# **CUTHBERTSON V. RASOULI: CONTINUED CONFUSION OVER CONSENT-BASED ENTITLEMENTS TO LIFE SUPPORT**

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#### I. INTRODUCTION

*Cuthbertson v. Rasouli*<sup>1</sup> had the potential to be the most significant case on the law of informed consent since *Reibl v. Hughes*<sup>2</sup> more than thirty years ago. The narrow issue before the Court was whether informed consent is required for doctors to withdraw life support they believe no longer to be medically appropriate. However, several broader unresolved questions about the scope of the law of informed consent were implicated. Could informed consent be required for treatment contrary to the standard of care? Could it create entitlements to treatment doctors do not offer to provide? Might the answer depend on the nature of the treatment (life support versus other treatments)? If the law of informed consent could create *de facto* entitlements to treatment, what limits would there be on such entitlements? To what extent does the law of consent in Ontario's Health Care Consent Act<sup>3</sup> differ from the common law?

When the Supreme Court of Canada ruled in *Rasouli*, a majority held that withdrawing mechanical ventilation, where death is the likely outcome and palliative care drugs will be administered, is treatment for which consent is required, regardless of the standard of care. This much is clear. But the decision left many of the questions above unanswered and, it is argued, answered others in a way that makes it difficult to apply the case's ratio to future disputes. As a result, there is arguably more uncertainty now than before the case was decided. For those who were seeking principled guidance, the case is a disappointment.

The Supreme Court erred in its interpretation of the HCCA. That statute's provisions regarding informed consent cannot reasonably be interpreted as creating entitlements to life support contrary to the standard of care. The Court's decision could have significant implications for resource allocation and for the future of the law of informed consent generally. The purpose of this comment, however, is not to argue that *Rasouli* was wrongly decided.<sup>4</sup> Instead, the focus is on uncertainty in the law given the Court's reasoning and on the implications of that uncertainty.

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<sup>[1980] 2</sup> SCR 880 [Reibl]. 2

<sup>3</sup> SO 1996, c 2, Schedule A [HCCA].

<sup>4</sup> For reasons why I conclude *Rasouli* was wrongly decided, see Hilary Young, "Why Withdrawing Life-Sustaining Treatment Should Not Require '*Rasouli* Consent'" (2012) 6:2 McGill JL & Health 54, which examines the similar reasoning of the Ontario Court of Appeal.

Specifically, because of the reasoning in *Rasouli*, it is difficult to know what outcome the case supports if: (1) the patient is not in Ontario; (2) the end of life treatment in question does not require physical interference (for example, withholding hydration and nutrition or placing a do-not-resuscitate order on a patient's chart); (3) palliative care medications will not be given when the ventilator is removed; or if (4) non-end-of-life treatments are at stake (cosmetic surgery, for example). The likely result of this uncertainty is more litigation, cases inappropriately being referred to Ontario's Consent and Capacity Board (CCB), and inconsistent future application of the law.

## II. THE CASE AND ITS REASONING

The *Rasouli* case centred on Hassan Rasouli, a Toronto man who has been in a vegetative or minimally conscious state<sup>5</sup> since the fall of 2010, when he suffered complications from brain surgery. He requires mechanical ventilation (a form of life support in which a machine effectively breathes for the patient) to remain alive and Mr. Rasouli's doctors saw no realistic prospect for improvement in his condition. They were therefore of the opinion that continued treatment is not medically indicated, that mechanical ventilation be withdrawn, and that Mr. Rasouli be allowed to die.

In November 2010, Rasouli's doctors sought a court order permitting them to remove Mr. Rasouli from the mechanical ventilator.<sup>6</sup> Patricher Salasel, Rasouli's wife and a physician herself, opposed withdrawing life support and litigation followed. The main legal issue in the case was whether withdrawing Rasouli's life support was a decision doctors could make based on their medical judgment, in accordance with the standard of care in negligence and their fiduciary and professional duties to their patient, or whether informed consent was required — either that of patients or of their substitute decision-makers (SDMs).

Perhaps surprisingly, this question was unresolved in law.<sup>7</sup> Some cases and commentary suggested that the law of informed consent had expanded, or could expand, to include the right to make decisions about treatment broadly, including the right to insist on continued life

<sup>&</sup>lt;sup>5</sup> Although initially diagnosed as being in a persistent vegetative state, Rasouli now has some degree of consciousness: see Lisa Priest, "Vegetative patient now able to give 'thumbs up,' fueling debate," *The Globe and Mail* (24 April 2012), online: The Globe and Mail <www.theglobeandmail.com/life/health-andfitness/vegetative-patient-now-able-to-give-thumbs-up-fuelling-debate/article1390975/>.

<sup>&</sup>lt;sup>6</sup> *Rasouli, supra* note 1 (Factum of the Appellant at para 19)

<sup>&</sup>lt;sup>7</sup> See Rasouli v Sunnbrook Health Sciences Centre, 2011 ONSC 1500, 105 OR (3d) 761 [Rasouli SC] ("[T]he common law position on whether consent is needed to withdraw or withhold treatment in Canada is not firmly decided" at para 83); Rasouli, supra note 1 ("The common law is not at all settled on this issue [whether consent is required for withdrawal of life support]" at para 53); Joan M Gilmour, "Death, Dying and Decision-Making about End of Life Care" in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, eds, Canadian Health Law and Policy, 4th ed (Markham: LexisNexis Canada, 2011) 385 at 410. Although these sources tend to address the common law position, until Rasouli there was no precedent interpreting the HCCA or analogous legislation on this issue.

support,<sup>8</sup> while others referred to the law of informed consent as relating only to permission to do what a doctor proposed, rather than grounding entitlements to treatment physicians do not propose to provide.<sup>9</sup>

At the court of first instance, the applications judge held that consent was required to withdraw Rasouli's mechanical ventilation. Justice Himel reasoned that "treatment" is broadly defined in the *HCCA* to include a "plan of treatment." A "plan of treatment" is also defined and Justice Himel cited authority for the proposition that "plan of treatment" includes withdrawing treatment.<sup>10</sup> In addition, she reasoned that since "treatment" includes things done for a "preventive" or "therapeutic" purpose, and since withdrawing treatment.<sup>11</sup> Since consent is required for all "treatment" under the *HCCA*, it is required to withdraw treatment.

