unilaterally decided to remove Hassan from the mechanical ventilator.	No comment. ⁵⁷	Doctors must act in their patients' best interests, and if they fall below the requisite standard of care in withholding treatment from the outset, they can be held accountable. No direct comment on criminal sanctions. ⁵⁸

⁵⁵See *Rasouli* (Ont. S.C.J.), *supra* note 1 at para. 105.

⁵⁶See *Rasouli* (Ont. C.A.), *supra* note 1 at para. 45.

⁵⁷But see *Rasouli* (Ont. S.C.J.), *supra* note 1 at paras. 6 and 12, where Herman J. outlines the doctors' seeking a declaration absolving them of criminal and civil liability for their actions. She declined to opine on the issue.

⁵⁸See *Rasouli* (Ont. C.A.), *supra* note 1 at paras. 43 and 57. The term "criminal" does not appear in the decision. However, the Court of Appeal's comment makes it clear that doctors are not absolved of criminal or civil liability for their actions.

Are life-saving measures in cases such as this of no medical value because they are futile or high medical value because they are keeping the patient alive?	No comment.	Ontario Court of Appeal stated that they do not need to resolve this metaphysical question to decide this case. ⁵⁹
Should scarcity of resources impact on the decision to withdraw treatment if doctors believe such treatment is not medically warranted?	HCCA provides options to doctors in the event that they believe someone is being kept on life support when it is not beneficial to them and not medically indicated. ⁶⁰	Appellants did not pursue this issue so the Court of Appeal addressed the case without turning their mind to fiscal issues. ⁶¹

Analysis

The Court of Appeal's analysis in paras. 42–65 of its decision is key. First the court observed:

And of course, if medically valueless measures are not to be regarded as treatment at all, as the doctors contend, then doctors would be free

⁵⁹*Supra* at para. 46.

⁶⁰See *Rasouli* (Ont. S.C.J.), *supra* note 1 at para. 46.

⁶¹See *Rasouli* (Ont. C.A.), *supra* note 1 at para. 34.

to withhold or withdraw such measures without first having to obtain their patients' consent; and patients would not be able to demand such measures from their doctors.⁶²

Yet the Court of Appeal then noted:

[R]emoval of the ventilator is a necessary precondition to the administration of end-of-life palliative care and end-of-life palliative care is a necessary response to removal of the ventilator. The two go hand in hand. One is integrally linked to the other. And they foretell a single certain result — the respondent's imminent death once the ventilator is removed. That is the essence of end-of-life palliative care. And where it is recommended as an adjunct to the withdrawal of life support, the two, in our view, cannot be separated. They are a "treatment package" and that is how they should be viewed for purposes of the Act.⁶³

Accordingly, even if being on the ventilator was a medically valueless procedure palliative care was of medical value and since they are, in this case a treatment package the Court of Appeal concluded that:

The proposal of the appellants to withdraw the respondent from life support and place him on end-of-life palliative care constitutes "treatment" under the Act for which the consent of Ms. Salasel is required. If her consent is not forthcoming, the appellants' proposal must be referred to the Board.⁶⁴

In summary, the appellants will be arguing before the Supreme Court of Canada that:

[T]his case raises an important and unresolved question about consent to medical treatment — namely, whether consent is required to withdraw or withhold medical treatment that provides no medical benefit to a patient. The applicants' position is that consent in such circumstances is not required even if the patient will die when the treatment is withdrawn or withheld.

As outlined above, the Court of Appeal accepted the doctors' argument that the HCCA does not require doctors to obtain consent from a patient or SDM to withhold or withdraw "treatment" that they view as medically ineffective or inappropriate. However, the Court of Appeal found that

⁶²*Supra* at para. 42.

⁶³*Supra* at paras. 50–52.

⁶⁴*Supra* at para. 65.

since removal from the mechanical ventilator must be accompanied by palliative care, which is “treatment,” the two activities are inseparable. Even if the ventilator was not medically warranted, no one was arguing that palliative care was medically unwarranted and it clearly requires consent. Here, given that there was no consent to palliative care, the doctors cannot withdraw life support without first turning to the Board.

In their appeal to the Supreme Court of Canada, the doctors submit that the Ontario Court of Appeal erred in a number of ways. They take issue with the court’s conclusion that the replacement treatment of palliative care is linked with the active treatment of life support because the concept of linkage is not found in the *HCCA*.⁶⁵ That observation is valid, but should be balanced against the observation that the concept of doctors unilaterally deciding to withhold or withdraw treatment is also not found in the *HCCA*.

