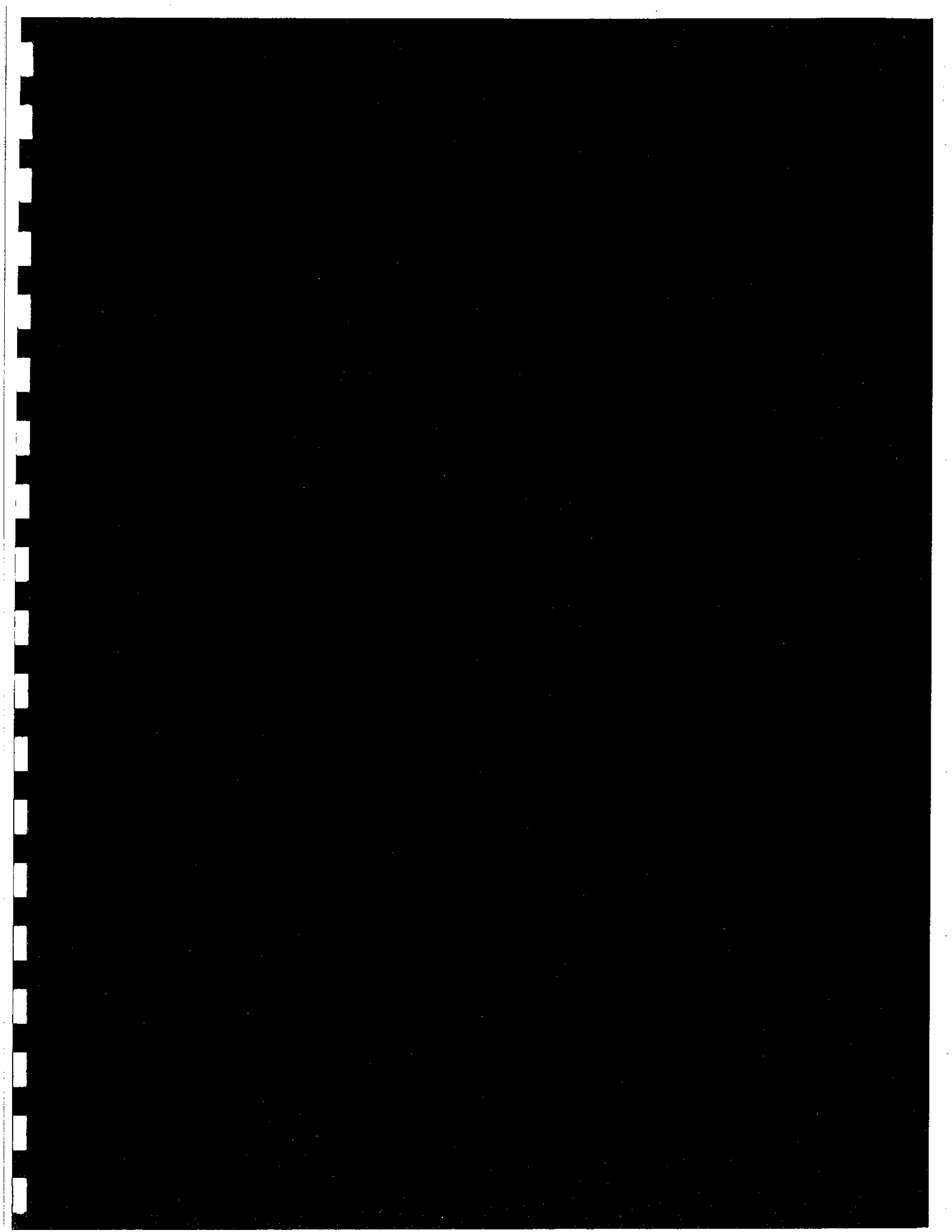

PART I—OVERVIEW

1. The intervener's stated position, in a nutshell, is that once a plan of treatment is proposed by a doctor and implemented, the treatment cannot be withdrawn under any circumstances except with the patient's consent. Crucial to its position is the fact that a doctor has "proposed" the plan of treatment. The intervener accepts that consent is not required for a doctor to <u>withhold</u> treatment because that is not treatment that the doctor has "proposed".

