

WHY WITHDRAWING LIFE-SUSTAINING TREATMENT SHOULD NOT REQUIRE “*RASOULI* CONSENT”

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Technology allows us to keep patients alive despite very poor prognoses and quality of life. We must therefore confront questions of when medical intervention should cease, and who should be allowed to make that decision.

Until recently it was unclear whether doctors or patients have the ultimate say in whether to withhold or withdraw life-sustaining treatment. In *Rasouli v Sunnyside Health Sciences Centre*, the Ontario Court of Appeal held that doctors may only withdraw certain life-sustaining treatment with the consent of patients or their substitute decision makers. It reasoned that withdrawing certain treatment is “treatment” for which consent is required under Ontario’s *Health Care Consent Act*. This effectively gives the patient an entitlement to continued life support.

I argue that the law of informed consent should not dictate who may decide whether treatment is withheld. When consent is applied to create *de facto* entitlements to medical treatment, as “*Rasouli* Consent” does, interests other than those of the patient become relevant, such as physicians’ interest in not having to provide non-beneficial treatment and the public interest in not having to fund treatment of little or no medical value. Yet the law of informed consent is exclusively patient-centered and does not allow these factors to be considered; neither the Consent and

La technologie nous permet maintenant de maintenir certains patients en vie malgré de mauvais pronostics et une pauvre qualité de vie. Il est donc important de se questionner sur le moment auquel ces interventions médicales devraient cesser ainsi que sur les personnes autorisées à prendre ces décisions.

Jusqu’à récemment, il était encore incertain à qui, des médecins ou des patients, il revenait de décider si les traitements permettant le maintien en vie devraient être suspendus. Dans l’affaire *Rasouli v Sunnyside Health Sciences Centre*, la Cour d’appel de l’Ontario a jugé que les médecins ne peuvent suspendre certains traitements vitaux qu’avec l’accord des patients ou de ceux légalement autorisés à décider pour eux. La Cour a conclu que la suspension d’un traitement constitue en soi comme une intervention nécessitant un consentement en vertu de la *Loi sur le consentement aux soins de santé* de l’Ontario. Ceci donne en pratique aux patients un droit au maintien de traitements.

Je soutiens ici que le droit portant sur le consentement éclairé ne devrait pas déterminer qui a le pouvoir de suspendre des traitements. En effet, lorsque la notion de consentement est utilisée afin de créer un droit *de facto* aux traitements médicaux, comme c’est le cas avec le « Consentement *Rasouli* », des intérêts autres que ceux des patients entrent en jeu, par exemple ceux des médecins à ne pas fournir des

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Capacity Board nor the courts may give weight to competing interests.

This is not to say that physicians should have the right unilaterally to withhold life-sustaining treatment. However, any entitlement to treatment should flow from laws other than the law of informed consent, such as the *Charter*, or ideally a new law that explicitly addresses the issue.

traitements sans bénéfices réels ou celui du public à ne pas financer d'interventions peu ou pas utiles d'un point de vue médical. Or, le droit sur le consentement éclairé se concentre exclusivement sur les patients, sans prendre ces autres facteurs en considération.

Cela ne signifie pas, par contre, que les médecins devraient posséder le droit d'unilatéralement suspendre des traitements vitaux. Il s'agirait en effet de ne pas faire découler le droit aux traitements du droit portant sur le consentement éclairé mais plutôt de lois comme la *Charte* ou, idéalement, d'une loi spécifique abordant la question de front.

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[C]onsent by itself creates no obligation to treat.

*It is merely a key which unlocks a door...*¹

Introduction

Hassan Rasouli is at the centre of a legal debate over who may decide whether to withdraw a patient's life support: the patient's substitute decision maker ("SDM"), or the treating physician. Since 2010 Mr. Rasouli has been at Sunnybrook Health Sciences Centre in Toronto, where he receives food and water through a tube inserted into his stomach, and requires a mechanical ventilator to breathe. Mr. Rasouli's doctors initially diagnosed him as being in a persistent vegetative state ("PVS") and wanted to withdraw his life-sustaining treatment.² They consider it contrary to their professional duties to continue treating a patient when there is no realistic hope that treatment will improve his condition.³ Although they later changed their diagnosis, concluding that Mr. Rasouli is now in a "minimally conscious state,"⁴ the doctors still believe that their patient's life support should be withdrawn. Mr. Rasouli's wife, Parichehr Salasel, insists that treatment continue. As a physician herself, she disputes the doctors' bleak diagnosis and holds out hope for her husband's recovery.

Decisions about whether to continue treating seriously ill patients must be made every day in hospitals, where Canadians increasingly spend their last days.⁵ Yet it has long been unclear who is legally entitled to make the

¹ *In Re R (A Minor) (Wardship: Consent to Treatment)*, [1992] Fam 11, 1 FLR 190 at 196 (Lord Donaldson of Lynton MR) (CA) [*In Re R*].

² I use the term life-sustaining treatment broadly to include any treatment necessary to prevent the patient from dying. This would therefore include life support, such as mechanical ventilation, and measures such as cardiopulmonary resuscitation ("CPR").

³ *Cuthbertson v Rasouli (Litigation Guardian of)*, SCC Docket No 34362 (10 February 2012) (Factum of the Appellant at para 61 [*Cuthbertson v Rasouli* FOA]).

⁴ Lisa Priest, "Vegetative Patient Now Able to Give 'Thumbs Up', Fuelling Debate over Life Support" *The Globe and Mail* (24 April 2012) online: [Globe and Mail <www.theglobeandmail.com/life/health/end-of-life/vegetative-patient-now-able-to-give-thumbs-up-fuelling-debate-over-life-support/article2413296/>](http://www.theglobeandmail.com/life/health/end-of-life/vegetative-patient-now-able-to-give-thumbs-up-fuelling-debate-over-life-support/article2413296/).

⁵ Close to 60% of Canadians now die in hospital. See Canadian Cancer Society et al, "Canadian Cancer Statistics 2010; Special Topic: End of Life Care" at 72-73 online: The Canadian Cancer Society <www.cancer.ca/Canada-wide/About%20cancer/Cancer%20statistics/~/_media/CCS/Canada%20wide/Files%20List/English>

decision whether to withhold or withdraw life-sustaining treatment. The question was answered in part in *Rasouli v Sunnybrook Health Sciences Centre*.⁶ In that case, the Ontario Court of Appeal held that if palliative care drugs are required following withdrawal of life-sustaining treatment, that treatment may not be withdrawn without the consent of the patient or patient’s SDM. It considered withdrawing life-sustaining treatment to be part of a treatment package for which consent is required according to the *Health Care Consent Act* (“HCCA”).⁷ Although the court’s decision is restricted to situations where withdrawing treatment leads both to palliative care and death, its effect is to create a kind of entitlement to life-sustaining treatment, even where physicians consider such treatment to be of no medical benefit.

Regardless of whether a legal entitlement to life-sustaining treatment is desirable as a matter of policy, neither the *HCCA*, nor the common law of consent to medical treatment, is best interpreted as creating an entitlement to treatment that doctors do not want to provide. The duty of physicians not to treat without first obtaining informed consent only applies where the physician is willing to provide treatment. In other words, the law of informed consent itself creates no entitlements to treatment.

That said, the law of consent has evolved considerably over the last few decades. The courts or legislatures could continue to expand its scope to encompass situations in which doctors do not wish to provide treatment, as the Ontario Superior Court and Court of Appeal have so far done in *Rasouli*. Given the significant implications of such expansion, however, the courts should leave any such change to the legislatures. The law of consent is one-sided and absolute, allowing competent patients to refuse treatment for almost any reason, in almost any circumstances, and requiring SDMs to decide based only on the patient’s wishes or best interests. This is appropriate in the context of the ability to refuse treatment, but different interests arise where patients may demand treatment, such that an absolute and one-sided approach requires justification. If applied to create entitlements to life support, the law of consent would require doctors sometimes to treat patients in a manner contrary to the standards of the medical profession. In addition, there are resource implications of consent-based entitlements to life-sustaining treatment: given *Rasouli*, a patient would effectively be entitled to treatment

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⁶ 2011 ONCA 482, 107 OR (3d) 9 [*Rasouli* CA].

⁷ *Health Care Consent Act*, SO 1996, c 2 Schedule A [*HCCA*].

regardless of cost or scarcity of resources. Also unclear is the justification for limiting consent-based entitlements to life-sustaining treatment, rather than to other treatments that implicate patients' fundamental interests in autonomy and bodily integrity. As a result, *Rasouli's* consent-based approach could ultimately result in entitlements to treatment other than life-sustaining treatment.

The Supreme Court of Canada has granted leave to appeal the Court of Appeal's decision. It should interpret "treatment" in the *HCCA* to exclude withholding and withdrawing treatment, such that a patient's or SDM's consent would not be required to withhold or withdraw treatment. As a result, a patient could not effectively demand treatment by refusing consent to that treatment being withheld. The Supreme Court should also clarify that the common law of consent, like the *HCCA*, creates no entitlements to treatment.

Rejecting a consent-based entitlement to life-sustaining treatment does not mean that patients do not have or should not have legal entitlements to such treatment, nor does it mean that physicians are permitted or should be permitted unilaterally to withdraw life-sustaining treatment. Rather, any entitlement to care that physicians do not want to provide must find its basis in laws other than the *HCCA* or the common law of consent to treatment, such as the *Charter* or the law of negligence. Given that there are limitations to the protections offered by existing laws, new more flexible laws or guidelines should be implemented. Although this article reviews some possible mechanisms for better protecting patients regarding access to life-sustaining treatment, its aim is not to argue for a particular approach.

I. Withholding and Withdrawing Life-Sustaining Treatment in Practice

Deciding whether to withhold or withdraw life-sustaining treatment from a patient is an extremely important and difficult decision. It is literally a matter of life and death. No one wants to deny care to a patient who could materially benefit from it, but advances in technology allow health practitioners to keep people alive even when there is no realistic prospect of improvement to their underlying condition.⁸ As a result, life-sustaining treatment *can* be provided, but as potential returns diminish and costs (including to the patient, in

⁸ This is the starting point for the debate about medical futility. See e.g. John J Paris, "Pipes, Colanders, and Leaky Buckets: Reflections on the Futility Debate" (1993) 2:2 *Camb Q Healthc Ethics* 147; M Gordon, "Cardiopulmonary Resuscitation in the Elderly Long-Term Care Population: Time to Reconsider" (1994) 27:2 *Ann R Coll Physicians Surg Can* 81.

terms of invasiveness and suffering, as well as to the public purse) increase, it is not obvious that such treatment *should* be provided.⁹ Also unclear is who should decide whether and when life-sustaining treatment is provided. Patients' interest in autonomy and dignity suggests that they or their SDMs should have a say.¹⁰ However, doctors also have legal and ethical obligations to treat patients according to certain standards, regardless of what patients want. In addition, when we grant entitlements to treatment, issues of resource allocation arise, such that the government may wish to limit available treatment.

In Canadian hospitals, policies and practices vary regarding how a decision whether to continue life-sustaining treatment is made and who ultimately decides.¹¹ To the extent there is a norm, however, it would seem to require the patient's physician to confer with the patient or SDM.¹² The physician's hope is that if he or she does not believe further treatment is medically war-

⁹ *Ibid*. Also consider that "at some point, when dealing with questions of serious medical treatment, a truly thoughtful society must ask itself not merely whether it can, but, also whether it should provide advanced medical treatment." (Paul A Gomez, "Promises and Pitfalls: An Analysis of the Shifting Constitutional Interests Involved in the Context of Demanding a Right to Treatment in Health Care" (2000-2001) 64 Alb L Rev 361 at 361).

¹⁰ See Jocelyn Downie, "Unilateral Withholding and Withdrawal of Potentially Life-Sustaining Treatment: a Violation of Dignity Under the Law in Canada" (2004) 20:3 Journal of Palliative Care 143.

¹¹ *Ibid* at 148.

¹² I arrive at this conclusion based on various articles and professional guidelines. For example, "[t]he physician must identify the person(s) with whom he/she must communicate about withholding or withdrawing life-sustaining treatment and communicate with that person as early as possible and, where possible before life-sustaining treatment is withheld or withdrawn" (The College of Physicians and Surgeons of Manitoba, "Withholding and Withdrawing Life-Sustaining Treatment", Statement No 1602 (First Print 2007) at 15-S7, online: The College of Physicians and Surgeons of Manitoba <cpsm.mb.ca/about-the-college/by-laws-code-of-conduct-statements-and-guidelines/statements/590-2> [Manitoba Guidelines]). A proposed practice for Ontario is discussed in Linda Hawryluck, Redouane Bouali & Nathalie Danjoux Meth, "Multi-professional Recommendations for Access and Utilization of Critical Care Services: Towards Consistency in Practice and Ethical Decision-Making Processes" (2011) 39:2 JL Med & Ethics 254; *Cuthberston v Rasouli* FOA, *supra* note 3 at paras 48-57, 104-108. For the US context, see Nicholas Smedira et al, "Withholding and Withdrawal of Life Support from the Critically Ill" (1990) 322:5 New Eng J Med 309.

ranted, the patient or SDM will agree that life-sustaining treatment may be withheld or withdrawn.¹³ If the patient or SDM still insists on treatment, it seems that most physicians accede to this wish even where they consider the treatment futile.¹⁴ Some, however, refuse to treat. Legal action may then follow, as was the case in *Rasouli*.