The Ontario Court of Appeal upheld the lower court's decision, but on different grounds. It reasoned that withdrawing mechanical ventilation and providing palliative care go hand in hand. Since no doctor could ever ethically refuse to provide palliative care drugs after mechanical ventilation had been withdrawn, the two steps (withdrawing ventilation and providing palliative care) amount to a "treatment package." Since consent is undeniably required to provide palliative care drugs, the Court reasoned that it was required to withdraw ventilation as well.<sup>12</sup> This is the Ontario Court of Appeal's treatment package reasoning.<sup>13</sup>

A majority of the Supreme Court of Canada, like the courts below, ruled that consent is required to withdraw life-sustaining treatment. Its reasoning is set out in more detail below, but it relied largely on the statutory definition of "treatment," which means:

[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.<sup>14</sup>

Because withdrawing mechanical ventilation may be done for a health-related purpose, such as preventing suffering, it is "treatment" under the *Act*.<sup>15</sup> Since the *HCCA* requires consent for all treatment, consent is required to withdraw mechanical ventilation. If doctors believe continued treatment is not medically appropriate, their main recourse is to argue

See e.g. Jocelyn Downie, "Unilateral Withholding and Withdrawal of Potentially Life-Sustaining Treatment: a Violation of Dignity Under the Law in Canada" (2004) 20:3 J Palliative Care 143 at 146. For case law, see *Sawatzky v Riverview Health Centre Inc* (1998), 132 Man R (2d) 222 (QB) [*Sawatzky*], in which the Court held that although what case law there was suggested that "a decision not to provide treatment is exclusively within the purview of the doctor" (at para 26), there was nevertheless a triable issue regarding the application of the *Charter* or the development of the common law. As a result, the Court granted an injunction against a doctor imposing a do-not-resuscitate order on a patient's chart. See also *Golubchuk v Salvation Army Grace General Hospital*, 2008 MBQB 49, 227 Man R (2d) 274 [*Golubchuk*] (holding in part on the basis of *Sawatzky*, that the law is unsettled as to who has the final say at para 25).

<sup>&</sup>lt;sup>9</sup> See e.g. Young, *supra* note 4; Glen Rutland, "Futile or Fruitful: The *Charter* and the Decision to Withhold or Withdraw Life-Sustaining Treatment" (2009) 17:1 Health LJ 81; *Child and Family Services* of Central Manitoba v RL and SLH (1997), 123 Man R (2d) 135 (CA) [RL].

<sup>&</sup>lt;sup>10</sup> In *Rasouli* SC, *supra* note 7 at paras 21-22 Justice Himel cites *Scardoni v Hawryluck* (2004), 69 OR (3d) 700 (Sup Ct J) which held in *obiter* that "plan of treatment" includes withdrawing treatment.

<sup>&</sup>lt;sup>11</sup> *Rasouli* SC, *ibid* at para 29.

<sup>&</sup>lt;sup>12</sup> Rasouli (Litigation Guardian of) v Sunnybrook Health Sciences Centre, 2011 ONCA 482, 107 OR (3d) 9 at paras 49-52 [Rasouli CA].

 $<sup>^{13}</sup>$  *Ibid* at para 52. See also Young, *supra* note 4 at 73.

<sup>&</sup>lt;sup>14</sup> *HCCA*, *supra* note 3, s 2(1) as cited in *Rasouli*, *supra* note 1 at para 30.

<sup>&</sup>lt;sup>15</sup> *Rasouli, ibid* at para 49.

before the Ontario Consent and Capacity Board that a substitute decision is not being made in the patient's best interests, as required by law.<sup>16</sup>

## III. UNCERTAINTY FOLLOWING RASOULI

As indicated above, there was considerable uncertainty in the law that *Rasouli* might have helped clarify. For example, may doctors unilaterally impose a do-not-resuscitate order on a patient's chart? May they refuse mechanical ventilation to a patient when it is not medically indicated but where the patient or family wants all heroic measures? May they decide when to stop treating a patient based solely on the standard of care? There was little doubt that patients and their families had at least to be consulted,<sup>17</sup> but in case of disagreement, the law provided little guidance.

One reason for the pre-*Rasouli* uncertainty is the fact that so few of these cases are heard by appellate courts. First, most conflicts are resolved through discussion. Either patients or their SDMs are convinced to follow the doctors' recommendation,<sup>18</sup> or else doctors may give in to requests for life support of questionable medical value to avoid causing family members distress or to avoid legal action.<sup>19</sup> Second, even where consensus cannot be achieved, patients often do not live long enough for cases to be resolved by the courts — especially at the appellate level.<sup>20</sup> Third, in Ontario these cases are often referred to the Ontario Consent and Capacity Board (CCB) for a best interests determination,<sup>21</sup> even though this would only be appropriate if consent were required for treatment that doctors do not wish to provide, which was unclear and the very issue at the heart of *Rasouli*.<sup>22</sup>

Another reason for uncertainty is that either the common law or the *HCCA* could have applied to cases like Rasouli's. To complicate matters further, the common law implicates two distinct causes of action: battery and negligence. Although the *HCCA* in many respects codifies the common law, there are important differences.<sup>23</sup> The outcome of cases might therefore depend on which source of law applies.