2. The intervener has adopted the position which, as the appellants submitted in their principal factum, is implicit in the reasons for decision of the judge in the court below. As a result, the intervener has brought out into the open the interpretation of the *Health Care Consent Act* that has to be adopted to accept its submission (and the respondents') that the Act requires consent to a withdrawal of treatment.

3. If, as the appellants submit, the doctor does not "propose" treatment when he or she proposes to withdraw treatment, then the interpretation advanced by the intervener must fail. The appellants submitted in their principal factum a number of considerations that should persuade this Court that the intervener's interpretation is illogical and wrong.

4. The intervener's interpretation is contrary to the law of informed consent as developed in the common law. The appellants submit that the common law should be applied as an aid to the interpretation of the relevant provisions of the Act. The intervener is constrained to argue that the Act has superseded the common law, a position for which it provides no grounds or evidence whatever except its own interpretation of the Act.

5. Policy considerations support the interpretation of the Act advanced by the appellants and not that advanced by the intervener. In particular, the intervener's interpretation would require doctors to continue to provide treatment that is not in the patient's best interests in that it provides no medical benefit to the patient or is detrimental, unless and until consent to discontinue that treatment is given. Such an interpretation leads to absurd results.

6. The intervener's submission that considerations of "personal autonomy" require this result misconstrues the law. The courts have never construed a right of personal autonomy to extend to a right to require the provision of medical treatment that is against medical indications.

PART II—THE FACTS

7. The appellants accept the facts set out in paras. 32, 27 and 41 of the intervener's factum and disagree with the allegations contained in paras. 33 – 36 and 38 – 40 thereof.

8. Mr. Rasouli suffered brain damage as a complication of bacterial meningitis. This caused bouts of apnea (failure to breathe). As a result, and as an emergency measure, he was placed on mechanical ventilation on October 19, 2010.

9. Para. 33 of the intervener's factum wrongly states that ventilation was deemed to be medically appropriate until a short time prior to the application to the court. In fact, the treatment was instituted at a time before Mr. Rasouli's prognosis was clear. Once it became clear that Mr. Rasouli was in a persistent vegetative state, the attending doctors concluded that the treatment was no longer medically indicated and they immediately advised their intention to discontinue it. It has continued until now only because the respondent Ms Salasel resisted the medical decision, brought the application, and obtained the order that is now appealed from.

10. The intervener wrongly states, in para. 36 of its factum, that the doctors "sought consent" to the withdrawal of mechanical ventilation. From time to time Mr. Rasouli was weaned from the ventilator. However, there is no evidence that consent was sought or given for the weaning or reinstitution of ventilation. On November 21, 2010, the doctors made it clear that they did not intend to continue to offer that treatment. They merely sought Ms Salasel's acquiescence to the decision, and thereafter forbore from implementing their decision in order to provide her with the opportunity to bring the application. To allege, as the intervener does, that this approach has denied "due process" to Mr. Rasouli is without merit.

PART III—ARGUMENT

11. The intervener has mis-characterized the appellants' position. The appellants do not assert that the attending doctors may impose palliative care or that they may, in any and all circumstances, withdraw life-sustaining treatment without consent and without any due process.

12. The administration of palliative care, namely, the provision of pain control, clearly requires patient consent. No conscientious substitute decision-maker would ever withhold such consent, since that would be contrary to the patient's best interests.

13. The withdrawal of treatment will also require consent if, but only if, the standard of care otherwise requires the treatment to be offered. It is the appellants' position, only, that consent is not required in order to withhold or withdraw treatment that cannot benefit the patient.

14. If a breach of the standard of care were ever to be threatened (e.g., if it appeared that doctors intended to withhold or withdraw beneficial treatment), the courts are fully empowered to intervene to enforce compliance with the standard of care. The evidence in this case is

overwhelming that the standard of care does not require mechanical ventilation to be offered to a patient in Mr. Rasouli's circumstances.