II. The Law of Consent to Withholding and Withdrawing Life-Sustaining Treatment

Although consensus is often possible, there are inevitably situations in which physicians and SDMs cannot agree on whether treatment should continue. A judicial resolution becomes necessary. Yet until recently it was unclear who has the legal right to decide whether to withhold or withdraw life-sustaining treatment. The issue is not addressed by statute, at least not explicitly.¹⁵ As for any decision making authority at common law, some courts have indicated that the case law is unresolved,¹⁶ while some courts and

¹³ *Ibid* at 312, discuss the family's role in decision making and note that most families agreed with the doctor's recommendation to withdraw life support from the outset. Of those who initially disagreed, eight out of ten were convinced to agree within a few days.

¹⁴ Smedira et al's study of California ICUs revealed that in the few cases in which the family could not be convinced to agree to withdraw life support, treatment continued (*ibid*). A dearth of legal cases in Canada suggests a similar practice here.

¹⁵ Glen Rutland states that "the question of who has the final authority when a demand for life-sustaining treatment is made has not been answered by statute" ("Futile or Fruitful: The *Charter* and the Decision to Withhold or Withdraw Life-Sustaining Treatment" (2009) 17 Health LJ 81 at 82). However, the courts in *Rasouli v Sunnybrook Health Sciences Centre and Cuthbertson*, 2011 ONSC 1500, 105 OR (3d) 761, 231 CRR (2d) 26 [*Rasouli SC*], and *Rasouli CA*, *supra* note 6, treated the *HCCA* and specifically its requirement for consent to treatment, as governing the issue.

¹⁶ According to the application judge in *Rasouli*, "the common law position on whether consent is needed to withdraw or withhold treatment in Canada is not firmly decided" (*Rasouli SC*, *supra* note 15 at para 83). See also Joan Gilmour, "Death, Dying and Decision-Making About End of Life Care" in Jocelyn Downie, Timothy Caulfield and Colleen Flood, eds, *Canadian Health Law and Policy* 4th ed (Markham: LexisNexis, 2011) 385 at 410.

commentators think case law indicates that doctors may make the final decision.¹⁷

Logically, doctors have no legal obligation to treat, including continuing treatment that has already begun,¹⁸ unless the law imposes such an obligation. Although this article argues that no such legal obligation is created by the *HCCA* or the common law of consent, it recognizes the existence of legal obligations to provide certain life-sustaining treatment on the basis of other laws. In this section I discuss the law of consent to medical treatment and why it does not ground an entitlement to life-sustaining treatment. I begin with the common law of consent, then examine consent under the *HCCA*. Although the courts resolved *Rasouli* on the basis of the *HCCA* alone, the common law of consent to medical treatment informs the interpretation of the *HCCA*. Finally, I consider the possibility that the law of informed consent has developed so as to now require consent to withholding and withdrawing life-sustaining treatment. In Section 5 I examine other laws that could ground an entitlement to life-sustaining treatment.

1. *The Common Law of Consent*

Before 1980, the legal role of consent to medical treatment was essentially that of a defence to the tort of battery.¹⁹ Non-trivial touching without permission is battery,²⁰ and that is also true of touching in the medical context. Thus, the requirement of consent to medical treatment "is designed to protect a person's bodily integrity from interference."²¹ As a defence to battery, consent is only relevant where medical treatment involves physical interference

¹⁷ See Rutland, *supra* note 15 at 82. See also *Child and Family Services of Central Manitoba v Lavallee et al*, 154 DLR (4th) 409, 123 Man R (2d) 135 (CA) [*Lavallee*].

¹⁸ Withdrawing and withholding treatment are treated identically in the common law and in the *HCCA*. Thus, consent is no more required to withdraw treatment than it is to withhold it.

¹⁹ It was also a defence to the crime of assault, but since neither the *HCCA*, nor the Ontario common law of informed consent affects the criminal law of Canada, I do not mention criminal assault again.

²⁰ *Non-Marine Underwriters, Lloyd's of London v Scalera*, 2000 SCC 24 at para 16, [2000] 1 SCR 551, 185 DLR (4th) 1 [*Scalera*].

²¹ Lorne Rozovsky, *The Canadian Law of Consent to Treatment*, 3d ed (Markham: LexisNexis Canada, 2003) at 5; *Scalera*, *supra* note 20 at para 10 (battery protects individual autonomy).

with the patient, since physical contact is an element of the tort. Because unwanted touching is a serious violation of personal autonomy, the tort provides broad protection against even relatively innocuous unwanted touching, and is actionable without proof of loss.²²

The protection is broad in the sense that a competent patient may refuse consent to treatment under almost any circumstances, including when refusal would lead to death,²³ and for any reason. The few exceptions relate to emergencies²⁴ and to public health threats.²⁵ It is no defence to argue that defendants had a good reason to touch plaintiffs or were acting in their best interests.²⁶

The law of consent as a defence to battery clearly cannot ground an entitlement to treatment a physician does not want to provide. Although the requirement of consent provides broad protection against unwanted touching, its scope is limited to situations where a physician intentionally touches a patient,²⁷ where a physician chooses to act in a manner objectionable to the patient, and where physical interference is involved. It cannot, by itself, ground an entitlement to be touched or otherwise treated.

²² Barney Sneiderman, John Irvine & Philip Osborne, *Canadian Medical Law*, 2d ed (Toronto: Carswell Thompson, 2003) at 20.

²³ *Malette v Shulman* (1990), 72 OR (2d) 417 at para 19, 67 DLR (4th) 321 (CA) [*Malette*].

²⁴ Emergencies are an exception in that health practitioners may treat without a basis to infer the patient's consent to treatment. That said, if there is good reason to believe the patient would have refused consent (as when a Jehovah's Witness carries a card indicating a refusal to receive blood transfusions), the health practitioner may not treat even in an emergency (*ibid* at paras 20-25).

²⁵ *Health Protection and Promotion Act*, RSO 1990, c H7, s 22.

²⁶ There is no "best interests" defence. The law is clear that informed consent is required: "It may be that in the operating room the parties hereto were of the opinion that they were acting in the best interests of Mrs. Yule in extracting the teeth, but that is not the point. That would have been very important in their consultation with and their advising of Mrs. Yule, but it does not justify their proceeding without her consent. As was said by Garrison J., 'No amount of professional skill can justify the substitution of the will of the surgeon for that of his patient.'" (*Parmley v Parmley*, [1945] SCR 635 at 646, 4 DLR 81). See also *HCCA*, *supra* note 7 s 10.

²⁷ Battery is an intentional tort (*Reibl v Hughes*, [1980] 2 SCR 880 at 890, 114 DLR (3d) 1).

Over the past thirty or forty years there has been a significant shift in the law of consent to medical treatment. Not only is it no longer exclusively an issue of battery, it is no longer even primarily an issue of battery. Rather, the law of consent has come to be understood primarily as an issue of negligence law.²⁸ Reasonable medical practice requires physicians to provide patients with relevant information about treatment, including its risks, likely outcomes, and alternatives to treatment. This enables patients to make an informed decision whether or not to be treated. Since the seminal cases *Hopp v Lepp*²⁹ and *Reibl v Hughes*,³⁰ failure to properly inform patients before treating them amounts to a breach of the standard of care in negligence.³¹

Furthermore, the duty to obtain informed consent does not depend on whether non-consensual treatment would amount to battery—that is, whether it involves physical touching. For example, the standard of care requires obtaining informed consent to treatment that does not involve touching, such as psychotherapy³² or prescribing medication.³³ This reflects the rationale for requiring consent to treatment: to ensure patients are able to make informed and autonomous decisions about their medical treatment, rather than having treatment paternalistically imposed on them.³⁴

Just as consent as a defence to battery cannot ground an entitlement to medical treatment, neither can the duty to obtain informed consent in the negligence context. The latter is fundamentally a duty to inform, or a duty not to treat without first informing, not a duty to treat. Its scope is limited to providing information about material risks, benefits, and alternatives to treatment.³⁵ The duty is part of a broader duty in negligence to treat according to the standard of a reasonable physician. A physician may have a duty under negligence law to provide life-sustaining treatment in certain circum-

²⁸ Patricia Peppin, “Informed Consent” in Jocelyn Downie et al, *Canadian Health Law And Policy*, 4th ed (Markham: LexisNexis Canada, 2011) at 154; Rozovsky, *supra* note 21 at 5.

²⁹ [1980] 2 SCR 192, 112 DLR (3d) 67.

³⁰ *Supra* note 27.

³¹ Peppin, *supra* note 28 at 153; Rozovsky, *supra* note 21 at 5.

³² Downie, *supra* note 10 at 145.

³³ Rozovsky, *supra* note 21 at 5.

³⁴ Peppin, *supra* note 28 at 153.

³⁵ See *HCCA*, *supra* note 7 at s 11, especially s 11(3). The *HCCA* largely reflects the common law in this respect.

stances, as discussed in Section 5(b). However, that duty does not arise specifically from the duty to obtain informed consent: it arises from the broader duty to provide care that a reasonable physician would provide.

Courts have generally rejected the proposition that the common law of informed consent—either as a defence to battery or as part of the duty of care in negligence owed to patients—creates entitlements to treatment. As stated in the English case of *Re R*, “consent by itself creates no obligation to treat. It is merely a key which unlocks a door... .”³⁶ The Manitoba Court of Appeal similarly stated in *Lavallee*:

It follows, in my opinion, that the word “treatment” when used in s. 25(3) [of the *Child and Family Services Act*] is used only in a positive sense. There is no need for consent from anyone for a doctor to refrain from intervening.³⁷

The issue in *Lavallee* was whether doctors could place a “do not resuscitate” (“DNR”) order on a patient’s chart against the wishes of the patient’s SDM. The Manitoba Court of Appeal held that doctors had no obligation to provide treatment against their clinical judgment. In particular, it held that individuals or their SDMs had no right to consent to treatment being withheld because “treatment” for which consent is required means positive treatment and does not include refraining from intervening.³⁸ The court concluded that

neither consent nor a court order in lieu is required for a medical doctor to issue a non-resuscitation direction where, in his or her judgment, the patient is in an irreversible vegetative state. Whether or not such a direction should be issued is a judgment call for the doctor to make having regard to the patient’s history and condition and the doctor’s evaluation of the hopelessness of

³⁶ *In Re R*, *supra* note 1 at 187.

³⁷ *Lavallee*, *supra* note 17 at para 13.

³⁸ *Ibid* at para 13. This aspect of the court’s reasoning has been criticized for its reliance on an untenable distinction between acts and omissions (consent, according to *Lavallee*, is only required for treatment that amounts to an act, not an omission). Joan Gilmour argues that because consent to CPR is presumed, consent is required in order *not to provide* CPR, even though not providing it is an omission (*supra* note 16 at 411). See also Barney Sneiderman, “A Do Not Resuscitate Order for an Infant Against Parental Wishes: A Comment on the Case of *Child and Family Services of Central Manitoba v. R.L. and S.L.H.*” (1999), 7 Health LJ 205.

the case. The wishes of the patient’s family or guardians should be taken into account, but neither their consent nor the approval of the court is required.³⁹

Sawatzky v Riverview Health Centre Inc.,⁴⁰ also involved a DNR order. In that case, the court was asked to grant an injunction preventing a physician from imposing a DNR order against the wishes of the patient’s SDM. The Manitoba Court of Queen’s Bench concluded based on the pre-*Charter* case law that “a decision not to provide treatment is exclusively within the purview of the doctor...the courts would not interfere with a medical decision not to provide treatment.”⁴¹ The court noted, however, that there was very little case law to rely on.⁴² The injunction was granted due largely to uncertainty as to whether the *Charter* or a human rights code might prevent a physician from unilaterally imposing a DNR. The implication of the Court’s decision is that the law of consent to medical treatment does not create entitlements to treatment a physician does not want to provide. Otherwise there would have been no need to rely on *Charter*-related uncertainty.

However, one Canadian case casts doubt on the proposition that the law of consent to medical treatment creates no entitlement to treatment—at least regarding life-sustaining treatment. In *Golubchuk v Salvation Army Grace General Hospital*,⁴³ the Manitoba Court of Appeal held that consent is not required for treatment that does not involve touching, but that removing life support would require some touching, including administering drugs for pain. Consent would therefore be required.⁴⁴ This reasoning relies on the law of consent as a defence to battery and the proposition that withdrawing life support necessarily involves touching. Note, however, that the court is not saying that turning off a ventilator or stopping artificial hydration or nutrition requires touching the patient. It is saying that the relevant touching may simply be administering drugs after life support is withdrawn.

This is presumably the origin of the “treatment package” reasoning used by the Ontario Court of Appeal in *Rasouli*. By conceptualizing two treat-

³⁹ *Ibid* at para 17.

⁴⁰ [1998] MJ No 506, 167 DLR (4th) 359 [*Sawatzky*].

⁴¹ *Ibid* at para 26.

⁴² *Ibid*.

⁴³ 2008 MBQB 49, [2008] MJ No 54 [*Golubchuk*].

⁴⁴ *Ibid* at para 23; *Sweiss v Alberta Health Services*, 2009 ABQB 691, [2009] AJ No 1303.

ments (one that requires touching the patient, such as administering palliative care drugs, and one that may not, such as turning off a ventilator) as a single treatment, the court concludes that consent is required. The treatment package reasoning will be considered in greater detail below, but for now it is sufficient to note that this argument creates an entitlement to life-sustaining treatment, but only where palliative care drugs will be administered. It would presumably not, for example, allow a patient or SDM to resist a physician placing a DNR order on a patient's chart, as in *Lavallee* or *Sawatzky*.