<sup>&</sup>lt;sup>16</sup> *Rasouli, supra* note 1 at paras 2, 116.

<sup>&</sup>lt;sup>17</sup> The standard of care would seem to require it. See Young, *supra* note 4 at 59, citing for example, a Statement by the Manitoba College of Physicians and Surgeons.

<sup>&</sup>lt;sup>18</sup> In a study conducted in the United States, most families agreed with the doctor's recommendation to withdraw life support from the outset. Of those who disagreed at first, eight out of ten were ultimately convinced to agree: Nicholas G Smedira et al, "Withholding and Withdrawal of Life Support from the Critically III" (1990) 322:5 New Eng J Med 309 at 312.

<sup>&</sup>lt;sup>19</sup> Ibid. It was suggested in Young, *supra* note 4 at 60, n 14 that a dearth of legal cases in Canada may suggest that doctors sometimes acquiesce rather than bring legal action.

<sup>&</sup>lt;sup>20</sup> Golubchuk and Sawatzky, supra note 8 were both cases involving interim injunctions. Although RL, supra note 9 suggests that the common law permits doctors to withdraw treatment without informed consent, it is a trial-level decision.

<sup>&</sup>lt;sup>21</sup> Laura Hawryluck, Robert Sibbald & Paula Chidwick, "The Standard of Care and conflicts at the End of Life in critical care: Lessons from medical-legal crossroads and the role of a quasi-judicial tribunal in decision-making" (2013) 28:6 J Critical Care 1055.

The best interests inquiry is only relevant in deciding whether to give or refuse consent. If consent is not required, it is inappropriate to engage in a best interests test as set out in the *HCCA*. The Rasouli family had argued throughout that the CCB was the proper body to decide whether treatment should be continued. However, as was argued in Young, *supra* note 4 at 93-94 the CCB's purview is limited to making decisions about matters such as capacity, who is the proper SDM and whether a decision to provide or withhold consent is made in a patient's best interests.

<sup>&</sup>lt;sup>23</sup> Ellen I Picard & Gerald B Robertson, Legal Liability of Doctors and Hospitals in Canada, 4th ed (Toronto: Thomson Canada, 2007) at 56. But see Rasouli, supra note 1 at para 52, which states that the HCCA is "entirely independent" of the common law.

At common law, informed consent is a defence to battery (although as such, consent need not actually be informed).<sup>24</sup> It is also a requirement of non-negligent medical practice. That is, doctors owe an affirmative duty of care to patients to inform them sufficiently of the risks and benefits of treatment before obtaining their consent and performing that treatment. If a failure to inform properly causes injury, the doctor may be liable in negligence.<sup>25</sup> The underlying principle is that of respect for patient autonomy — competent patients may accept or reject any treatment, so they must not only be given that choice, but be given enough information to be able to make a choice that reflects their values.

The common law of informed consent as a defence to battery would only apply to requests to withdraw life support if in so doing, doctors had to touch patients. If life support can be withdrawn without touching, battery would not lie regardless of consent, otherwise consent would be required.

It is less clear, however, whether the duty in negligence to obtain informed consent applies to withdrawing life support when continued treatment is contrary to the standard of care. On the one hand, because the law of consent originally focused on permission to interfere with bodily integrity, some courts have held it cannot create entitlements to treatment doctors do not propose to provide.<sup>26</sup> It is still a question of permission.

On the other hand, because the law of informed consent has changed significantly over the past fifty years or so to protect and promote patient autonomy in medical decisionmaking, moving beyond the battery context, it seems arbitrary to limit patient choice to interventions doctors are willing to provide. Patient autonomy is equally implicated when a patient wants a treatment doctors consider ill advised. On that logic, the common law has expanded or could expand to include the right to insist on certain treatment.<sup>27</sup>

According to the Supreme Court in *Rasouli*, the common law is unresolved. This author's view is that at common law, consent is only required for treatments proposed by a doctor — that is, informed consent only allows patients to reject or accept proposed treatment, not to demand non-recommended treatment.<sup>28</sup> It is open to future courts to extend the principle of informed consent to include the ability to demand certain treatments, but there is little in the case law to suggest that that is the present state of the common law.

To further complicate matters, Ontario has a statutory informed consent regime (the *HCCA*) that exists alongside the common law. There is little if any case law on whether the circumstances under which consent is required differ between the *HCCA* and the common law. It was therefore unclear whether the question of consent to withdraw treatment contrary to the standard of care would be answered differently under the *HCCA* than under the common law.

Reibl, supra note 2.

<sup>&</sup>lt;sup>25</sup> *Ibid.* <sup>26</sup> Sec.

<sup>&</sup>lt;sup>26</sup> See e.g. Re R (a minor), [1991] 4 All ER 177 CA, Lord Donaldson of Lymington MR; RL, supra note 9

<sup>&</sup>lt;sup>27</sup> See Downie, *supra* note 8.

<sup>&</sup>lt;sup>28</sup> See also Young, *supra* note 4 at 66.

Given all this, Rasouli had the potential to resolve significant areas of uncertainty in the law. In the end, it resolved uncertainty only in one narrow set of circumstances and in so doing, introduced new uncertainties regarding how to apply Rasouli to future cases.

#### A. THE LAW OUTSIDE ONTARIO

The first area of uncertainty relates to the law outside Ontario. The Supreme Court explicitly refused to rule on whether the common law requires consent for treatment contrary to the standard of care.<sup>29</sup> Instead, its ruling is based almost entirely on the meaning of "treatment" in the HCCA. Since the HCCA is an Ontario statute, the Court's reasoning has no direct application outside Ontario.