In paras. 32 and 33 of the Applicants’ Memorandum of Argument on Application for Leave to Appeal, the doctors submit that the Court of Appeal misapplied the law because it effectively permits patients to insist upon a treatment that is not medically warranted. The doctors are arguing that “informed consent” is not the issue when a particular medical treatment is unwarranted. They cite an English case, *Airedale NHS Trust v. Bland*⁶⁶ for the proposition that the question to be asked is whether or not doctors have a legal duty to keep a patient alive in a PVS. The *Airedale* case, decided by the House of Lords, suggests that the answer to the question requires a review of health practitioners’ duties arising under the criminal law and under the medical standard of care. When dealing with a PVS patient the *Airedale* decision stands for the proposition that doctors are legally permitted to cease providing medical treatment even if death would follow thereafter. The Law Lords did so because, in their view, it is in the patient’s best interests. The Law Lords also accepted the argument that treatment of a totally unconscious patient where there is no prospect of any improvement, is in medical terms, useless.

The underlying premise of the doctors’ position, which was accepted by the Court of Appeal in *Rasouli*, was that they should not be required to provide “medically useless” treatment. In the absence of context, that

⁶⁵ Applicants’ Memorandum of Argument on Application for Leave to Appeal at para. 29(d).

⁶⁶[1993] A.C. 789 at 866, 868-869 (U.K. H.L.) (“*Airedale*”).

proposition is unassailable. The respondents in the *Rasouli* case would argue that in the facts specific to this case the proposition is not applicable.

Much of the decision making process in medicine is art as opposed to science. The doctors in *Rasouli* argued that Hassan was in a PVS with no chance of recovery. Parichehr’s factum presented a different perspective.⁶⁷

Based on authoritative medical literature and admissions made by the doctors on cross-examination, Parichehr argued that patients in a PVS may regain consciousness and physical independence. When cross-examined, the applicants conceded that there are patients in a minimally conscious state (“MCS”) that have some similar symptoms as to those under PVS. The distinction is important because while some patients in a PVS (less than 10 per cent) recover consciousness, patients in a MCS have a better chance. Having in mind that the medical tests needed to discern whether Hassan was in a PVS or MCS were not conducted, it was unwarranted to conclude that he was in a PVS. This is especially so considering that some authoritative medical literature suggests that the rate of misdiagnosing MCS as PVS is as high as 29 per cent. The Court of Appeal did not address this issue, but the conclusion drawn — that life-sustaining treatment is medically useless because there is no chance of recovery — is fundamental to the doctors’ submissions. Indeed, if there was suddenly evidence that life-sustaining treatment was medically useful, the doctors’ submissions would lose their foundation. In an unexpected twist, this seems to have happened in Hassan’s case. According to a CBC News report dated April 25, 2012, Hassan recently gave a “thumbs up” sign to his family, causing his attending physicians to change their diagnosis from PVS to MCS. According to the report, the doctors have nonetheless declined to change their recommendation that Hassan be taken off life support and Parichehr has filed an application to quash the appeal to the Supreme Court of Canada.⁶⁸ Of course, the Court

⁶⁷The factum dated May 2, 2011 (the Respondent’s Factum) was prepared by J. Garner of Hodder of Hodder Barristers, who acted as lawyers for the Applicant/Respondent in Appeal to the Ontario Court of Appeal.

⁶⁸CBC News, “‘Thumbs-up’ from man on life-support revives family’s hope: doctors recommended withdrawing life-support from man in ‘vegetative state’” (Posted April 25, 2012). The oral hearing on the motion to quash the appeal is

of Appeal did not have the benefit of this evidence when it made its decision last year, but a thumbs up from Hassan illustrates a very salient point. Arguably, in the absence of true certainty that the treatment is medically useless, the decision ought to lie with the party upon whom the decision has a primary impact. Given the 29 per cent misdiagnosis rate, can there really be certainty?⁶⁹

It is so important, especially in the context of end-of-life situations, to remember that so much of medicine is art — not science. Many of us have experienced situations where we accompany our elderly parents, spouses or children to hospitals and either in the application of the science of medicine or in the practice of its art, the health practitioner's misdiagnose illness or fails to take into account other variables that affect the patient's prognosis. Arguably, when there is a 29% chance of misdiagnosis there is no certainty. Arguably, even if there is only a 10% chance of success in treating Hassan, such treatment cannot be considered medically useless. Moreover, concluding that end-of-life treatment is futile does not take into account the rate of medical advances.

At one point, the life expectancy for HIV patients was very low. Today, the life expectancy of people infected has improved dramatically. Those who thought initial efforts for HIV patients were futile have been proven wrong. The same argument made today about futility of treatment of patients in PVS could have been made by doctors treating HIV patients in the early 1980s and diabetics in the summer of 1921 before the discovery of insulin. Imagine the diabetic patient in a coma in the summer of 1921

scheduled for May 17, 2012, at 9:30 a.m. Further information is available on the S.C.C. website at:

<http://www.scc-csc.gc.ca/case-dossier/cms-sgd/dock-regi-eng.aspx?cas=34362>.