Other than *Golubchuk*, I am aware of no cases that recognize an entitlement to medical treatment on the basis of the common law of informed consent.⁴⁵ Rather, consent as a defence to battery or as part of the physician's duty to inform before treating is generally considered an issue of permission for physicians to do what they are willing to do. Physicians may not treat until they have both provided material information to patients and obtained their permission to proceed.

A review of the common law of consent to medical treatment gives little reason to think it creates entitlements to treatment. That said, the fundamental rights that the law of informed consent protects, such as self-determination, could arguably justify interpreting the law more broadly. This will be addressed following the discussion below of informed consent under the *HCCA*.

2. *The Health Care Consent Act*

The Ontario Court of Appeal applied the *HCCA* rather than the common law to Mr. Rasouli's case. It is therefore possible that the law of consent as set out in the *HCCA* creates an entitlement to life-sustaining treatment, even if the common law does not. For the following reasons, I conclude that it does not.

The *HCCA* was not intended to override the common law regarding when consent is required, but rather primarily to allow for orderly and principled substitute decision making where the patient lacks capacity.⁴⁶ It sets

⁴⁵ *Rasouli* relies on the same reasoning, but in relation to the *HCCA* rather than the common law.

⁴⁶ *HCCA*, *supra* note 7 s 1, entitled "Purposes", lists "to facilitate treatment...for persons lacking the capacity to make decisions about such matters," and "to ensure

out rules for deciding who may make substitute medical decisions and on what basis.⁴⁷ Other provinces also have legislation that provides for substitute decision making, usually on similar bases as the *HCCA*, although some laws only apply where the patient, while competent, has designated an attorney for personal care.⁴⁸

The *HCCA* largely modifies rather than displaces the common law of consent to medical treatment. Despite acknowledging the necessity of consent in order for medical treatment to be lawful, the *HCCA* creates no new causes of action or remedies in relation to a failure to obtain consent. Therefore, the common law torts of battery and negligence continue to apply to non-consensual treatment.⁴⁹ In addition, courts and commentators have stated that the *HCCA* codifies and modifies the common law.⁵⁰

a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment...,” among others.

⁴⁷ *Ibid* ss 20, 21.

⁴⁸ Alberta: *Adult Guardianship and Trusteeship Act*, SA 2008, c A-4.2, ss 89, 92, 93; *Personal Directives Act*, RSA 2000, c P-6, s 14. British Columbia: *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181, ss 4, 16, 19. Manitoba: *Health Care Directives Act*, CCSM c H27, s 13. New Brunswick: *Infirm Persons Act*, RSNB 1973, c I-8, ss 40-44. Newfoundland: *Advance Health Care Directives Act*, SNL 1995, c A-4.1, ss 10, 12. North West Territories: *Personal Directives Act*, SNWT 2005, c 16, s 15. Nova Scotia: *Personal Directives Act*, SNS 2008, ss 14 and 15. Prince Edward Island: *Consent to Treatment and Health Care Directives Act*, RSPEI 1988, c C-17.2, ss 4, 11, 13. Quebec: *Civil Code of Québec*, LRQ, c C-1991, arts 10-12. Saskatchewan: *Health Care Directives and Substitute Health Care Decision Makers Act*, SS 1997, c H-0.001, s 16. Yukon: *Care Consent Act*, SY 2003, c 21, Schedule B, ss 3, 12, 20.

⁴⁹ Courts continue to apply the law of battery and negligence under the *HCCA*. See e.g. *Remtulla v Zeldin*, 2005 CanLII 28428 (available on CanLII) (ONSC); *Thompson v Zeldin*, 2008 CanLII 46703 (available on CanLII); *Bafaro v Dowd*, 2008 CanLII 45000 (available on CanLII). In fact, “courts have largely ignored the legislation in their analysis of tort claims” (Robert Solomon et al, *Cases and Materials on the Law of Torts* 8th ed (Toronto: Carswell, 2011) at 198).

⁵⁰ See Justice Ellen I Picard & Gerald B Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed (Toronto: Carswell, 2007) at 56. The applications judge in *Rasouli SC*, *supra* note 15 at para 53 cites Dr Hy Bloom & Michael Bay, *A Practical Guide to Mental Health, Capacity, and Consent Law of Ontario* (Scarborough: Thomson Canada, 1996) at 17: “[t]he common law continues to

Rasouli has so far been resolved on the basis of the *HCCA*. Specifically, the issue has been whether the *HCCA*'s definition of "treatment", for which consent is required, includes treatment a physician does not want to provide. The *HCCA* is silent on this matter, so it does not change the common law.

The legislative history of the *HCCA* provides no evidence that the Ontario government intended the *HCCA* to require consent for a procedure that a physician is not willing to provide, and thereby to create an entitlement to that procedure. Like the *HCCA* itself, the legislative history is silent on this issue. Legislators were primarily concerned with protecting patients' ability to designate an SDM and to have their own wishes respected; codifying who would be the SDM if no one was appointed by the patient; and codifying principles for substitute decision making.⁵¹

The only discussion found in the legislative history relating to what counts as treatment for the purposes of the *HCCA* relates to the exclusion of minor or trivial acts from the definition of treatment. For example, no consent is required under the *HCCA* for taking a medical history, because taking a medical history is explicitly excluded from the definition of treatment.⁵² At least one member of provincial parliament expressed concern that this gives doctors too much power to treat without consent.⁵³ However, the exclusion from the definition of treatment of certain routine and low-risk acts, such as communicating a diagnosis, was legislated. If anything, this suggests a legislative intent to narrow rather than expand the common law definition of treatment. There is certainly no indication that the common law or earlier legislation was being altered to include procedures not offered by a physician in the definition of "treatment." One would expect clear language, as well as debate in the legislature, if the legislature were intending to create de facto entitlements to treatment through the *HCCA*. The reasonable conclusion is that the *HCCA* does not alter the common law of consent by creating an entitlement to treatment.

apply to any matters that fall outside the purview of the [*HCCA*] and the [*Substitute Decisions Act*]."

⁵¹ See Ontario, Legislative Assembly, *Official Report of Debates (Hansard)*, 36th Parl 1st Sess, No 28, (22 Nov 1995) at 1710, 1730.

⁵² The *HCCA*, *supra* note 7. See definition of "treatment" at s 2(1).

⁵³ Ontario, Legislative Assembly, *Official Reports of Debates (Hansard)*, 36th Parl 1st Sess, No 30, (27 Nov 1995) at 1700 (Rosario Marchese).

We therefore return to the common law position, which is that consent creates no entitlements to treatment, subject to the *Golubchuk* treatment package reasoning, to which I shall return. There may be legal entitlements to certain treatment, including life-sustaining treatment, but these must derive from other laws, such as the *Charter*, the broader law of negligence, and the law of professional responsibility.

3. *Incremental Change to the Law of Consent?*

One further possibility is that the law of informed consent, although not originally capable of grounding entitlements to treatment, should now be understood as doing just that. After all, the law has been evolving: what began as a defence to battery is now much broader. The law of informed consent applies in an expanding range of contexts in order to "protect a patient's right to control his or her medical treatment."⁵⁴ Whether or not a treatment is offered to patients certainly implicates their ability to control their medical treatment and implicates the underlying principles of autonomy and bodily integrity. It may therefore be appropriate to extend the law of consent.

This is essentially what Jocelyn Downie suggests. She reasons that requiring informed consent to medical treatment protects self-determination, and that self-determination is implicated in a fundamental way when patients are precluded from making decisions about life-sustaining treatment. Thus, the law of consent also protects patients' ability to make decisions about whether treatment will be given, even if a doctor does not want to provide it.⁵⁵

In Downie's opinion, the law of informed consent does not grant an absolute entitlement to life-sustaining treatment. Rather, it grants the presumption of an entitlement, which may be rebutted by relevant countervailing considerations.⁵⁶ To Downie, the most compelling such consideration relates to scarce resources.⁵⁷ She may also consider the nature of the medical treatment to be a relevant consideration in whether the law of informed consent creates entitlements. I infer this from the fact that she only argues that life-sustaining treatment should require consent in the demand context; she does

⁵⁴ *Malette*, *supra* note 23 at para 18.

⁵⁵ Downie, *supra* note 10 at 146.

⁵⁶ *Ibid* at 146.

⁵⁷ *Ibid* at 147.

not state that the law of informed consent creates a presumption of entitlement to antibiotics or a hip replacement. There may be good reasons for this, in that decisions about life-support implicate self-determination and dignity in ways that other treatment decisions may not, or it may be that she believes the law of informed consent grounds entitlements to all medical treatment, subject to resource limitations.

As for physicians' interests in not treating against their clinical judgment, Downie is less convinced that this could justify withholding life-sustaining treatment. The situation could usually be avoided, she suggests, by arranging for another physician to take over a patient's care. Where they cannot, a physician should be required to treat.⁵⁸

The above reasoning has some appeal, and would continue the trend of expanding the law of informed consent in order to protect individual autonomy and bodily integrity. My concern, however, is that such an expansion could undermine fundamental characteristics of the law of informed consent—specifically that where consent is required, a competent refusal of consent must always be respected,⁵⁹ and that the need for consent does not depend on the kind of treatment in question. Downie's proposal would mean that consent to withdrawing life support must only be respected if no countervailing considerations (lack of resources, for example) override the patient's wishes. In other words, if wanting ongoing life support is construed as refusing consent to have life support withdrawn, then that refusal of consent must sometimes yield to other interests such as the cost or availability of life support.

Another way to conceive of the same concern is that expanding the law of consent in this way would require creating one or more new exceptions to the requirement of consent to treatment. Assuming that considerations of cost and perhaps the standard of care could justify withdrawing life support even where a patient's SDM refuses consent, we would have to add such circumstances to the list of exceptions to the requirement for informed consent. Thus, in addition to public health threats, the fact that treatment is unreasonably expensive might justify not respecting a refusal to consent to treatment.

⁵⁸ Ibid.

⁵⁹ There is currently only one exception to this proposition, relating to public health threats. See the *Health Protection and Promotion Act*, *supra* note 25.

The second fundamental characteristic of the law of informed consent, that the need for consent does not depend on the type of treatment,⁶⁰ would be called into question if consent to withholding or withdrawing treatment were only required for withholding or withdrawing life support, as opposed to other treatments. This is exactly what *Rasouli* dictates.

One way around these potential problems is simply to accept that the law of informed consent applies differently when a physician is offering to provide treatment (which I will call the refusal context)⁶¹ than where a physician is not offering to provide treatment (the demand context). In the refusal context, the law of consent would be inflexible, whereas in the demand context, the law of consent would create only a presumption of patient choice. In the refusal context, consent would be required for all types of treatment. In the demand context, it would only be required in relation to withholding or withdrawing life-sustaining treatment.

The danger in this approach is that by referring to both as the law of informed consent, the current understanding of the law as inflexible, broadly applicable, and exclusively patient-centered could give way to a more flexible, less certain approach to informed consent generally. After all, there may be allocation issues associated with a refusal to accept treatment,⁶² and there may be good reasons to extend a *Rasouli* approach to withdrawing treatment other than life-sustaining treatment. Thus, the expansion of the law of informed consent to the demand context could affect its interpretation in the refusal context. Even if patients' right to refuse treatment almost always prevailed over competing interests, the law would have lost some of its certainty and predictability.

Instead of expanding the law of informed consent to include the demand context, I therefore suggest that the law of informed consent be interpreted so as not to apply in the demand context. In deciding whether a patient is legally entitled to life-sustaining treatment, other laws should dictate the outcome.

⁶⁰ The fact that this characteristic is fundamental does not mean it is absolute. For example, as discussed above, the *HCCA* excludes certain extremely low-risk treatment from the requirement of informed consent.

⁶¹ The refusal context does not mean that consent is denied, only that the patient has the option of accepting or rejecting offered treatment, as opposed to being able to demand or not demand it.

⁶² For example, if patients refuse surgery, it may ultimately cost more to treat their condition.

III. The *Rasouli* Decisions

This was the state of the law of consent to medical treatment when Hasan Rasouli's wife sought an injunction to prevent his doctors from withdrawing life support. Recall that Mr. Rasouli's doctors initially diagnosed him as being in a persistent vegetative state due to complications from an operation to remove a brain tumour. His physician wife disagreed that her husband was permanently unconscious and subsequent events have largely vindicated Dr. Salasel in this respect.⁶³ The doctors wanted to withdraw mechanical ventilation, but Mr. Rasouli's wife and SDM under the *HCCA*, wanted treatment to continue. The primary issue for the courts was who has the final say in whether life-sustaining treatment is withdrawn: treating physicians or patients (or their SDMs). Both the application judge and the Ontario Court of Appeal addressed the issue in terms of whether withdrawing treatment is "treatment" for which consent is required according to the *HCCA*. Both courts concluded that life-sustaining treatment is "treatment" and therefore cannot be withdrawn, at least in certain circumstances, without the patient's or SDM's consent.