This is proper in that, having concluded the HCCA applies, anything said about the common law would be obiter. Further, courts should generally confine themselves to the facts and issues before them. However, it is not unusual or inappropriate for appellate courts to provide guidance in *obiter*. Given the Supreme Court's mandate to decide cases of public importance,<sup>30</sup> which is often understood to mean *national* importance,<sup>31</sup> it is unfortunate that the Court answered the question in a narrow way inapplicable to most of the country without addressing the common law — which applies throughout Canada's common law jurisdictions.

Notwithstanding the fact that the decision is binding only in Ontario, other jurisdictions have statutes that may be interpreted in light of the Supreme Court's decision in Rasouli. In order to examine how Rasouli may be applied outside Ontario, it is useful to group these jurisdictions' statutes into four categories.

First, some jurisdictions have statutes that, like the HCCA, explicitly require consent for "treatment" or "health care" and define those terms similarly to the HCCA's definition of "treatment." Provinces and territories falling into this category are British Columbia, 32 Prince Edward Island,<sup>33</sup> and the Yukon.<sup>34</sup> For example, British Columbia's Health Care (Consent) and Care Facility (Admission) Act states that consent is required for all "health care" (section 5) and defines "health care," in part, as "anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health." Given that these statutes set out a requirement of consent for treatment or health care and define treatment or health care similarly to the HCCA's definition of "treatment," Rasouli's holding that consent is

<sup>29</sup> 

Rasouli, supra note 1 at para 53. Supreme Court Act, RSC 1985, c S-26, s 40(1). 30

<sup>31</sup> Donald R Songer, The Transformation of the Supreme Court of Canada: An Empirical Examination (Toronto: University of Toronto Press, 2008) at 46-47. 32

Health Care (Consent) and Care Facility (Admission) Act, RSBC 1996, c 181, ss 1, 5.

<sup>33</sup> Prince Edward Island's Consent to Treatment and Health Care Directives Act, RSPEI 1988, c C-17.2, s 1, defines "treatment" almost identically to the definition in the HCCA, and explicitly requires consent for all treatment.

<sup>34</sup> The Yukon Care Consent Act, s 3, being Schedule B to the Decision Making Support and Protection to Adults Act, SY 2003, c 21, requires consent for "care" (s 3) and defines care in section 1 as "(a) health care, (b) admission to live in a care facility, and (c) personal assistance services." "Health care" is further defined similarly to the HCCA definition of treatment. In particular, it includes anything done for a health-related purpose. Interestingly, the Yukon also has its own Capability and Consent Board with a mandate similar to that of Ontario's Consent and Capacity Board. See Part 3 of the Care Consent Act.

required to withdraw mechanical ventilation is likely to be the most persuasive in British Columbia, Prince Edward Island, and the Yukon.

Second, some provinces and territories have statutes that define "treatment" or "health care" in a manner similar to that in the *HCCA*, but only for specific purposes, such as creating advance health care directives, and without imposing a general statutory requirement of consent for treatment. Manitoba,<sup>35</sup> Newfoundland and Labrador,<sup>36</sup> and the Northwest Territories<sup>37</sup> are such jurisdictions. For example, Manitoba's *Health Care Directives Act* allows capable people to make binding health care directives regarding treatment, and defines "treatment" as "anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment."

One might assume that *Rasouli* would be persuasive in these those jurisdictions as well, given a broad definition of "treatment" or "health care" that seems to mirror the definition in the *HCCA*. This would be mistake. Although the Supreme Court described Manitoba's legislation as "similar" to the *HCCA*,<sup>38</sup> there is an important difference: the Manitoba legislation does not require consent for treatment generally. Like the Newfoundland and Labrador, and Northwest Territories legislation, Manitoba's relates only to health care directives and substitute decision-making and says nothing about the circumstances in which consent is required.

In fact, these statutes appear to invoke the common law as to when consent is required. They state that substitute decisions and advance health care directives are as effective as if they had been made by the patient, assuming the patient were presently capable.<sup>39</sup> They do not indicate when consent is required: they simply place the directive or SDM in the place of the patient. Thus, if the capable patient's consent or refusal is not required for a particular decision, an advance health care directive giving consent would be irrelevant. An SDM's consent is equally irrelevant. Unlike the *HCCA*, these statutes cannot be interpreted as dictating the kinds of interventions that require consent.

It would therefore be wrong to conclude that the definition of "treatment" or "healthcare" in Manitoba, Newfoundland and Labrador, and the Northwest Territories legislation supplants the common law regarding when consent is required. In these jurisdictions, *Rasouli* should not be considered persuasive authority.

<sup>&</sup>lt;sup>35</sup> The Health Care Directives Act, SM 1992, c 33, CCSM c H27, ss 1, 7 [Manitoba Act].

<sup>&</sup>lt;sup>36</sup> The Advance Health Care Directives Act, SNL 1995, c A-4.1 [Newfoundland and Labrador Act] defines "health care decision" and allows for advance health care directives and substitute decisions regarding "health care decisions."

<sup>&</sup>lt;sup>37</sup> The Personal Directives Act, SNWT 2005, c 16 [Northwest Territories Act] defines "health care" in a broad manner, similar to the definition in the British Columbia legislation, but does not state that consent is required for health care.

<sup>&</sup>lt;sup>38</sup> Rasouli, supra note 1 at para 22. Other statutes said to be "similar" to the HCCA are those of British Columbia, Prince Edward Island, the Yukon, and Quebec.

<sup>&</sup>lt;sup>39</sup> Manitoba Act, supra note 35, ss 7(1)-(2); Newfoundland and Labrador Act, supra note 36, ss 5(1)-(2); Northwest Territories Act, supra note 37, s 11(2).