15. Moreover, the appellants do not contend (as is asserted in para. 68 of the intervener's factum) that patients are not entitled to make any contribution to the determination of their own best interests or well-being. The appellants acknowledge that it always appropriate for doctors to confer with the patient or substitute decision-maker concerning the patient's wishes and beliefs. It does not follow that these alone will determine the treatment that is ultimately offered.

16. In asserting that doctors, in a proceeding such as this, are attempting to impose their "subjective views" on patients about the quality of their lives and to assert their autonomy, the intervener uses unwarrantedly emotive language. Its submission should be seen for what it is: an attack on the decision-making model that applies universally in medicine. The intervener fails to explain why it is considered reasonable to trust doctors in every other field of medicine to propose only such treatments as will benefit the patient, while in respect of end of life decisions their motivation should be suspected.

17. The suggestion that doctors would ever want to do the things they are accused of by the intervener in its submissions is completely unsupported by evidence and experience. The actions of the profession as a whole and of the appellants in particular show this to be so. The appellants point to the adoption by the College of Physicians and Surgeons of Ontario of careful policies respecting end of life decision-making, which require the same considerations to be applied to such decisions as are applied to medical decisions generally.

18. There is no issue that the appellants conscientiously applied the policies of the College and of the Hospital in this case. They did not make subjective assessments concerning the value

of Mr. Rasouli's life. They made assessments based on well-defined objective criteria (his prognosis and the potential for benefit from the desired treatment) which applied their specialist knowledge, including their knowledge of what medicine can and cannot achieve.

19. The task for the intervener, which it has failed even to attempt, is to demonstrate to this Court why a <u>different</u> model should apply to end of life decisions than does to all other medical decisions. Its brandishing of shibboleths about "patient autonomy" is completely unhelpful. What it is instead obliged to provide is an explication of why the criterion for providing life-sustaining treatment to a dying patient should be patient wishes rather than patient benefit.

20. Throughout its factum, the intervener prefers to deal in generalities, as if there existed some treatment that could benefit Mr. Rasouli, rather than to confront the hard fact that he suffers from a condition that has left him with permanent and irreversible unconsciousness.

21. Recognizing that fact makes the intervener's position starkly clear: the benefit of any proposed of treatment is, to it, irrelevant; it is only the patient's wishes (or in this case, those of the substitute decision-maker) that matter. The intervener never faces up to the implications of this position, which is that patients or SDMs can compel doctors to provide treatment that has ceased to provide a benefit and may be providing a detriment.

22. Similarly, when the intervener equates the withdrawal without consent of life-sustaining treatment to "physician-imposed death", it fails to face up squarely to the consequences of its position, which is that patients or their substitute decision-makers can impose upon doctors the duty to attempt to keep a dying patient alive by all available means, however futile in their effect.

23. These are the drastic effects that flow from the interpretation of the *Health Care Consent Act* that the intervener urges (and the judge below accepted). In their principal factum, the appellants have shown this interpretation to be strained as well as contrary to sound policy considerations.

24. There is one new substantive submission made by the intervener in support of its interpretation. In para. 6 of its factum, the intervener argues that since the Act does not specifically designate a withdrawal of treatment to be an excluded act (one for which consent is not required), the statutory intent is to require consent. The Act, however, also does not designate a withholding of treatment to be an excluded act, and yet the intervener accepts that the intent of the Act is to exclude any obligation to obtain consent to a withholding of treatment. It follows that the intervener accepts, as the appellants do, that the intent of the Act must be gleaned from all of its terms.

25. As to the assertion of the intervener that the *Health Care Consent Act* is intended to be a complete code, section 8(2) is directly to the contrary. It provides:

> Subject to section 3, this Part does not affect the law relating to the giving or refusing consent to anything not included in the definition of "treatment" in subsection 2(1).

To the extent that this case does not engage the definition of "treatment" in the Act, the common law clearly applies.