The application judge, Justice Himel, arrived at this conclusion on the basis that the *HCCA* requires consent for "treatment", and by interpreting the word "treatment" in the *HCCA* to include withdrawing treatment. "Treatment" is a defined term and includes a "plan of treatment." Since a "plan of treatment" may provide for withdrawing treatment, Justice Himel held that withdrawing treatment is "treatment" for which consent is required. Justice Himel also noted that "treatment," as defined in the *HCCA*, relates to things

⁶³ Nothing in my analysis turns on whether Mr. Rasouli is in a PVS or a minimally conscious state. However, the fact that doctors made a mistake here (if not in the original PVS diagnosis then in their conclusion that Mr. Rasouli would never regain any degree of consciousness) illustrates that decisions about what treatment is appropriate, reasonable, beneficial, or indicated may be extremely difficult and controversial. Knowledge of possible and likely outcomes is imperfect, and in any event must often be considered in light of non-medical factors such as the patient's wishes and values. Recent research demonstrates that a significant percentage of people diagnosed as being in a persistent vegetative state are, in fact, conscious but unable to communicate in any way. See Damian Cruise et al, "Bedside Detection of Awareness in the Vegetative State: A Cohort Study" (2011) 378 *Lancet* 2088. I do not pretend to resolve the issue of what amounts to reasonable, appropriate, or futile treatment in this article. Rather, I simply proceed on the assumption that circumstances exist in which providing requested treatment would be unreasonable because the treatment would be harmful, ineffective, or inefficient.

done for a “therapeutic” or “preventive” purpose.⁶⁴ Because withholding or withdrawing treatment could be therapeutic or preventive (based on definitions of those terms in medical dictionaries), she held that withdrawing or withholding treatment could count as “treatment” under the *HCCA*.

The Court of Appeal took a different approach, but arrived at the same conclusion, that a patient’s or SDM’s consent is required to withdraw life-sustaining treatment, albeit in narrower circumstances. It reasoned that palliative care is treatment for which no reasonable decision maker would refuse to grant consent once life-sustaining treatment is withdrawn. Because consent to palliative care is the necessary result of withdrawing life-sustaining treatment, it must also be required for withdrawing life support. The court referred to the two as a “treatment package,” such that consent for one cannot be separated from consent for the other.⁶⁵ The treatment package reasoning only applies in circumstances where death will follow imminently and inevitably from withdrawing treatment.⁶⁶

The Ontario Court of Appeal’s treatment package reasoning mirrors that in *Golubchuk*, where the Manitoba Court of Queen’s Bench stated that removing life support without consent amounted to imposing non-consensual treatment on the patient: “it involves the providing of narcotics over the plaintiff’s objection in the sense that, if the ventilator is not disconnected, it will not be necessary to give [narcotics].”⁶⁷ In other words, although the patient would presumably consent to having narcotics administered under the circumstances, the court considers giving narcotics to be non-consensual treatment if the need for drugs resulted from the non-consensual withdrawal of life support.

The court was willing to assume that the *HCCA* does not require physicians to obtain consent for medically ineffective or inappropriate treatment generally,⁶⁸ but held that the consent of Mr. Rasouli’s SDM was nevertheless required in order for treatment to be withdrawn. It acknowledged that where

⁶⁴ *Rasouli CA*, *supra* note 6 at para 29.

⁶⁵ *Ibid* at para 52.

⁶⁶ *Ibid* at para 53.

⁶⁷ *Golubchuk*, *supra* note 43 at para 23.

⁶⁸ “For present purposes, we are prepared to accept 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” (*Rasouli CA*, *supra* note 6 at para 46).

a patient had requested, before becoming incompetent, that all possible life-support interventions be used, doctors would be unable to challenge that decision,⁶⁹ presumably no matter how harmful or pointless ongoing treatment would be.

The Ontario Court of Appeal indicated that its ruling is limited to contexts in which death would follow inevitably and almost immediately from a treatment decision such that palliative care is, for all intents and purposes, immediately required. In other words, it apparently relates only to withdrawing life-sustaining treatment where death is the imminent and necessary result of such withdrawal. The narrowness of the treatment package reasoning avoids the slippery slope argument raised by the appellant doctors that requiring consent would create an unaffordable entitlement for patients to demand many types of treatment, but it also leaves unanswered who may make decisions whether to withhold or withdraw treatment in other circumstances.

There are two significant problems with the Ontario Court of Appeal's analysis. First, its basis in the law of consent to medical treatment is tenuous. Second, the absolute and one-sided nature of the law of informed consent has significant implications for the demand context that do not arise in the refusal context. These implications are not explored or justified in *Rasouli*. This section examines the Ontario Court of Appeal's reasoning, and the problems that arise from treating the issue as one of consent.

The Ontario Court of Appeal created a new kind of consent, which I call "*Rasouli* Consent." Whereas the law of consent has long protected patients against unwanted touching and requires health professionals to provide information about the material risks of and alternatives to treatment, *Rasouli* Consent creates an entitlement to a particular kind of treatment regardless of physicians' willingness to provide it. As a result, *Rasouli* Consent amounts to a significant and problematic departure from the law of consent to medical treatment.

Even if there were not such a long and clear history of the law of consent to medical treatment providing for informed permission or refusal, rather than creating entitlements to treatment, the Ontario Court of Appeal's interpretation of the *HCCA* would still be unconvincing. The court reasoned that since no one would reasonably refuse consent to palliative care after life-sustaining treatment is withdrawn, that decision, for which consent is re-

⁶⁹ *Ibid* at para 59.

quired, cannot be separated from the decision to withdraw treatment. This is the treatment package theory. The argument appears to be that granting the ability to insist on continued life support is the only way to avoid non-consensual touching in the form of palliative care, since once life-sustaining treatment has been withdrawn, no reasonable person would refuse to consent to palliative care.

There are three problems with the treatment package reasoning. First, it is not true that consent to palliative care is inevitable when life-sustaining treatment is withdrawn. Second, even if it were true, it is not clear why this would create an entitlement to life-sustaining treatment. Third, it is not clear that death does, in fact, follow immediately and inevitably from withdrawing life support in a way that would meaningfully distinguish life-sustaining treatment from other treatment.

Although in most circumstances patients or their SDMs will consent to palliative care when life support is withdrawn, patients are entitled to reject palliative care just as they are entitled to reject any other type of treatment.⁷⁰ So long as patients are competent (or were competent when they decided), their decision need not be reasonable.⁷¹ Where substitute consent is required, SDMs must make decisions based first on what a patient wanted: only if that is not known does the SDM decide based on the patient's best interests. Since the best interests test incorporates patients' values and wishes, even on a best interests standard it is not obvious that SDMs must always affirmatively consent to palliative care when life support is withdrawn, although it is admittedly inconceivable that a doctor or SDM would suggest that receiving palliative pain medication is not in a patient's best interests.

Consent to palliative care could conceivably be refused—perhaps because it involves drugs patients do not want to take (e.g. former addicts to pain killers who want to die “clean”), or because patients want to be left alone. It is also possible that patients might want life-sustaining treatment withdrawn even if no palliative care resources were available. The connection between affirmative consent to palliative care and withdrawing life support is statistical, in that the vast majority of people would presumably want the comfort that palliative care brings and there are few reasons to reject drugs that min-

⁷⁰ People may generally refuse consent to any treatment regardless of whether doctors agree with the decision and even if refusal to consent would lead to death (*Malette*, *supra* note 23 at para 19).

⁷¹ *Ibid*; *Nancy B v Hotel Dieu de Quebec* (1992), 86 DLR (4th) 385 [*Nancy B*].

imize pain and distress at the end of life. Withdrawing mechanical ventilation without palliative drugs could lead to “air hunger and distress,” which would not only be traumatic for the patient, but extremely difficult for family and staff present.⁷² However, the connection between withdrawing life support and palliative care is not inevitable. There is no barrier to refusing palliative care following withdrawal of life support. In fact, any attempt to create such a barrier would presumably be considered a violation of patients’ almost absolute right to refuse unwanted treatment.⁷³

Further, some patients on mechanical ventilators will already be receiving palliative care. For these patients, consent to palliative care has already been given and so consent to palliative care cannot be integrally linked to consent to withdrawing life support.⁷⁴

The fact that affirmative consent to palliative care is not inevitable upon withdrawing life support means that the treatment package reasoning fails. A high correlation between withdrawing life support and consenting to palliative care is insufficient to create a treatment package because the whole point of the treatment package reasoning is that the decisions cannot be separated. Consent must be obtained for the “entire treatment package.”⁷⁵ This suggests the impossibility of consenting to withdrawing treatment but refusing palliative care, whereas in reality these are separate decisions that may be based on different motivations. In addition, consent to palliative care may precede a decision to withdraw life support.

Two treatments may be related in the sense that rejecting one leads to the need for another treatment that patients would most likely consent to or that doctors must provide to meet the standard of care. This does not mean that if consent is required for the latter it must be required for the former. Consider what would follow if this were so. Imagine that Robert has kidney disease and requires a transplant. A doctor denies Robert a transplant because the only available kidney must be given to a different patient in accordance with organ allocation protocols. Refusing to provide the transplant would inevitably lead to the need for Robert to continue dialysis in order to prevent death.

⁷² Smedira et al, *supra* note 12. In personal communication, a critical care physician described the prospect of a patient being withdrawn from mechanical ventilation without accompanying palliative drugs as “horrible.”

⁷³ *Malette*, *supra* note 23; *Nancy B*, *supra* note 71.

⁷⁴ *Cuthbertson v Rasouli* FOA, *supra* note 3 at para 79.

⁷⁵ *Rasouli CA*, *supra* note 6 at para 58.

Consent is required for dialysis. That hardly means that Robert can demand (i.e. must consent to the withholding of) a kidney transplant on the basis that refusing a kidney transplant inevitably leads to more dialysis, for which consent is required. This would mean that a doctor who refuses to provide a requested kidney transplant violates the duty to obtain informed consent.⁷⁶ Similarly, if a doctor performs emergency surgery on an unconscious patient, there will inevitably be invasive follow-up for which consent will be required once the emergency has passed. This does not mean that consent is necessarily required for the emergency surgery.⁷⁷

The Ontario Court of Appeal distinguished this kind of example on the basis that death does not follow immediately from the refusal to provide a kidney transplant. The court makes clear that two preconditions are required before consent is required for withdrawing treatment: not only must there be a need for palliative care as a result of withdrawing treatment, but death must also follow imminently. Thus, with regard to a decision to end medically futile chemotherapy, the court states that “[e]nding chemotherapy does not spell the patient’s imminent death – and it does not trigger a requirement for a particular form of palliative care.”⁷⁸

Given the law of consent to medical treatment discussed above, however, either at common law or under the *HCCA*, it is unclear why the imminence of death or the need for “a particular form of palliative care” should determine whether consent is required. The need for consent has only ever been triggered where a doctor is willing to provide treatment. Then the doctor must provide information and obtain consent before treating to avoid poten-

⁷⁶ I acknowledge that the allocation issues are different in this hypothetical than those regarding mechanical ventilation, for example. This difference, however, should not affect the critique of the treatment package reasoning.

⁷⁷ Emergencies are a clear exception to the consent requirement both at common law and according to the *HCCA*, *supra* note 7. Section 25(2) of the *HCCA* states that despite the general rule that a health practitioner must not treat without consent, “a treatment may be administered without consent to a person who is incapable with respect to the treatment, if, in the opinion of the health practitioner proposing the treatment, (a) there is an emergency; and (b) the delay required to obtain a consent or refusal on the person’s behalf will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm.” It must not be possible for the doctor to obtain consent, and—to satisfy *Malette*, *supra* note 23—it must also be true that there is no reason to believe the patient would have refused consent.

⁷⁸ *Rasouli CA*, *supra* note 6 at para 53.

tial legal problems. Whether informed consent is required has never been a function of whether withholding treatment would lead to death or to the need for other procedures for which consent is required. The reasoning seems to be an arbitrary mechanism to limit, for policy reasons, the ability to use the law of consent to demand treatment.

It is also worth noting that withdrawing life-sustaining treatment does not necessarily lead immediately and inevitably to death. A study published in the *New England Journal of Medicine* revealed that of 166 patients who had mechanical ventilation withdrawn in anticipation of the patient's death (as opposed to for purposes of weaning a patient off ventilation), only 87.3% died in the intensive care unit ("ICU"). More than 12% survived at least long enough to be transferred out of the ICU. In fact, 3.6% (6 patients) were ultimately discharged from hospital.⁷⁹ This study suggests that withdrawing mechanical ventilation, which is the most common form of life-sustaining treatment in the ICU,⁸⁰ need not inevitably lead to death, and even if it does, death is not necessarily imminent. The Tony Bland case in the UK involved the permissibility of discontinuing life support in the form of artificial feeding.⁸¹ Death would then follow within one to two weeks. This illustrates that, depending on the particular life-sustaining treatment to be withdrawn and the individual patient's condition, removing life support may result in almost immediate death, result in death after two weeks, or not result in death at all.

This is problematic for the Ontario Court of Appeal's reasoning in *Rasouli* because it makes it unclear which treatments may only be withheld or withdrawn with the patient's or SDM's consent. If withdrawing life support does not necessarily lead immediately or inevitably to death, it is less distinguishable from withdrawing other treatments, such as chemotherapy. If the time frame is days or even weeks instead of minutes, it becomes more plausible to say that withholding kidney transplants or withdrawing chemotherapy leads to death in the same way as withdrawing artificial nutrition or mechanical ventilation. As a result, the Ontario Court of Appeal's criteria of imminent and inevitable death create considerable uncertainty. Arguably, on the court's reasoning, consent would be required to withdraw Mr. Rasouli's mechanical ventilation, but not to withdraw his artificial nutrition and hydration.

⁷⁹ Cook et al, "Withdrawal of Mechanical Ventilation in Anticipation of Death in the Intensive Care Unit" (2003) 349:12 *New Eng J Med* 1123 at 1126.

⁸⁰ *Ibid* at 1124.

⁸¹ *Airedale NHS Trust v Bland*, [1993] 1 All ER 821, [1993] AC 789 HL (Eng).