Third, there are jurisdictions that neither set out a statutory requirement of consent for medical treatment, nor define "treatment" for health-related purposes. The provinces and territories falling into this third category are Alberta,<sup>40</sup> New Brunswick,<sup>41</sup> Nova Scotia,<sup>42</sup> Saskatchewan,<sup>43</sup> and Nunavut.<sup>44</sup> In these jurisdictions, it is even clearer that the *Rasouli* decision has no impact on the law. Although statutes in these jurisdictions may provide for advanced directives or substitute decision-making, they do not address the fundamental issue of when consent is required. The common law therefore necessarily governs with regard to this question, and it remains unresolved.

Fourth, as is often the case, Quebec is unique. Its *Civil Code* prohibits treatment without consent, but treatment is not defined.<sup>45</sup> The common law would not apply, given that Quebec is a civil law jurisdiction, but for the same reason, the Supreme Court's interpretation of an Ontario statute in *Rasouli* should have no influence in interpreting Quebec's *Civil Code*.

In other words, there is uncertainty about whether informed consent is required to withhold or withdraw life support, or treatment contrary to the standard of care generally, in most of Canada's provinces and territories. This is true even within the confines of the facts in *Rasouli*: only in Ontario can we conclude with certainty that consent is required to withdraw mechanical ventilation in anticipation of imminent death when palliative care follows withdrawal of treatment. Since the Supreme Court's interpretation of the *HCCA* is persuasive but not binding outside Ontario, the narrow conclusion above would most likely apply in British Columbia, Prince Edward Island, and the Yukon as well. In every other Canadian jurisdiction, *Rasouli* has very little relevance.

## **B.** THE SCOPE OF THE RIGHT TO CONSENT TO WITHDRAWING LIFE SUPPORT

The remaining areas of uncertainty apply even within Ontario. One relates to which kinds of interventions or non-interventions require consent.

It is clear that whether consent is required does not depend on the distinction between "active" treatment on the one hand and withholding or withdrawing treatment on the other. A majority of the Supreme Court rejected the doctors' argument that withdrawing treatment could never be "treatment" for which consent is required.<sup>46</sup> But it did not go so far as to say

H-0.001 deals with health care directives and does not define "treatment" for which consent is required.
Nunavut has no relevant legislation.

<sup>&</sup>lt;sup>40</sup> In Alberta, neither the Adult Guardianship and Trusteeship Act, SA 2008, c A-4.2 nor the Personal Directives Act, RSA 2000, c P-6 define "treatment." The former is largely concerned with patients' capacity and with substitute decision-making, while the latter is concerned with the ability to make binding advance directives.

<sup>&</sup>lt;sup>41</sup> New Brunswick's Infirm Persons Act, RSNB 1973, c I-8 does not define "treatment." Its primary healthrelated purpose is to allow for substitute medical decision-making.

<sup>&</sup>lt;sup>42</sup> The *Personal Directives Act*, SNS 2008, c 8 does not define health care or treatment and does not indicate when consent is required.

 <sup>&</sup>lt;sup>43</sup> Saskatchewan's *Health Care Directives and Substitute Health Care Decision Makers Act*, SS 1997, c

<sup>&</sup>lt;sup>45</sup> Art 11 CCQ states that: "No person may be made to undergo care of any nature, whether for examination, specimen taking, removal of tissue, treatment or any other act, except with his consent." However, "care" is not further defined.

<sup>&</sup>lt;sup>46</sup> *Rasouli, supra* note 1 at paras 45-70.

that withholding or withdrawing treatment *always* requires consent, since this would lead to absurd consequences:

Common sense suggests that many withdrawals of treatment — for example, refusal to renew a prescription for a drug that may harm a patient — must be excluded from the definition of "treatment" under the Act.

A more nuanced view that withdrawal of treatment may sometimes, although not always, constitute "treatment" better fits the provisions of the *HCCA* and the realities of medical care.<sup>47</sup>

The question, therefore, is when withholding or withdrawing care amounts to "treatment" for which consent is required. Another way of phrasing this question is to ask what care a patient can demand despite the fact that a physician does not want to provide it. The only certainty is that in Ontario, withdrawing mechanical ventilation where palliative care and death follow imminently is "treatment" and that refusing to prescribe a harmful drug is not. It also appears to be true that withholding life support generally requires consent where palliative care or other touching occurs during or shortly after withdrawing treatment.<sup>48</sup>

The Court provides some clues as to what principles guide the determination, but those principles do not necessarily support the relevant outcome, or they support outcomes the Court may not have intended them to. I discuss problems associated with two such principles: the "health-related purpose" and autonomy.

## 1. "HEALTH-RELATED PURPOSE"

The first clue is the Supreme Court's statutory interpretation of a "health-related purpose": "At a minimum, if the processes involved in withdrawal of care are health-related, they do not cease to be treatment merely because one labels them cumulatively as 'withdrawal of treatment."<sup>49</sup> This is consistent with the Court's statutory interpretation of "treatment" including anything done for a "health-related purpose." At first blush this would seem to distinguish withdrawing mechanical ventilation (which may have health-related purposes, such as alleviating suffering) from refusing to write a prescription for a harmful drug (which presumably has no health-related purpose).

The distinction, however, is not so clear. Consider the meaning of "health-related purpose." Although it is not a defined term, the definition of "treatment" in the *HCCA* indicates that "therapeutic, preventive, palliative, diagnostic, [and] cosmetic" purposes are a non-exhaustive list of health-related purposes. The Court also states that alleviating suffering, minimizing distress, and preventing indignity are health-related purposes.<sup>50</sup>

<sup>&</sup>lt;sup>47</sup> *Ibid* at paras 58-59.