⁶⁹The arguments in this paragraph are found at paras. 15–18 of the Respondent's Factum. Its conclusion on this point was:

To summarize, medical literature accepted by the Physicians to be authoritative supports the statistically significant possibility that Mr. Rasouli may regain consciousness even if he is in PVS. There is an even more significant possibility that Mr. Rasouli is in a "locked-in state," being a characteristic of MCS. A patient in MCS has a higher chance of making a marked recovery than a patient in PVS. MCS is commonly misdiagnosed as PVS.

where then-current medical understanding of the condition did not contemplate any viable treatment. The doctors would have, understandably, believed that the quality of life and prospects for the patient were certainly untenable. They would have been wrong. For the family, who believed that "where there is life there is hope," they would have been right.

Often a significant part of a court decision is the refusal of the court to directly address an issue raised. Let's review the first part of para. 46 of the Court of Appeal decision:

As indicated, in order to decide this appeal, we need not resolve the metaphysical debate over whether life saving measures in cases such as the respondent's are of no medical value because they are futile, or of high medical value because they are keeping him alive while his family continues to hold out hope for his recovery.

It was, I submit, with great wisdom that the Court of Appeal declined to address this metaphysical question and the refusal is wholly in keeping with Canadian culture and values.

In the earlier part of this paper, the authors examined how Israeli courts and its Parliament (the Knesset) dealt with decisions relating to end-of-life issues. While Israel is a secular democratic state, it drew upon its Jewish history and culture, and rooted its law surrounding end-of-life issues in the nationally shared value of the sanctity of life. To Israelis, regardless of where they reside on the religious or political spectrum, that value is primary to its over-2,000-year history, and it is for that reason that the sanctity of life is where the Israeli discussion starts.

Canada too has its shared values, some of which find expression in the *HCCA*, the *Charter* and in the Court of Appeal's decision declining to address the metaphysical question raised by the *Rasouli* case. We Canadians share the common ideal of the right of the individual to freedom of thought, belief, opinion and expression. While Canadians may be of many different ethnic origins and/or faiths, there is a shared belief that each of us has the right to life, liberty and security of the person. To that end, each of us has a right to answer metaphysical questions in our own way with our own belief system. It is, I suggest, one of the reasons the *HCCA* states that its purpose is to promote the autonomy of the individual when it comes to consenting to treatment. In the Canadian context, the starting point of our discussion should be that each of us has the right to choose.

The doctor's position, that they may unilaterally withdraw treatment, is coloured with their personal metaphysical perspective. When making decisions of medical futility they are saying that a 10 per cent chance of recovery is not enough, that the quality of life for a PVS patient is not worth saving. Arguably, if Canadians value the individual's right to choose, how can doctors be permitted to unilaterally usurp those rights? Query whether a medical or Board decision contrary to the wishes of the patient contravenes the *Charter*?

While the *HCCA* is open to more than one interpretation, it should be construed in a manner consistent with the *Charter*.⁷⁰ However, being consistent with the *Charter* is different than being subject to the *Charter*. Before Himel J., Parichehr argued that the hospital is an agent of the state and may not breach Hassan's *Charter* right to freedom of conscience and religion (under subs. 2(a)), nor his right to life, liberty and security of the person (under s. 7). In the trial decision, Himel J. observed that there was mixed case law on the topic and concluded that:

[A]pplying the relevant jurisprudence to the circumstances of the case before me, I am not persuaded that the *Charter of Rights* applies to the proposed decision of the physicians to withdraw treatment.⁷¹

In *Eldridge v. British Columbia (Attorney General)*,⁷² the Supreme Court of Canada concluded that the *Charter* applied to a hospital's decision not to provide sign language interpretation services to patients. Even if hospitals may be autonomous in their day-to-day operations, they are funded by and carry out services as set out in governing legislation. Consequently, the *Charter* applies to hospital decisions. Arguably doctors, in

⁷⁰See *M. (A.) v. Benes* (1999), 46 O.R. (3d) 271 (Ont. C.A.) at para. 22; *Slaight Communications Inc. v. Davidson*, [1989] 1 S.C.R. 1038 at p. 1078 (S.C.C.); and *Rasouli* (Ont. C.A.) *supra* note 1 at para. 36.