It is also unclear whether consent would be required where a physician wishes to place a DNR on a patient's chart, as in *Lavallee* and *Sawatzky*. Although death would presumably follow imminently from a refusal to provide CPR, it is not clear whether the relevant treatment decision is the imposition of a DNR order on the patient's chart, which could happen weeks before any need for CPR (in which case there is no imminence), or whether it is the refusal to provide CPR at the time it is needed.⁸² It is also unclear whether the palliative care requirement of the Court of Appeal's test in *Rasouli* would be met.

Even if the uncertainty could be resolved, the Court of Appeal's reasoning is arbitrary, in the sense of being unrelated to the principles underlying the law of consent to medical treatment. There is no obvious reason to make the determination of whether consent is required depend on how quickly death results, whether or not death is the inevitable result of withdrawing treatment, or whether narcotics will be administered. For these reasons, the court's treatment package reasoning is seriously flawed. It relies on incorrect assumptions, creates uncertainty, and in any event does not support the court's conclusions.

IV. Implications of *Rasouli* Consent

Regardless of whether the Court of Appeal's reasoning in *Rasouli* is persuasive, creating an entitlement to life support through the law of informed consent has significant implications that require justification and policy debate. Most of the implications arise from the one-sided and essentially absolute nature of the law of consent, which is more easily justified in the refusal context than the demand context. They include requiring doctors to treat even when treatment would not be beneficial, tying doctors' hands regarding resource allocation, and leaving decisions to the Consent and Capacity Board, a body created by the *HCCA* whose primary role is to resolve disputes about capacity and to decide whether substitute consent decisions are made in accordance with the *HCCA*.⁸³ An additional implication, discussed

⁸² At least some have suggested that the act of placing a DNR order on a patient's chart, regardless of whether CPR is subsequently required, amounts to treatment. Gilmour argues that imposing a DNR is treatment, and notes that the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research rejected the claim that DNR orders are not treatment (*supra* note 16 at 411).

⁸³ See *HCCA*, *supra* note 7 ss 32, 37, 70-81.

first, relates to confusion regarding remedies for a breach of *Rasouli* Consent.

1. *Uncertain Remedies*

Imagine that in post-*Rasouli* Ontario, a physician withdraws life-sustaining treatment from a patient without consent because she considers continued treatment to be contrary to the standard of care. The patient dies. What remedy might be granted given the breach of the requirement to obtain *Rasouli* Consent?

Recall that informed consent is a defence to the tort of battery and a component of non-negligent medical treatment. Since the *HCCA* does not create new causes of action or remedies, it modifies, but does not replace, common law causes of action related to a failure to obtain informed consent, namely negligence and battery.

At common law, treatment without any consent (as opposed to treatment with insufficiently informed consent) may be battery, and the Ontario Court of Appeal held that withdrawing life support is “treatment” according to the *HCCA*. Thus, at first blush, failing to obtain *Rasouli* Consent (that is, failing to obtain permission *not* to treat) could constitute battery. Yet battery has for centuries required physical contact.⁸⁴ It is therefore necessary to know whether life support can be removed without touching the patient. If we ignore the sleight of hand that necessarily makes withdrawing life-support touching by inextricably linking it with providing palliative care drugs, it is at least possible sometimes to remove life support without touching the patient.⁸⁵ In those circumstances, you would have a failure to obtain *Rasouli* Consent but no battery.⁸⁶

⁸⁴ “The common law over the centuries has always protected individuals from unwanted intentional contacts with their person... . The common law action of battery developed out of the law’s recognition of an individual’s interest in personal autonomy and bodily integrity—that is, the right of a person to participate in and make decisions about his own body” (*People v Medina* 705 P 2d 961 at 968 (Colo Sup Ct 1985)).

⁸⁵ Withdrawing life-sustaining treatment can be done in a number of ways, some of which may involve touching the patient. Mechanical ventilation is the most common means of life support in the ICU (Cook et al, *supra* note 79 at 1123). It may require touching the patient (*Golubchuk*, *supra* note 43 at para 23), although it

More realistically, failing to obtain *Rasouli* Consent could constitute negligence. However, negligence requires a breach of the standard of care. The standard of care is "that degree of care and skill which could reasonably be expected of a normal, prudent practitioner."⁸⁷ Therefore, negligence requires an unreasonable act or omission. We must therefore examine whether a failure to obtain *Rasouli* Consent would breach the standard of care.

The standard of care does not require doctors always to provide treatment requested by patients. For example, doctors presumably do not breach the standard of care by refusing to prescribe requested antibiotics to patients with viral conditions. They may, in fact, breach the standard of care by doing precisely what a patient asks them to do.⁸⁸ "[w]hat is demanded may not be indicated, effective or beneficial."⁸⁹

Of course, the reason a doctor withholds treatment will be highly relevant to whether the standard of care is breached. One legitimate reason for withholding treatment is that it would not be effective. "General agreement exists that if the desired intervention were truly futile, there would be no duty on the part of the health care team to provide the intervention."⁹⁰ Arguing

would seem equally possible to turn off the machines without touching the patient. Ceasing to provide artificial nutrition or hydration, or ceasing to provide life-sustaining drugs, could logically be accomplished without touching the patient.

⁸⁶ This is in no way to suggest that the ability to demand continued life support should depend on whether life support could be withdrawn without touching the patient. See Downie, *supra* note 10 at 145.

⁸⁷ *Crits v Sylvester* [1956] OR 132 at 143, 1 DLR (2d) 502 (CA), affirmed [1956] SCR 991, 5 DLR (2d) 601.

⁸⁸ "In general medical practice, it is well recognized that physicians have an ethical and professional obligation not to provide medically inappropriate or unethical treatment no matter how insistent the patient may be" (Manitoba Law Reform Commission, *Withholding or Withdrawing Life-Sustaining Medical Treatment, Report #109* (Winnipeg: Manitoba Law Reform Commission, 2003) at 4 [Manitoba LRC].

⁸⁹ Edmund Pellegrino, "Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship" (1994) 10 J Contemp Health L & Pol'y 47 at 59.

⁹⁰ Amir Halevy, "Medical Futility, Patient Autonomy, and Professional Integrity: Finding the Appropriate Balance" (2008) 18:2 Health Matrix 261 at 271. This source discusses US law, but Canadian law similarly imposes no duty of care to provide futile treatment (Manitoba LRC, *supra* note 88 at 4). See also Picard, *supra* note 50 at 346 ("there is no legal duty to perform treatment the doctor

against a patient's right always to demand treatment, Pellegrino notes that physicians have a "moral obligation...to avoid medically useless or futile treatments."⁹¹ Controversy regarding this matter relates less to whether physicians may properly refuse to provide futile treatment, and more to how one decides which treatments are futile.⁹²

That the standard of care does not always require even life-sustaining treatment to be provided, if it is not beneficial, is evident from the binding guidelines of Manitoba's College of Physicians and Surgeons and the Ontario College of Physicians and Surgeon's policy statement on the issue. These guidelines allow physicians to withhold or withdraw life-sustaining treatment against the wishes of a patient or SDM under certain circumstances. In Manitoba, clinical assessment must be based on a minimum goal of life-sustaining treatment, which means the goal should be

maintenance of or recovery to a level of cerebral function that enables the patient to:

- achieve awareness of self; and
- achieve awareness of environment; and
- experience his/her own existence.⁹³

Whether or not this minimum goal is achievable affects the physician's clinical assessment. If it is potentially achievable, the patient's values are to be considered in light of any benefits and negative effects on the patient that will result from providing life-sustaining treatment. If it is not realistically achievable, the physician may conclude that life-sustaining treatment should be withheld or withdrawn and, so long as certain procedures are followed,

reasonably believes to be medically futile, that is, treatment which offers no prospect of therapeutic benefit for the patient").

⁹¹ Pellegrino, *supra* note 89 at 59.

⁹² See e.g. Robert Truog, Allan Brett & Joel Frader, "The Problem With Futility" (1992) 326:23 *New Eng J Med* 1560; Charles Weijer & Carl Elliott, "Pulling the Plug on Futility: Futility is not the Ethical Trump Card Some Would Like it to Be" (1995) 310:6981 *Brit Med J* 683; Steven Leuthner, "Futility: Interpretation and Usefulness in Clinical Practice" (2008) 18:2 *Health Matrix* 245.

⁹³ Manitoba Guidelines, *supra* note 12 at 15-S6.

may withhold or withdraw life-sustaining treatment without the patient's or SDM's consent.⁹⁴

The Ontario policy statement similarly provides that no consent is needed to withhold or withdraw life-sustaining treatment from a patient who will almost certainly not benefit from it, although the question of benefit must take into account patient values.⁹⁵

The fact that these guidelines were set by the Manitoba and Ontario Colleges of Physicians and Surgeons is excellent evidence that they represent the standard of care in those provinces, since members of the medical profession determine the standard of care.⁹⁶ In addition, some critical care practitioners in Ontario have suggested more specific guidelines for critical care practice. The proposed guidelines make clear that

if these reasonable medical goals [improving the patient's well-being, and taking the patient's best interests into account] cannot be achieved as outlined, the use of potentially life-sustaining treatment *would fall outside the standard of care* and any patient or SDM wishes to initiate/continue on life support would not prevail.

...

Participants recommended that critical care services should NOT be used (since would not be of benefit) if any of the following apply:

1. there is no reversible cause for the need for the ICU admission;

⁹⁴ *Ibid.*

⁹⁵ College of Physicians and Surgeons of Ontario, "Decision-Making for End of Life" 2002 (updated 2006) at 4-5, online <www.cpso.on.ca/policies/default.aspx?ID=1582>. See also Canadian Medical Association, Canadian Nurses Association, Canadian Healthcare Association and the Catholic Healthcare Association of Canada, "Joint Statement on Resuscitative Interventions" (1995) 153 CMAJ 1652A-C.

⁹⁶ *Crits v Sylvester*, *supra* note 87 at 143. It is possible for a customary medical practice to be negligent if it is unreasonable, since the standard of care is reasonableness. However, a profession's customary practices will only breach the standard of care if their unreasonableness is "fraught with obvious risks". See *Ter Neuzen v Korn* [1995] 3 SCR 674 at para 41, 127 DLR (4th) 577.

2. the patient would not be expected to survive an ICU admission:
 - a. due to very poor baseline quality of life ...;
 - c. if the patient is in very end-stage of life due to illness;
3. the patient's quality of life is expected to be extremely poor should the patient survive the ICU...⁹⁷

Significantly, the guidelines state that if basic medical goals cannot be achieved, not only does it fall within the standard of care to withhold treatment, but it would actually breach the standard of care to provide it.

These guidelines have not been adopted by the Ontario College of Physicians and Surgeons, and it is not clear to what extent they represent the standard of care in Ontario. However, an Ontario survey indicated that 92% of responding critical care practitioners considered the guidelines reasonable.⁹⁸ Given the general rule that doctors have no duty to their patients to provide non-beneficial treatment, the guidelines of the Manitoba and Ontario Colleges of Physicians and Surgeons' guidelines, and attempts in Ontario to promote specific critical care guidelines, the standard of care in Ontario at the very least sometimes permits physicians to withhold life-sustaining treatment, regardless of the patient's or SDM's wishes, and may sometimes actually *prohibit* doctors from providing such treatment. Withholding treatment under certain circumstances would therefore not be negligent, regardless of the patient's or SDM's wishes.

One way to avoid the conclusion that withholding life-sustaining treatment may not breach the standard of care in negligence is to conclude that failing to respect *Rasouli* Consent is *necessarily* unreasonable, and a breach of the standard of care, given the Ontario Court of Appeal's decision in *Rasouli*. In other words, the court will have dictated a new standard of care. If this is so, it may not be a legitimate exercise of the court's power. On the one hand, lawmakers, including common law courts, are entitled to limit physicians' ability to regulate their own practice. For example, the criminal prohibition on assisted suicide conflicts with what many physicians would

⁹⁷ Hawryluck, Bouali & Meth, *supra* note 12 at 257 [emphasis added].

⁹⁸ Four hundred and three Ontario "critical care leaders," including critical care leaders, ICU directors, and nurse managers, responded to the survey (*ibid* at 258). Since not all respondents were physicians, they would not all be qualified to opine on the standard of care. In addition, respondents were commenting on the reasonableness of the set of guidelines as a whole.

consider the humane practice of medicine. On the other hand, given the judiciary's role and expertise, it is often reluctant to dictate appropriate medical practice,⁹⁹ believing that: "[t]he less the courts try to tell doctors how to practice medicine the better."¹⁰⁰ In *Rotaru v Vancouver General Hospital Intensive Care Unit*, Justice Burnyeat agreed with the position that it would be "an abuse of [the court's] power to require a medical practitioner to act contrary to the fundamental duty which that practitioner owed to his or her patient."¹⁰¹ That duty, as seen above, sometimes requires a doctor not to treat. It is also worth noting that if the Ontario Court of Appeal has changed the standard of care in negligence, it has done so implicitly without providing reasons.

Thus, where withdrawing life-sustaining treatment is reasonable (because treatment cannot benefit the patient, for example),¹⁰² physicians do not breach the standard of care by doing so, even without *Rasouli* Consent, unless the Ontario Court of Appeal dictated a new standard of care in *Rasouli*. If there is no breach of the standard of care, there is no liability in negligence. If the court changed the standard of care, we should be dissatisfied by its unexplained intrusion into what is normally the domain of the medical profession.