<sup>&</sup>lt;sup>48</sup> The Court refers not only to withdrawing mechanical ventilation but sometimes also to withdrawing life support as amounting to "treatment." See e.g. *Rasouli, ibid* at para 69. That said, some of its requirements rely on physical interference, and not all withdrawals of life support involve physical interference.

 $<sup>^{49}</sup>$  *Ibid* at para 60.

<sup>&</sup>lt;sup>50</sup> *Ibid* at para 61.

"Health-related purpose" is therefore a very different concept than "medically appropriate" or meeting the standard of care in negligence. The Court goes to great lengths to distinguish the standard of care from the broader concept of "health-related purpose":

The issue here is not the correctness of the physicians' professional opinion that sustaining life in Mr. Rasouli's situation confers no medical benefit. In fact, their opinion appears to reflect a widely accepted view in the medical community. The issue at this stage of the argument is whether maintaining Mr. Rasouli's life serves a health-related purpose within the meaning of the *HCCA*.<sup>51</sup>

Given this understanding of "health-related purpose," withholding a prescription for a harmful drug has a health-related purpose. The doctor refuses to prescribe in order to prevent the effects of the drug — that is, to prevent the patient's suffering and to prevent illness, both of which are health-related purposes. And yet the Court implies without explanation that refusing to prescribe a harmful drug does not have a health-related purpose.

In fact, it might even serve a health-related to purpose to actually prescribe harmful drugs that patients very much want. It might alleviate their physical or mental suffering (through a placebo effect or simply because they get what they want). It might minimize patients' distress. Even if the drug were harmful it is not obvious that prescribing it could not serve a "health-related purpose" if "health related purpose" and "medically appropriate" mean different things as the Supreme Court has stated.

Consider two other hypothetical examples, one with extreme consequences and one with relatively trivial ones. The first involves bodily integrity identity disorder (BIID), a recognized psychiatric condition in which patients want a healthy limb amputated.<sup>52</sup> Patients believe these limbs are foreign and suffer great distress when amputation is refused, sometimes resorting to self-amputation.<sup>53</sup> There is some dispute as to whether such amputations are ethically permissible,<sup>54</sup> but let us assume that the standard of care prohibits removing a healthy limb from a patient who wants the amputation because of a psychiatric disorder.<sup>55</sup>

On the Supreme Court's "health-related purpose" reasoning, the standard of care would not govern: if there is a health-related purpose, consent *not* to amputate would seem to be required (and could therefore be refused). Given the nature of BIID, removing a limb likely has health-related purposes: alleviating suffering and minimizing distress. If so, it follows that withholding amputation is "treatment" for which consent is required. BIID patients in Ontario could use the consent requirement in the *HCCA* to insist on amputation. Doctors who refused would be in breach of their duty to obtain informed consent. Surely this is not what the Supreme Court had in mind.

<sup>&</sup>lt;sup>51</sup> *Ibid* at para 38; see also paras 35-37.

Sabine Müller, "Bodily Integrity Identity Disorder (BIID) — Is the Amputation of Healthy Limbs Ethically Justified?" (2009) 9:1 The Am J Bioethics 36.

<sup>&</sup>lt;sup>53</sup> *Ibid* at 36.

<sup>&</sup>lt;sup>54</sup> *Ibid* at 39-40

<sup>&</sup>lt;sup>55</sup> Although people suffering from BIID have a psychiatric condition, it does not follow that they have insufficient capacity to make their own medical decisions. See *Starson v Swayze*, 2003 SCC 32, [2003] 1 SCR 722 in which a patient suffering from bipolar disorder had sufficient capacity to refuse consent to being medicated.

One might respond that refusing to perform an amputation is *withholding* treatment, not *withdrawing* it. While true, this distinction is only helpful if there is any principled reason to distinguish between withholding and withdrawing in determining what counts as treatment under the *HCCA*. The Supreme Court does not draw such a distinction; on the contrary, it notes that a "plan of treatment" may provide for withholding or withdrawing treatment. Since treatment includes plan of treatment, it is hard to see how the difference between withdrawing and withholding treatment could determine whether something counts as "treatment."<sup>56</sup>

Now consider a less extreme example. What if, although not medically indicated, the (non-)intervention a patient seeks is relatively harmless? A common example is a patient with a viral condition who insists on being prescribed antibiotics.<sup>57</sup> Again, there would seem to be a health-related purpose, as the Court defines it, in prescribing the drug. There may be a placebo effect. The patient's psychological distress may be reduced. Antibiotics could perhaps be considered preventive in the sense of preventing the patient from acquiring a bacterial infection. And yet, there are good medical reasons not to prescribe antibiotics to people with viral conditions.

The point of these examples is not to suggest that doctors should have to amputate healthy limbs or to prescribe harmful or useless drugs when patients request them. It is not even to suggest that courts will interpret *Rasouli* this way in the future — after all, the Court suggests that common sense must play a part.<sup>58</sup> Rather, the point is to demonstrate that the Court's reliance on a "health-related purpose" to determine when consent is required and when it is not is ultimately not helpful. The concept is too broad to distinguish meaningfully between the kinds of interventions the Court says require consent (withdrawing mechanical ventilation in anticipation of imminent death) and interventions that the Court says do not require consent (withholding prescriptions for harmful drugs). As a result, the concept provides insufficient guidance to doctors, patients, and their families.

#### 2. Autonomy

The Court provides a second clue as to which (non-)interventions require consent and which do not. It relates to a fundamental principle guiding the law of informed consent (and the *HCCA* in particular), respecting patient autonomy:

The objects of the *HCCA* also support the view that "treatment" may include withdrawal of treatment. The values of autonomy — critical where life is at stake — and providing a meaningful role for family members support regarding withdrawal of life support as "treatment" requiring consent. These values must be balanced against that of ensuring appropriate care for incapable patients.<sup>59</sup>

<sup>&</sup>lt;sup>56</sup> Rasouli, supra note 1 at para 50. Note also the Ontario Court of Appeal's discussion of withholding versus withdrawing treatment: Rasouli CA, supra note 12 at paras 55-56.