26. In general, the intervener asserts the Act requires consent only to treatment that is "proposed" by a health care practitioner. The appellants accept this position. The intervener also asserts that a health care practitioner "proposes" treatment where he or she proposes to withdraw treatment. This position the appellants deny.

27. Throughout its submissions, the intervener makes the incorrect assumption that a treatment plan (understood as a proposed form of treatment) does not change despite changes in the patient's clinical condition or prognosis which may cause the original treatment plan to be no longer medically indicated.

28. As the appellants submitted in the principal factum, that is not how medicine is practised. Every treatment is a trial of treatment, which is subject to be discontinued if the treatment should prove no longer to serve its intended purpose. This must be so, in the patient's own interest.

29. The evident good sense of this approach, which conforms exactly to the common law, argues that the Act should be interpreted to accord with it, if possible.

30. The intervener does not show that it is impossible, on its language, to read the Act consistently with the common law. Instead, it argues that the court should reject the common law approach in favour of a vague conception of "patient autonomy". In that regard, the intervener fails to appreciate that this concept has never been considered to embrace a right to require the continuation of treatment that has become futile or harmful.

31. As the applicants have previously submitted, the courts have previously sorted out the meaning and implications of personal autonomy in the context in medical decision-making: a capable adult patient has an absolute right to refuse any treatment but has no right to require treatment to be provided.

32. In its factum (e.g., at para. 35), the intervener asserts or implies that the adoption of a plan of treatment, with consent, should be seen as, or as analogous to, the formation of a contract

which the doctor is obliged to carry out to its conclusion if the patient so insists and unless an escape clause had been agreed to in advance.

33. If this model were to be accepted, it would not avail the respondents in this case. There is no evidence that the appellants ever proposed a plan of treatment under which Mr. Rasouli would receive life support for so long as he could be kept alive. There was no undertaking to provide life support for any definite period of time.

34. Regardless of that fact, this would be the wrong model to adopt for medical decision-making for the reasons previously given (it makes something other than the patient's interests the criterion of the treatment to be provided), and because it would introduce an undesirable legalism into the doctor-patient relationship. Moreover, it would require doctors to do the impossible to contemplate all potential outcomes that they may wish to guard against.

35. One implication of the intervener's approach is that one doctor's judgment will bind all the doctors who may treat the patient subsequently. This would prevent the subsequent doctors from exercising their professional judgment as they are obliged to do in order to conform to the standard of care that they must observe.

36. If however the approach suggested by the intervener is to apply, then it must be recognized that every offer of treatment a doctor makes is subject to an implied condition that the treatment may be withdrawn at any time on the basis of medical appropriateness.

37. There is a principled reason for implying such a condition, which is that treatment should in every case continue only if it continues to provide a medical benefit to the patient, which can only be assessed by a doctor.

38. There is no principled reason not to imply such a condition. That is because patients have no legal right to insist upon receiving any particular treatment.

39. The intervener attempts (at para. 87 of its factum) an alternative argument that withdrawal of treatment requires consent at common law. This is so, it is asserted, because otherwise the physical contact required to effect the withdrawal would amount to an assault. This position involves an overly technical approach to the law of consent, an approach that supposes that consent must be separately obtained to each and every touching associated with a treatment that is itself consented to. Common sense requires a different conclusion, namely, that anyone who consents to a treatment impliedly consents to any touching associated with the treatment, including the touching required to withdraw the treatment if medically appropriate to do so.

40. Finally, the intervener has submitted that the *Health Care Consent Act* provides an effective process to resolve disputes between a doctor and a patient's substitute decision-maker where there has been a refusal to consent to the withdrawal of treatment. This is the process conducted by the Consent and Capacity Board. The intervener favours resort to this process because it is its position that the wishes of the patient must always govern, even in the face of medical indications that demonstrate that the patient's wishes do not conduce to his or her own medical benefit. Once it is accepted that the patient's wishes do not always appropriately govern whether treatment should continue, then it can be seen that a process which is directed towards

ascertaining the patient's wishes will not always be effective to resolve the dispute.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

Date: May 3, 2011

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