Section 5 discusses the possibility of remedies for withdrawing life support without consent under laws other than battery and negligence. There could be professional sanctions or a criminal charge, for example. However, most other legal mechanisms are, like negligence, based on the standards of the profession. Thus, for the reasons that I claim there would be no breach of

⁹⁹ Sneiderman, Irvine & Osborne, *supra* note 22 at 94.

¹⁰⁰ *McLean v Weir*, [1977] 5 WWR 609, 3 CCLT 87 at para 40 (BCSC), *aff'd* (1980), 18 BCLR 325 (BCCA), 4 WWR 330.

¹⁰¹ *Rotaru v Vancouver General Hospital Intensive Care Unit*, 2008 BCSC 318 at para 16, 165 AC/WS (3d) 746.

¹⁰² One potential complication relates to the difference between what is reasonable in the sense of the standard of care and what the profession considers reasonable. The profession may decide what is reasonable based primarily on medical facts, whereas the reasonableness analysis for the purposes of the standard of care may be broader, giving greater weight to patient's wishes. The law establishes that custom need not be reasonable in the latter sense, but for such custom to breach the standard of care, it must be "within the ordinary common sense of juries" that the custom is unreasonable (*Ter Neuzen v Korn*, [1995] 3 SCR 674 at para 44, 127 DLR (4th) 577). Whether doctors must provide futile but desired life-sustaining treatment is not a matter that could be resolved on the basis of ordinary common sense.

the standard of care, there may be no basis for professional sanctions or for criminal charges. Finally, since there is no tort of breach of statute in Canada, breach of the *HCCA* itself would not be sufficient to create a private cause of action. Rather, regular negligence principles would apply.¹⁰³ Since the *HCCA* imposes no public law sanctions, it is not clear that any remedy would lie for a reasonable withdrawal of life-support, notwithstanding a failure to respect *Rasouli* Consent.

As a practical matter, the issue of remedies for a failure to respect *Rasouli* Consent will rarely arise. Physicians who wish to avoid legal problems will abide by the Court of Appeal's clear pronouncements and take any disputes about the validity of a refusal to consent to the Consent and Capacity Board. They are presumably unlikely to expose themselves to tort liability and other legal sanctions by withdrawing treatment from a patient if the Board determines that treatment should continue.

Nevertheless, the existence of *Rasouli* Consent is premised on the court's interpretation of the statutory duty on health practitioners to obtain informed consent. A breach of that duty must have consequences. That reasonably withdrawing life-sustaining treatment without obtaining *Rasouli* Consent may amount neither to battery nor to a breach of the standard of care in negligence¹⁰⁴ suggests that *Rasouli* Consent is a significant departure from the law of consent to medical treatment under the *HCCA*.

2. *Requiring Physicians to Provide Non-Beneficial Treatment*

Despite the potential absence of legal sanctions, the Ontario Court of Appeal has clearly held that the *HCCA* imposes a duty on doctors to obtain *Rasouli* Consent before withholding life-sustaining treatment, regardless of whether that treatment is medically beneficial. It stated in *obiter* that physicians should not have to provide treatment they consider non-beneficial, “[f]or present purposes, we are prepared to accept 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 inappropri-

¹⁰³ *R v Saskatchewan Wheat Pool*, [1983] 1 SCR 205 (*sub nom Canada v Saskatchewan Wheat Pool*), 143 DLR (3d) 9.

¹⁰⁴ Contrast this with treating despite consent having been refused. That will *always* amount to a breach of the standard of care in negligence unless an emergency or public health exception applies.

ate.”¹⁰⁵ Yet this is the inevitable result of an entitlement to life-sustaining treatment grounded in the law of consent to medical treatment, since the requirement of informed consent arises regardless of the physician’s clinical judgment or even the reasonableness of the treatment. The court acknowledges as much when it says that if an SDM’s decision to continue treatment respects a wish expressed by the patient, “the [Consent and Capacity] Board’s hands are tied and this effectively ends the matter.”¹⁰⁶

Ultimately, everything turns on the test set out in section 21 of the *HCCA*. If the patient’s wishes are to continue treatment, the court’s consent-based reasoning dictates that a doctor may not withhold or withdraw treatment against the patient’s wishes regardless of how hopeless or even harmful continued treatment would be. If the incompetent patient’s wishes are not known, the best interests test prevails per subsection 21(2) of the *HCCA*. The best interest test balances medical considerations against the patient’s wishes and values. Specifically, one must balance a) the patient’s values and beliefs; b) any wishes the patient expressed while incompetent; and c) a range of medical factors, including the prospect for improving the patient’s condition, preventing deterioration, the risk of harm, and the existence of alternative treatments.¹⁰⁷

It is clear that a doctor cannot impose unwanted treatment on a capable patient, and this is because the patient has a nearly absolute right to be free from unwanted medical treatment. That right flows from the patient’s interest in self-determination. Yet just because self-determination is also implicated where the patient does want medical treatment, it does not follow that a doctor must provide all treatment that a patient requests, even if resource allocation is not at issue. If this were true, what patients want would always determine what they are entitled to receive from a doctor. Clearly this is not the case.¹⁰⁸

Whether and to what extent patients should be allowed to demand life-sustaining treatment of questionable medical benefit is debatable. Patients have an interest in self-determination that justifies their playing a significant

¹⁰⁵ *Rasouli CA*, *supra* note 6 at para 46.

¹⁰⁶ *Ibid* at para 59.

¹⁰⁷ *HCCA*, *supra* note 7 s 21(2).

¹⁰⁸ See the discussion of the standard of care above. See also the discussion below of what is required by *Regulated Health Professions Act, 1991*, SO 1991, c 18 [*RHPA*].

role in deciding what treatment they will receive. On this basis, Jocelyn Downie argues that doctors are, or should be, required to provide life-sustaining treatment patients want, regardless of whether doctors consider it beneficial. At the very least, they must find another doctor who will take over the patient's care before they may decline to treat.¹⁰⁹

Physicians have an interest in practicing medicine according to their own clinical judgment.¹¹⁰ For many years Canadian society has considered this interest insufficient to justify imposing unwanted treatment on patients. The physician-patient relationship is a fiduciary one, and doctors must therefore place their patients' interests above their own.¹¹¹ The patient's interests prevail, and a patient is the best judge of her own interests.

However, when the issue is not simply preventing physicians from treating how they would like, but rather forcing them to treat contrary to ethical and legal duties owed to patients and the profession, the balancing of interests changes. This is in part because requiring doctors to act is generally a greater interference with their liberty than preventing them from acting.¹¹² Even then, however, doctors must place patients first when deciding whether to treat. Physicians are therefore sometimes morally and legally required to treat patients, perhaps even when doing so poses a risk to themselves.¹¹³

¹⁰⁹ Downie, *supra* note 10 at 147.

¹¹⁰ "The physician as a human being has the same claim to respect for his or her capacity to make personal choices, to follow his or her conscience about what is good medicine and what is morally acceptable as a person... [T]he patient's moral right of autonomy must be balanced with respect for the physician's autonomy" (Pellegrino, *supra* note 89 at 51).

¹¹¹ Picard, *supra* note 50 at 4-7.

¹¹² Consider that the law is much more reluctant to proscribe omissions than acts. It is considered a greater interference with liberty to require someone to act in a particular way than to prevent them from acting in a particular way. See Gomez, *supra* note 9 at 391. That said, I acknowledge that the difference between an act and an omission is not always clear, and that scholars dispute the moral significance of requiring someone to act versus prohibiting them from acting.

¹¹³ The regulations to the *Medicine Act, 1991*, SO 1991, c 30, require doctors not to withhold medically necessary treatment (*Professional Misconduct*, O Reg 856/93, s 1(1)(7) [*Professional Misconduct Regulation*]). In addition, some have argued that doctors' fiduciary obligation to patients requires them to treat AIDS patients and SARS patients despite a risk to themselves. See Edwin C Hui, "Doctors as Fiduciaries: Do Medical Professionals Have the Right Not to Treat?" (2005) 3 *Poiesis Prax* 256.

However, physicians sometimes refuse to practice at all rather than provide what they see as harmful treatment.¹¹⁴

There is, however, at least one limitation on physicians' affirmative legal duty to treat. They may refuse to provide treatment that would not be beneficial to a patient, at least under some circumstances.¹¹⁵ The reasons for this are somewhat unclear but likely relate to physicians' interest in practicing medicine according to the standards of the profession. And while the profession recognizes patients' interest in autonomy, it also recognizes principles of beneficence and non-maleficence, such that doctors should not provide treatment they consider to be harmful or non-beneficial.¹¹⁶

Sometimes the patient's interest in self-determination will conflict with the physician's interest in not providing useless or harmful medical treatment. Whether a doctor should be required to provide life-sustaining treatment requested by a patient when the doctor considers the treatment harmful or non-beneficial is debatable. This article does not set out to answer this question. Rather, it suggests that resolving the issue requires policy debate by the legislatures or principled analysis by the courts. It is insufficient to base a significant change to the law (namely that doctors must provide life-sustaining treatment regardless of whether they believe it to be medically indicated) on an analysis that simply treats the law of informed consent the same way in the demand context as in the refusal context, when the contexts clearly suggest that a different balancing of interests is warranted.

¹¹⁴ Three doctors resigned from their ICU practice rather than treat Samuel Golubchuk following a court order requiring treatment to continue. One considered such treatment "tantamount to torture" (CBC News, "2 More Winnipeg Doctors Resign in Dispute Over Elderly Man's Treatment" *CBC News Manitoba* (16 June 2008) online CBC News Manitoba <www.cbc.ca/news/canada/manitoba/story/2008/06/16/golubchuk.html>).

¹¹⁵ The pronouncement of the Court of Appeal in *Rasouli* that doctors may generally withhold non-beneficial treatment without consent suggests as much. In the US context, see Pellegrino, *supra* note 89 at 59.

¹¹⁶ See James Drane & John Coulehan, "The Concept of Futility: Patients Do Not Have a Right to Demand Medically Useless Treatment" (1993) 74:10 *Health Progress* 28. See also Gilmour, *supra* note 16 at 407-08 ("health care providers raise legitimate concerns about the morality of being required to provide what they consider ineffective and sometimes damaging therapy to a patient contrary to their own beliefs and those of the medical profession generally").

Rasouli places physicians in the unenviable situation of having to decide between providing treatment they consider inappropriate or breaking the law. It may be good policy to sometimes require physicians to provide requested treatment of questionable medical value, but the Ontario Court of Appeal's analysis in *Rasouli* does not justify this outcome on policy grounds. Rather, the conclusion follows from a mechanical application of the law of informed consent to the demand context.

3. *Precluding Efficient Resource Allocation*

Although few like to admit it, health care is a limited resource that must be rationed.¹¹⁷ Canadian provinces cannot realistically provide all the medical care that their citizens would like. And with the cost of health care increasing much faster than the rate of inflation,¹¹⁸ rationing will become an increasingly necessary exercise.

Both health practitioners and governments have a role in allocation decisions. Governments decide, for example, which pharmaceuticals will be covered by provincial insurance plans and which will not.¹¹⁹ Health practitioners also make many allocation decisions: they decide who gets a bed, what tests to order, which patients get priority, etc.¹²⁰ Doctors' clinical decisions are at

¹¹⁷ In his recent report on the future of Canadian healthcare, Don Drummond states: "economic realities mean that provincial governments will soon be compelled to rein in healthcare cost increases" ("Therapy or Surgery? A Prescription for Canada's Health System" (CD Howe Institute Benefactors Lecture, delivered in Toronto, 17 November 2011) at 1, online: CD Howe Institute <www.cdhowe.org/pdf/Benefactors_Lecture_2011.pdf>). He later states: "The primary method to control costs in a large public health system is by rationing services" (*ibid* at 7). See also David Naylor, "Allocation of Health Care Resources: a Challenge for the Medical Profession" (1986) 134:4 Can Med Assoc J 333.

¹¹⁸ Don Newman, "Cut Health-care Costs by Getting Back to Basics", 22 April 2010, online: CBC News <www.cbc.ca/news/canada/story/2010/04/22/f-vp-newman.html>.

¹¹⁹ "Because no federal guidelines or laws currently cover outpatient drug reimbursement policies, provinces establish and fund their own plans" (Virginie Demers et al, "Comparison of Provincial Prescription Drug Plans and the Impact on Patients' Annual Drug Expenditures" (2008) 178:4 Can Med Assoc J 405 at 405).

¹²⁰ Naylor notes: "[D]octors are expected to serve both as suppliers of services and as purchasing agents on their patients' behalf for services such as hospital days,

least sometimes legitimately influenced by cost considerations. John Irvine notes that it would be unreasonable for physicians to pursue any gain in health at any cost. "Physicians, then, *do* on a daily basis...weigh economic considerations against purely clinical or therapeutic ones when assessing therapies."¹²¹ The extent to which physicians may legitimately be influenced by resource allocation considerations is controversial,¹²² but in the absence of more detailed legislative or other guidance, I suggest that it is both necessary and desirable for physicians to play at least *some* role in allocating health care resources.

The Ontario Court of Appeal did not consider rationing arguments because such arguments were not before it: the defendant doctors in *Rasouli* did not argue that they have insufficient resources to provide all the life-sustaining treatment their patients desired. Strategically, this was probably the right approach. However, the court's decision has implications for physicians' ability to allocate health care resources.