One might take issue with the contention that prescribing unnecessary antibiotics is relatively harmless.
However, it is only harmful at a public health level, generally not to the particular patient to whom they have been prescribed.

<sup>&</sup>lt;sup>58</sup> *Rasouli* SCC, *supra* note 1 at para 58.

<sup>&</sup>lt;sup>59</sup> *Ibid* at para 51.

The majority further states: "By removing medical services that are keeping a patient alive, withdrawal of life support impacts patient autonomy in the most fundamental way."<sup>60</sup>

The majority's reasoning therefore seems to be that there is something special, seen through the lens of autonomy, about decisions whether or not to withdraw life support, relative to decisions that do not involve life and death. Deciding whether to receive a prescription for harmful or useless drugs, or deciding to amputate one's limb might implicate autonomy to a lesser degree than whether to withdraw life support. Since enhancing autonomy is an explicit purpose of the *HCCA*, it helps determine what counts as "treatment."

On closer examination, however, autonomy is not a reliable guide in assessing what counts as "treatment" — at least not in a way that produces the result in *Rasouli*. The Court assumes a context of substitute decision-making, as was the case on the facts. One purpose of a regime of substitute decision-making is to promote incompetent patients' autonomy by respecting their wishes and allowing people who know patients best to make decisions that reflect patients' values and beliefs.<sup>61</sup>

Substitute decisions may be the best we can do when a patient lacks capacity, but they are inherently less autonomy-promoting than decisions made by patients with capacity. In fact, in *Rasouli*, the majority stated that:

When such capacity is lacking, the patient is not in a position to exercise his autonomy by consenting to or refusing medical treatment.

If a patient is incapable, disputes over consent to treatment at common law are resolved in the courts. The focus shifts from the patient's autonomy interest, *which is compromised or extinguished*, to whether receiving treatment is in the best interests of the patient.<sup>62</sup>

How then can respect for autonomy justify requiring a substitute decision to withdraw life support? Given that Rasouli is in a minimally conscious state, he has no capacity to decide and little if any ability to experience the effects of the decision in question. The fact that life and death are at issue in *Rasouli* may make an autonomous decision more desirable, but it does not mean an autonomous decision is actually possible, as the Court itself acknowledges.

Arguably, the goal of enhancing autonomy more strongly supports allowing capable patients to insist on being prescribed useless or harmful drugs or having limbs amputated than it supports substitute decisions involving life and death. Autonomy is the reason we allow patients to refuse medically necessary drugs. Should not respect for autonomy suggest, all other things being equal, that people may demand medically harmful treatment just as they may refuse medically necessary treatment? Respect for autonomy grounded a New Jersey patient's entitlement to refuse an amputation that could have saved his life:<sup>63</sup> it should equally support a BIID patient's entitlement to obtain an amputation.

 $<sup>^{60}</sup>$  Ibid at para 68.

<sup>&</sup>lt;sup>61</sup> *Ibid* at para 87.

<sup>&</sup>lt;sup>62</sup> *Ibid* at paras 20-21 [emphasis added].

<sup>&</sup>lt;sup>63</sup> In Re Quackenbush, 383 A (2d) 785 (NJ Super Ct 1978).

If autonomy is a guiding principle, and the standard of care is not relevant, it becomes hard to distinguish between the kinds of decisions that the Court says require consent (withdrawing mechanical ventilation) and those it says do not (renewing a prescription for a harmful drug). Even if we were to accept that autonomy justifies requiring consent for life and death decisions but not others, this would surely not apply where an autonomous decision is impossible.

Consider a further example in which life and death *are* at stake: physician-assisted dying. The Supreme Court of Canada recently held that the criminal prohibition on assisted suicide is unconstitutional to the extent that it applies to certain forms of physician-assisted dying.<sup>64</sup> The Supreme Court's autonomy-based reasoning in *Rasouli* could be interpreted so as to prevent physicians from withholding assistance in dying.

The Supreme Court has stated that nothing in its decision should be understood as prohibiting doctors' conscientious objection to assisting patients with dying,<sup>65</sup> and *Carter* will surely not be understood to require doctors to assist their patients if they request help dying. On the logic of *Rasouli*, however, consent to withhold a physician-assisted death could be refused, such that a doctor would have to provide such assistance. "An individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy."<sup>66</sup> Autonomy is clearly implicated, especially assuming that the individual seeking physician-assisted suicide is capable.<sup>67</sup>

Again, this author is not suggesting that a patient's consent will be required in order for a physician to refuse to assist the patient in dying. The point of these examples it is to demonstrate that a concern for autonomy does not support the Court's distinction between withdrawing life support and refusing to renew a dangerous prescription. Rather, respect for autonomy would seem to support a patient's entitlement to demand a wide range of treatments, including harmful ones. The fact that a decision is one of life and death may implicate autonomy to a greater degree than decisions with less serious consequences,<sup>68</sup> but in *Rasouli* a fully autonomous decision was impossible. Even where it is possible, as with a competent request for physician-assisted dying, common sense suggests that the patient's autonomous wishes cannot always be determinative. Thus, to the extent that autonomy is a guiding principle in determining which medically unwarranted interventions require consent and which do not, it does not necessarily lead to the outcome the Court prescribes, nor does it provide sufficient guidance to courts in future cases.