⁷¹Herman J. canvassed numerous cases and authorities either supporting or opposing the proposition that the decisions of doctors and hospitals must comply with the *Charter*. In support of that proposition she cited *Sawatzky v. Riverview Health Centre Inc.* (1998), 167 D.L.R. (4th) 359 (Man. Q.B.); and *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624 (S.C.C.) ("*Eldridge*"). In opposition, she cited *Stoffman v. Vancouver General Hospital*, [1990] 3 S.C.R. 483 (S.C.C.); and Peter W. Hogg, *Constitutional Law of Canada* (Ontario: Thomson Canada Limited, 2007) Vol. II, Chap. 37.2(c), 88.

⁷²*Eldridge*, *ibid.*

providing treatment and making decisions about the allocation of health care resources, act as government agents in the same manner as hospitals. Therefore, a doctor's decision is arguably just as subject to the *Charter* as the decision of a hospital. Both Himel J. and the Court of Appeal rejected this argument. However, the rejection of this argument is inconsistent with one of the positions taken by the doctors at trial.

In para. 46 of the trial decision in *Rasouli*, Himel J. noted:

The respondent Hospital further contends that a consequence of adopting the withdrawal of life support into the definition of treatment under the *HCCA* may be that the limited resource of intensive care will be overwhelmed with individuals with no hope of recovery remaining on life support for extended periods of time.

This argument was dismissed by Himel J. by pointing out the efficient, cost-efficient and timely way in which these issues are dealt with under the *HCCA*. On appeal the appellants did not pursue the issue and accordingly the Court of Appeal did not contemplate fiscal concerns in their decision.⁷³ That does not mean that the Supreme Court of Canada will restrict itself in the same manner.

Allocating limited public resources is a difficult task requiring prioritization of needs. The hospital's argument, before Himel J., was that given the medical futility of treating patients in a PVS, scarce resources can be better spent elsewhere. While this may be a political matter as opposed to a legal one, it once again raises the question of the *Charter*. Does the individual's right to life take precedence over the hospital's understanding of fiscal priority? If hospitals and doctors are funded by the provincial government and essentially fiscal gatekeepers, why would the *Charter* not apply? Essentially, the government is deciding that an incapable person's life with less than a 10 per cent chance of survival is not worth saving. Does that not breach the patient's s. 7 right to "life, liberty and security of the person" as guaranteed under the *Charter*? Even if the *Charter* does not apply, but interpretation of the *HCCA* must be consistent with the principles of the *Charter*, how is it demonstrably justifiable to value one life over the other based on a doctor's personal metaphysical position?⁷⁴

⁷³See *Rasouli* (Ont. C.A.) *supra* note 1 at paras. 31–33.

⁷⁴For members of the Jewish faith, the metaphysical question of how to value the life of the elderly or incapacitated is reflected in a story from the Talmud

Ultimately, the question before the Supreme Court of Canada is whether doctors in end-of-life situations may unilaterally make life and death decisions when they disagree over the value of the patient's life. To permit doctors that right is contrary to the Canadian cultural ethos and inconsistent with the *Charter*. After reviewing the law and preparing this article, the authors observed that most people signing health care directives or powers of attorney for personal care are unaware that if they have not contemplated exactly the type of situation that might befall them, their health care directive will fall short.⁷⁵ Query whether the designation of an SDM should be determinative. When a client chooses a person he trusts to make arguably the most important decision of his life, he makes such a choice based on the trust he has for the SDM to carry out his wishes. It is not some unknown doctor or the Board who he trusts to carry out his wishes. Query whether the legislative process in and of itself offends the rights of a person to consent to treatment.⁷⁶

(Berachos 8b). A rabbi taught that we must always revere an elderly scholar who has involuntarily forgotten his learning. Why? Says the Talmud, just as we store the broken pieces of the first Ten Commandments in the Ark of the Covenant because they retain their sanctity, so too do we revere the elderly and unwell even after they are no longer capable. The lesson from the Talmud is obvious. Life still has value worth saving even if the vessel in which it is housed is broken.

⁷⁵Please see analysis above of the *Grover* case, where the doctors argued that the incapable person could not have contemplated the medical situation being faced and therefore the decision of the SDM was not determinative.

⁷⁶It does not appear as if a patient's health care directive can oust the jurisdiction of the *HCCA*. Nonetheless, s. 26 of the *HCCA* and the case law make it clear that:

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.

For those who wish the SDM's decisions to be adhered to, perhaps the following clause should be inserted in all health care directives:

Notwithstanding anything to the contrary in the *HCCA* and in the absence of my known wishes for unanticipated situations arising out of my personal care, it is my express wish that the judgment and

decision of my attorneys be honoured. I have absolute trust in the judgment of those appointed as my attorney for personal care who know me best and understand what my wishes would be in every instance. My wish in those end-of-life instances is that the attorneys appointed be permitted to make those choices necessary. I specifically do not want any doctor to make those decisions on my behalf, nor do I want the Consent and Capacity Board to determine what is in my best interests.