Although *Rasouli* does not require the government or hospitals to provide sufficient resources to fund life-sustaining treatment,¹²³ it limits doctors' ability to allocate health resources among their patients. Whether to consent is a decision left entirely to patients or SDMs, and does not permit an inquiry into the decision's reasonableness,¹²⁴ or the competing interests of those other than the patient. It therefore follows from *Rasouli* that doctors cannot withhold or withdraw ineffective life-sustaining treatment in order to free up a bed for someone with a better prognosis unless the competent patient agrees that treatment should be stopped, the incompetent patient's prior capable wishes were to stop treatment, or withdrawing treatment is in the incompetent patient's best interests.

drugs, diagnostic tests and consultations with other physicians" (*supra* note 117 at 334).

¹²¹ John Irvine, "The Physician's Duty in the Age of Cost Containment" (1994) 22:3 Man LJ 345 at 346.

¹²² See Downie, *supra* note 10 at 147.

¹²³ This follows from the fact that the duty to obtain informed consent is a duty imposed on health practitioners. A breach subjects only health practitioners to legal sanctions. The law of informed consent creates no cause of action against governments or hospitals.

¹²⁴ Except as relevant to a patient's best interests in the context of substitute decision making.

Rationing decisions are, of course, extremely difficult. Much has been written about the basis on which such decisions should be made. The literature on Quality Adjusted Life Years alone fills volumes.¹²⁵ It is beyond the scope of this article to discuss how rationing should be accomplished. Suffice it to say that health care rationing, in the sense of not providing all the health care that individuals want, is necessary and desirable.

This is not to suggest that doctors should be permitted unilaterally to pull the plug on patients to save resources. Jocelyn Downie argues that allocation decisions are for society to make,¹²⁶ and I agree (unless she means that physicians have *no* legitimate role in allocation decisions). But changing the status quo by preventing physicians from giving *any* weight to cost and scarcity of resources is another seemingly unintended consequence of treating the question of a right to life support as an issue of informed consent.

As a practical matter, health practitioners are unlikely to withdraw life-sustaining treatment for reasons of resource allocation. When it comes to life and death, most will go to great lengths to ensure that all medically appropriate treatment is provided.¹²⁷ However, due to the Ontario Court of Appeal's

¹²⁵ See Michael Nichol et al, "Evaluating Quality-Adjusted Life Years: Estimation of the Health Utility Index (HUI2) from the SF-36" (2001) 21:2 *Medical Decision Making* 2; John LaPuma & Edward Lawler, "Quality-Adjusted Life-Years: Ethical Implications for Physicians and Policymakers" (1990) 263:21 *Journal of the American Medical Association* 2917; Yolanda Verel & Mark Sculpher, "Quality-Adjusted Life Years" (2008) 8 *Practical Neurology* 175.

¹²⁶ Downie, *supra* note 10 at 147.

¹²⁷ This follows from the nature of the medical profession and physicians' duties to patients. For example, the College of Physicians and Surgeons of Ontario states: "Service is not only competence; it is also putting the patient first. A physician has professional responsibility to their patients, individually and collectively; their patients' families; their own practice; and the health care system. However, at any given time a physician's primary responsibility is to the individual patient before them" ("The Practice Guide: Professionalism and College Policies", 2008, at 8, online: CPSO <www.cpso.on.ca/policies/guide/default.aspx?id=1696>). Anecdotally, one physician and ethicist refused to remove an infant, Baby X, from a life-sustaining machine even though from a resource allocation standpoint, it made sense to do so. The number of machines available was limited and Baby X's chances of survival were less than 5% even with continued treatment. Baby Y had a 95% chance of survival if given access to a machine but only about a 50% chance of survival without it. Because Baby X was already on the machine, the doctor refused to withdraw treatment from Baby X in order to allow Baby Y to

conclusion that consent is required to withdraw life-sustaining treatment, doctors apparently no longer even have the possibility of freeing up a needed bed or machine for someone who could benefit from it more. The result may be justifiable, but it has not yet been justified.

4. *The Consent and Capacity Board’s Limited Mandate*

Those who believe patient consent should be required to withhold or withdraw treatment, or who otherwise have concerns about physicians’ power to make life and death decisions, often cite the fact that the *HCCA* provides for a dispute resolution mechanism by way of the Consent and Capacity Board (“Board”).¹²⁸ The Ontario Court of Appeal agreed that “if the physician is not content with the refusal of [an SDM] to provide consent to the withdrawal of life support, the physician’s recourse is to refer the matter to the Board for disposition.”¹²⁹ The Board’s mandate, however, does not permit it to consider the range of relevant issues that arise regarding decisions whether or not to continue treatment, including the physician’s interest in not having to provide medically non-beneficial treatment, and resource allocation issues. In addition, board members do not necessarily have any medical expertise that would permit them to determine whether continued treatment is *medically* appropriate.¹³⁰ Because of the Board’s mandate and composition, it is not suited to resolving disputes about whether to withhold or withdraw life support.

have access to the machine (personal communication with Dr. Robert Truog, 2011).

¹²⁸ Mr. Rasouli’s lawyers made this argument and it was raised by some who emailed me in response to an op-ed I published in the *Toronto Star*, Hilary Young, “When Family and Doctors Disagree on When to End Life”, *The Toronto Star* (20 September 2011) online: *Toronto Star* <www.thestar.com/opinion/editorialopinion/article/1057057--when-family-and-doctors-disagree-on-when-to-end-life>. See e.g. Alex Schadenberg’s blog: “Article Concerning the Rasouli Case is Based on False Assumptions” (27 September 2011), online: <alexschadenberg.blogspot.com/2011/09/article-concerning-rasouli-case-is.html>.

¹²⁹ *Rasouli CA*, *supra* note 6 at para 45.

¹³⁰ As noted by the Appellants, the Board is currently composed primarily of lawyers, psychologists, and laypersons (*Cuthbertson v Rasouli FOA*, *supra* note 3 at para 100). The choice of psychologists rather than other health professionals reflects the Board’s mandate in determining patients’ capacity.

The Board's statutory mandate includes advising SDMs how best to make a consent decision that complies with the *HCCA*,¹³¹ and resolving disputes where a health practitioner believes a consent decision has been made inappropriately.¹³² In addressing these consent decisions, the Board must decide based first on the desires expressed by the patient while competent. If no such desires were expressed before incapacity, the decision must be based on the patient's best interests.¹³³ Relying on wishes and best interests, originally common law considerations now codified in the *HCCA*, aims to promote respect for the patient's autonomy and bodily integrity. It reflects the fact that a patient has an almost absolute right to refuse treatment while acknowledging the reality that a person may not be competent to make treatment decisions.

Thus, according to *Rasouli*, if a physician wishes to withdraw life-sustaining treatment because it is no longer helping a patient, and the competent patient wants treatment to continue, the Board *must* side with the patient: her wishes prevail according to the *HCCA*. If the patient's wishes are not known but the SDM wants treatment to continue, the Board may only consider whether continued treatment is in the patient's best interests, an analysis that combines medical criteria and the patient's values. The Board may not consider that the physician does not want to treat, except insofar as that is relevant to the medical criteria under the best interests test. The Board may also not give *any* weight to the cost or availability of health care resources. There may be reasons, such as respect for religious freedom, to provide expensive treatment that is not likely to be beneficial. However, the Board is not statutorily permitted to engage in such debates.

This demonstrates again that while it is appropriate to rely exclusively on the patient's wishes and best interests to resolve disputes about whether a patient or SDM should accept or refuse offered treatment, it may be inappropriate to rely solely on those factors to resolve disputes over whether a patient may *demand* treatment. Competing interests come into play in a demand context that do not in a permission context. Specifically, whether the doctor is willing to provide non-beneficial treatment and whether the doctor thinks scarce resources would be more effective if expended elsewhere are relevant in a demand context in a way that they are not in a refusal context.

¹³¹ *HCCA*, *supra* note 7 s 35.

¹³² *Ibid* s 37.

¹³³ *Ibid* s 21.

V. Alternatives to Consent

I have argued that the law of informed consent to medical treatment, as it relates to battery and negligence, does not and should not ground entitlements to treatment, including entitlements to life-sustaining treatment. I have also been careful to note, however, that this does not mean doctors do have or should have free reign in deciding whether or not to offer certain treatments. Existing laws other than the law of informed consent (as it relates to negligence and battery) prevent physicians from withholding or withdrawing life-sustaining treatment in certain circumstances. I discuss how the *Charter*, criminal law, and the law of professional responsibility protect patients.¹³⁴ However, because the protection offered by existing law is limited, additional, more specific guidelines or laws are desirable. I briefly examine two proposals that address the question of whether life support may be withheld or withdrawn. The first suggests that the decision is entirely up to physicians if a certain threshold of benefit to the patient cannot be attained. The second suggests that the decision should always be up to the patient unless others' rights are affected.

1. The Charter

The *Canadian Charter of Rights and Freedoms*¹³⁵ may protect against a doctor withholding or withdrawing life-sustaining treatment against a patient's or SDM's wishes. Specifically, section 7 of the *Charter* (life, liberty and security of the person), section 2(a) (freedom of religion) or section 15 (equality) could support entitlements to care, at least under certain circumstances. That said, no court has yet recognized a *Charter* right to life-sustaining medical treatment.

The first barrier to a *Charter* right not to have life-sustaining treatment withheld or withdrawn is uncertainty regarding whether the *Charter* applies to doctors' treatment decisions at all. *Stoffman v Vancouver General Hospital* held that it does not.¹³⁶ Other cases and commentators cast doubt on that

¹³⁴ Having discussed the role of the standard of care in negligence in Section 4a, I do not do so again here.

¹³⁵ *Canadian Charter of Rights and Freedoms*, Part 1 of the *Constitution Act, 1982*, being Schedule B to the *Canada Act, 1982* (UK), 1982, c 11 [*Charter*].

¹³⁶ *Stoffman v Vancouver General Hospital*, [1990] 3 SCR 483, 76 DLR (4th) 700, 1990 CarswellBC 277 (WL Can) at para 106.

proposition,¹³⁷ but the trial judge in *Rasouli* held that the plaintiff had failed to prove that the *Charter* applied to doctors' decisions. Mr. Rasouli's *Charter* argument was therefore not addressed on its merits.¹³⁸ The Ontario Court of Appeal declined to comment on Justice Himel's holding on the applicability of the *Charter*.¹³⁹

If a court were to find the *Charter* applies to doctors' decisions not to provide treatment,¹⁴⁰ it might well conclude that the *Charter* confers a right to some degree of life-sustaining treatment—even if the treating physician did not want to provide it. The Supreme Court of Canada has stated that there is no general constitutional right to health care,¹⁴¹ but in certain cases a specific right has been held to exist. For example, in *Eldridge v British Columbia (AG)*, the Supreme Court held it unconstitutional for British Columbia not to provide sign language interpreters to deaf people seeking medical treatment.¹⁴² In other words, it created an entitlement to sign language interpreters. It reasoned that not to provide such interpreters was discriminatory, contrary to section 15 of the *Charter*.

It is beyond the scope of this article to examine whether a denial of life-sustaining treatment would be unconstitutional, and under what circumstances. Suffice it to say that in the context of *Rasouli*, where the refusal to provide treatment is grounded in clinical judgment that such treatment is not beneficial to the patient, it is arguable whether the *Charter*, if it applied, would protect an entitlement to treatment. On the one hand, the *Charter* may not require offering treatment that physicians reasonably consider medically ineffective. On the other hand, patients may have a constitutional right to life-sustaining treatment where denying that treatment would implicate patients' fundamental values and beliefs about a good life and a good death.¹⁴³

¹³⁷ See the discussion in *Rasouli* SC, *supra* note 15 at paras 84-93.

¹³⁸ *Ibid* at para 93.

¹³⁹ *Rasouli* CA, *supra* note 6 at para 36.

¹⁴⁰ Alternately, if a government were to make a legislative or operational decision that limited people's access to life-sustaining treatment, the application question would presumably not arise.

¹⁴¹ See *Chaoulli v Quebec (AG)*, 2005 SCC 35 at para 104, [2005] 1 SCR 791.

¹⁴² [1997] 3 SCR 624, 151 DLR (4th) 577.

¹⁴³ See Downie, *supra* note 10 for a discussion of how dignity and self-determination are implicated even where treatment offers little or no medical benefit.

If the refusal to offer treatment were based in part on resource allocation decisions, it is perhaps more likely that a *Charter* right would be found, since "budgetary considerations cannot be used to justify a [*Charter*] violation."¹⁴⁴ Even then, however, courts are often reluctant to interfere with allocation decisions made for policy reasons.¹⁴⁵ For example, a couple that was denied fertility treatments by the Nova Scotia government challenged the constitutionality of that decision. The Nova Scotia Court of Appeal held that the government's allocation decision was discriminatory, but that it was saved by section 1 of the *Charter*, since the government's means for achieving the important goal of funding medically necessary health care with limited resources were reasonable.¹⁴⁶

2. *Criminal Law*

Criminal law provides some protection against a doctor refusing to treat. Criminal negligence,¹⁴⁷ like the tort of negligence, is based on the concept of reasonableness, although unlike negligence in tort, the criminal offence requires a marked departure from the reasonableness standard as well as a "wanton or reckless disregard for the lives or safety of other persons."¹⁴⁸ Thus, in egregious cases of unreasonably withholding or withdrawing life-sustaining treatment, a physician could be found guilty of a criminal act. As with tortious negligence, however, this is unlikely to be the case where a decision not to provide life-sustaining treatment is based on reasonable clinical judgment. It will therefore rarely apply to protect patients in *Rasouli*-type situations.

¹⁴⁴ *Schachter v Canada*, [1992] 2 SCR 679 at 709, 93 DLR (4th) 1.