 <sup>&</sup>lt;sup>64</sup> Carter v Canada (Attorney General), 2015 SCC 5, [2015] SCJ No 5 (QL) [Carter].
<sup>65</sup> Hild Larger 122, "In provide a characterization of invalid to the second sec

<sup>&</sup>lt;sup>65</sup> Ibid at para 132: "In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying."

<sup>&</sup>lt;sup>66</sup> *Ibid* at para 66.

<sup>&</sup>lt;sup>67</sup> Note also that the requirement of a health-related purpose will not exclude withholding assistance in dying from the scope of "treatment", given the Supreme Court's broad understanding of such purposes. Withholding assistance in dying is preventive in that it prevents death. It could also arguably prevent indignity, if deliberately causing death were viewed as contrary to a patient's dignity. The Supreme Court noted in *Carter*, *ibid* at para 10 that both sides of the physician-assisted death debate invoke the patient's dignity.

<sup>&</sup>lt;sup>68</sup> For present purposes the author concedes this, although it strikes one as arguable.

## C. TREATMENT PACKAGES

And then there is the "treatment package" reasoning. The Ontario Court of Appeal reasoned that because palliative care is unequivocally "treatment" for which consent is required, and because palliative care will necessarily follow withdrawal of mechanical ventilation, the two are inseparable. They are a "treatment package" such that consent is required to withdraw mechanical ventilation because it is required to provide palliative care.<sup>69</sup> this author has criticized this reasoning before,<sup>70</sup> but this comment addresses only the uncertainty raised by the Supreme Court's approach to treatment packages in *Rasouli*.

On the one hand, Chief Justice McLachlin appears to adopt the treatment package reasoning. Responding to criticisms of that reasoning she states: "what seems clear is that palliative care will inevitably be administered in Ontario hospitals as part of the process of withdrawing life support in cases like Mr. Rasouli's. The simple fact is that appropriate medical care at the end of life, including palliative care, is closely tied to the withdrawal of life support."<sup>71</sup>

On the other hand, the Court acknowledges a flaw in the Ontario Court of Appeal's reasoning, namely that palliative care does not always follow withdrawal of life support.<sup>72</sup> If the two are not inseparable — if they do not necessarily coincide — it is hard to see how the treatment package reasoning survives. How can consent be required for an intervention, or lack thereof, solely on the basis that that intervention *often* coincides with another for which consent is required? To the extent the treatment package reasoning ever had a logical basis, the Supreme Court would seem to have deprived it of one. Thus, the status of the treatment package reasoning remains uncertain.

If taken seriously, the treatment package reasoning would result in arbitrary consequences that courts will surely want to avoid. For example, withdrawing mechanical ventilation where palliative care has not yet been administered, but would be administered after the machines are turned off, would require consent. Withdrawing mechanical ventilation where palliative had already been consensually administered, and therefore would not be administered after the machines are turned off, would *not* require consent. Withdrawing artificial hydration and nutrition would not require consent unless new palliative care drugs are administered. Placing a DNR order on a patient's chart would not require consent because there would be no touching — at least not until the time the decision not to resuscitate is implemented.

#### **IV. CONCLUSION**

How then should courts interpret *Rasouli*? The answer certainly depends on the jurisdiction in question. Given the case's narrow reliance on the language of the *HCCA*, it should have little if any impact in most of Canada.

<sup>&</sup>lt;sup>69</sup> *Rasouli* CA, *supra* note 12 at para 53.

<sup>&</sup>lt;sup>70</sup> Young, *supra* note 4 at 73-79.

*Rasouli, supra* note 1 at para 67.

<sup>&</sup>lt;sup>72</sup> *Ibid:* "While the Court of Appeal's assertion that removal of life support will *always* lead to the administration of end-of-life palliative care may be too broad" [emphasis in original].

In Ontario and those jurisdictions with statutes similar to the *HCCA*, the answer is only a little clearer. It is possible to understand *Rasouli* as requiring consent for every (non-) intervention having a "health-related purpose." However, given the breadth of the Supreme Court's understanding of "health-related purpose," that would seem to capture too much — including withholding treatment where the Supreme Court states that consent is not required (for example, not renewing a prescription for a harmful drug).

*Rasouli* also emphasizes patient autonomy, but again this is problematic. Rasouli is incapable of communicating his present wishes, although undoubtedly that his wife accurately states what she believes he would want. Further, many interventions the court would surely want to exclude from the definition of "treatment," such as prescribing harmful drugs and withholding physician-assisted dying certainly implicate autonomy.

The Ontario Court of Appeal's "treatment package" reasoning makes an appearance in the Supreme Court's reasons, but the future of this potentially significant new principle is uncertain. On the one hand the Court appears to rely on the treatment package reasoning. On the other, it acknowledges that withdrawing life support does not *necessarily* lead to palliative care. Does the reasoning depend on whether in any particular case palliative care will follow, or does the principle apply generally because of the correlation between withdrawing life support and palliative care? Time will tell.

Given this uncertainty, it will be difficult for doctors, patients, and lawyers to anticipate how courts will apply the reasoning in *Rasouli* to future cases. Other than withdrawing mechanical ventilation in Ontario, where palliative care drugs will be administered after ventilation is withdrawn, and other than refusing to prescribe harmful drugs demanded by a patient, it is hard to know when informed consent is required under the *HCCA*.

Of course it is perfectly legitimate to decide a case on its facts and leave other situations to be decided in future cases. The problem with *Rasouli*, however, is that the principles on which future courts should rely are not clearly set out, or do not convincingly support the position of the Court, or both.

*Rasouli* is a lost opportunity to clarify the law. Such cases rarely make their way to appellate courts, and legislators appear unwilling to resolve the legal uncertainty. This uncertainty will inevitably cause patients to suffer needlessly, cause doctors and substitute decision-makers to agonize more over these decisions, and lead to more legal challenges.