¹⁴⁵ The likelihood of success of allocation arguments in *Charter* cases depends in part on the section of the *Charter* being invoked. Courts hesitate to use section 7 to second-guess decisions of pure policy, whereas they may be more likely to invalidate allocation decisions that are discriminatory and contrary to section 15. See Louise R Sweatman & Diane Woollard, "Resource Allocation Decisions in Canada's Health Care System: Can These Decisions Be Challenged in a Court of Law?" (2002) 62:3 Health Policy 275 at 284.

¹⁴⁶ See *Cameron v Nova Scotia (AG)* (1999), 204 NSR (2d) 1, 177 DLR (4th) 611 (CA), leave to appeal to SCC refused, 531 (November 9, 1999).

¹⁴⁷ See *Criminal Code*, RSC 1985, c C-46, ss 219-221.

¹⁴⁸ *Ibid*, s 219. See also *R v Rogers*, [1968] 4 CCC 278, 65 WWR 193 (BCCA). For an example of criminal negligence involving a medical practitioner, see *R v Manjanatha*, [1995] 8 WWR 101, 131 Sask R 316 (CA).

3. *The Regulated Health Professions Act*¹⁴⁹

Medicine is a self-regulating profession and the *Regulated Health Professions Act (RHPA)* seeks to ensure that “practitioners meet agreed standards of practice and competence.”¹⁵⁰ The *RHPA* allows the profession to impose sanctions on physicians who commit misconduct or who are incompetent. Misconduct includes failing to meet the standards of the profession¹⁵¹ and discontinuing professional services that are needed.¹⁵² Thus, failure to provide needed or appropriate medical treatment, whether life-sustaining or otherwise, could expose physicians to professional discipline, including a fine or suspension or loss of their license to practice medicine.¹⁵³ As a result, professional regulation of the medical profession helps protect against unreasonable or improper withholding of medical treatment.

Professional self-regulation, however, suffers from the same limitations as tortious and criminal negligence in that the reasonable exercise of clinical judgment is unlikely to run afoul of professional standards of conduct. The *RHPA* proscribes improper or unreasonable medical practice. It is not concerned with broader moral questions, such as whether and when people should be entitled to life-sustaining treatment of questionable medical benefit. Nor should it be, since the medical profession has no legitimate claim to making moral decisions for patients.

The three legal mechanisms above are not necessarily the only ways in which the law may protect against a doctor withholding life-sustaining treatment against a patient’s will. Other laws, such as human rights legislation, may protect against denials of life-sustaining treatment. Together, these mechanisms demonstrate that it is not necessary to rely on the law of informed consent in order to protect a patient’s interest in not having life-sustaining treatment withheld or withdrawn. That said, as tools to protect patients against a doctor withholding life-sustaining treatment, the laws discussed above all have limitations. The *Charter* may not apply at all. Criminal

¹⁴⁹ *RHPA*, *supra* note 108.

¹⁵⁰ Ontario, Health Professions Regulatory Advisory Council, *Regulation of Health Professions in Ontario: New Directions* (Toronto: HPRAC, 2006) at 7, online: <www.health.gov.on.ca/english/public/pub/ministry_reports/new_directions/new_directions.pdf>.

¹⁵¹ *Professional Misconduct Regulation*, *supra* note 113 s 1(1)(2).

¹⁵² *Ibid* s 1(1)(7).

¹⁵³ *RHPA*, *supra* note 108, Schedule 2, s 51(2).

prohibitions and professional self-regulation, like the law of negligence, target breaches of the standards of the medical profession. But since existing medical standards may be uncertain or may not sufficiently protect patients, some commentators have suggested new protocols—in the form of professional guidelines or legislation—that would help ensure a more nuanced and appropriate approach to whether certain life-sustaining treatment will be offered. As examples, I briefly describe certain Ontario critical care workers’ suggestions for guidelines, and Jocelyn Downie’s informed consent-based proposal.

4. *The Hawryluck Proposal*

In Section 4a, I noted that certain Ontario critical care practitioners proposed a set of guidelines that would help them make principled and transparent decisions about whether to treat or continue treating critical care patients.¹⁵⁴ Although many people were involved in developing the guidelines, I refer to them as the “Hawryluck proposal” for the sake of simplicity. These guidelines are said to represent a “proposed new standard of care,”¹⁵⁵ although in some respects the proposal likely codifies the existing standard of care for life-sustaining treatment in a critical care setting.¹⁵⁶

The Hawryluck proposal makes clear that the goal should be shared decision making. Practitioners should provide all relevant information; make efforts to determine how various options fit with the patient’s wishes, values, and goals; answer all a patient’s or an SDM’s questions; make recommendations; and document the process.¹⁵⁷ It recommends second opinions where patients want them, and promotes continued assessment of the patient’s condition.

Whether treatment is offered should depend on whether treatment is beneficial. Benefit to the patient takes into account the patient’s informed wishes

¹⁵⁴ Hawryluck, Bouali & Meth, *supra* note 12.

¹⁵⁵ *Ibid* at 256.

¹⁵⁶ I suggested in Section 4a that the Hawryluck proposal reflects the standard of care—at least to the extent of permitting treatment sometimes to be withheld despite the objections of the patient or SDM. That said, since practice varies, it is unclear what exactly the standard of care requires.

¹⁵⁷ Hawryluck, Bouali & Meth, *supra* note 12 at 256.

and factors related to a patient's best interests, as set out in the *HCCA*.¹⁵⁸ However, it also takes into account medical reasonableness. Treatment is only reasonable where it can achieve certain minimum medical goals, taking into account a patient's wishes or values. If it is not reasonable in this sense, it should not be offered. Thus, certain treatment would not have to be provided regardless of a patient's wishes or values:

Participants recommended that critical care services should NOT be used (since would not be of benefit) if any of the following apply:

1. there is no reversible cause for the need for the ICU admission;
2. the patient would not be expected to survive an ICU admission:
 - a. due to very poor baseline quality of life ...;
 - c. if the patient is in very end-stage of life due to illness;
3. the patient's quality of life is expected to be extremely poor should the patient survive the ICU...¹⁵⁹

The Hawryluck proposal has strengths and weaknesses. It provides guidance regarding how to decide whether life-sustaining treatment should be provided—at least in the critical care setting—and takes into account the patient's wishes and best interests. It aims to resolve conflicts between patients or SDMs and doctors regarding whether life-sustaining treatment should be continued, and to that end requires a number of procedures aimed at achieving consensus. It neither gives doctors free reign to decide based only on medical considerations, nor does it always allow patients' wishes to be determinative.

However, the Hawryluck proposal may give insufficient weight to the wishes and values of patients. It is unclear whether doctors should ever have the authority unilaterally to deny life-sustaining treatment, even under the limited circumstances described above. In addition, the proposal leaves many questions unanswered. Assuming the minimum medical goals *can* be achieved, it is unclear how competing factors (e.g. the extent of the medical benefit, and the patient's wishes and values) should be balanced in deciding whether treatment should be provided. The Hawryluck proposal implies that

¹⁵⁸ *Ibid.*

¹⁵⁹ *Ibid* at 257.

doctors may still be entitled to refuse life-sustaining treatment if treatment is on the whole unreasonable, taking into account a patient's wishes and best interests. This is so even where the minimum goals of treatment can be met. The implication is that the decision whether to treat would still ultimately be up to physicians, so long as they consider the relevant factors. The proposal accepts the premise that physicians do not have to provide non-beneficial treatment. It may therefore be that the Hawryluck proposal would still give too much discretion to physicians.

5. *The Downie Proposal*

Jocelyn Downie's proposal for resolving disputes about whether life-sustaining treatment may be withheld or withdrawn is much less deferential to physicians' judgment. I discussed her proposal in Section 2c above, in the context of whether the law of informed consent applies to create entitlements to life-sustaining treatment. I concluded that the law of informed consent should not be interpreted as creating such entitlements, but Professor Downie's proposed solution could nevertheless form the basis of policy that need not flow from the law of informed consent.

Recall that Downie proposes a presumption in favour of patients deciding whether or not life-sustaining treatment is provided. The primary and perhaps sole factor Downie considers relevant in rebutting the presumption is resource allocation. Further, resource allocation decisions are only legitimate, she implies, where made by policymakers.¹⁶⁰ She largely dismisses physicians' interest in not treating against their clinical judgment, although that interest would seem to at least justify physicians removing themselves from a patient's care if another physician were willing to take over.¹⁶¹

Professor Downie's proposal has the benefit of being more simple and predictable than the Hawryluck proposal. The decision whether to withdraw life-sustaining treatment would be entirely up to patients unless resource allocation was at issue. Even then, she implies that life-sustaining treatment could not be withheld in the absence of a legislative or other policy decision to limit such treatment. That legislative decision would be based on balancing the public interest against the patient's interest, but no ad hoc balancing

¹⁶⁰ Downie, *supra* note 10 at 147.

¹⁶¹ *Ibid.*

by doctors would be permitted. It would ultimately be for legislators or hospitals to decide how these decisions should be made.¹⁶²

The problem with simplicity and predictability, as is often the case, is that it comes at the cost of flexibility. According to Professor Downie's proposal, in the absence of an explicit policy, resource scarcity must be ignored. As with the status quo since *Rasouli*, patients may essentially demand life-sustaining treatment regardless of the medical benefit that treatment would provide, or the cost of that treatment to the taxpayer. That said, Downie's proposal would apply more broadly than *Rasouli* since it would not be limited to situations in which palliative care drugs are administered when life-sustaining treatment is withdrawn.

In fact, Professor Downie's proposal might apply much more broadly. There is no apparent reason to limit her approach to life-sustaining treatment at all. Downie's proposal is based on the right to self-determination. Other types of medical treatment implicate self-determination to a similar degree as life-sustaining treatment. It is unclear whether Downie would advocate for presumed entitlements to all treatment that significantly implicates bodily integrity, subject only to explicit policies limiting access to such treatment for reasons of resource allocation. That should perhaps be the law, but I believe it would amount to a significant change to the status quo—one that requires debate and consultation with stakeholders such as taxpayers, hospitals and patients.

VI. What Should the Supreme Court Do?

Given all this, what should the Supreme Court of Canada do when it ultimately hears the *Rasouli* case? Its options are limited, in that it cannot simply legislate a better solution to the issue of entitlements to life-sustaining treatment. While a legislative response is desirable, realistically it is the Supreme Court that will set the law on this subject.

There are a number of ways in which the Court could resolve *Rasouli*. The first is to simply uphold the Court of Appeal's decision without altering its reasoning. It should be clear why I reject this approach. Similarly, I reject any other consent-based mechanism for creating entitlements to treatment, such as Justice Himel's approach. Rather, the Court should hold that the law of informed consent, under the common law and the *HCCA*, creates no entitlements to medical treatment.

¹⁶² *Ibid.*

If this were the result, the Court would presumably send the matter back for a new trial in which Mr. Rasouli could seek an injunction on the basis that withdrawing treatment would breach the standard of care in negligence, for example. I think this is the most reasonable outcome on the existing law. However, I acknowledge the limitations, discussed above, of negligence law as a mechanism for deciding whether life-sustaining treatment should be provided. In particular, since it is based on the standards that doctors set for themselves, negligence law may insufficiently reflect non-medical factors.

The Court could conceivably resolve Mr. Rasouli's case on constitutional grounds. However, since Mr. Rasouli's physicians did not appeal the trial judge's holding that the *Charter* does not apply to doctors' decisions, either to the Ontario Court of Appeal or to the Supreme Court, this seems unlikely.

There are undoubtedly other ways of resolving the legal issues *Rasouli* raises, and I hope the Court will arrive at a solution that is consistent with the law of informed consent, which creates no entitlements to treatment—either at common law or in the *HCCA*. That outcome may not be ideal from a policy perspective, but it is not for the Court to set policy on the fundamental question of whether people should be entitled to life-sustaining treatment of questionable medical value.

Conclusion

For more than a year, Hassan Rasouli has been lying in a hospital bed at Sunnybrook Health Sciences Centre. Without modern technology, he would long ago have died. The increasing availability of such life-sustaining technology creates a need for decisions that raise complex issues regarding quality of life, autonomous decision making, health care rationing, and the proper role of physicians. Few decisions are more fraught than deciding that there is no longer hope, or that someone's life is no longer worth living. Yet these decisions must be made. It is not simply a matter of erring on the side of providing life-sustaining treatment. This too is a decision, and a costly one—both in terms of health care resources and in terms of the toll it takes on families and health practitioners. Do we want to provide an unlimited right to life-sustaining treatment at any cost because of the way we value life? If not, how do we decide when enough is enough, given that medical knowledge is incomplete and that people have different values when it comes to a good death? More importantly for the purpose of this article, who should decide?

There are, of course, no easy answers. I have argued that the *Rasouli* approach to this last question does not follow from existing law and is seriously

flawed. By treating the entitlement to demand treatment the same way as the entitlement to refuse it, *Rasouli* ignores relevant differences between the two contexts. It makes the decision whether to provide life-sustaining treatment one based solely on the patient's desires and interests, whereas the interests of physicians and the public interest in the appropriate use of health care resources are also relevant in the demand context. That is not to say that physicians should unilaterally decide whether treatment is offered, but nor should the decision necessarily belong solely to the patient. *Rasouli* Consent is therefore an inappropriate mechanism for resolving disputes about whether life-sustaining treatment should be withdrawn or withheld. The issue is a policy matter for the legislatures. In the meantime, the Supreme Court of Canada should interpret the law of informed consent as creating no entitlements to treatment.