S.C.C. No.: 34362

IN THE SUPREME COURT OF CANADA
(ON APPEAL FROM THE COURT OF APPEAL OF ONTARIO)

BETWEEN:

DR. BRIAN CUTHBERTSON and DR. GORDON RUBENFELD

Applicants
(Appellants)

-and-

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

Respondents
(Respondents)

-and-

THE CONSENT AND CAPACITY BOARD

Intervener

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Part I – Overview and Statement of Facts

1. The Euthanasia Prevention Coalition ("EPC") accepts the facts as set out by the Respondent, but highlights the fact of Mr. Rasouli's changed diagnosis from that of a persistent vegetative state on which the Appellants relied to justify their arguments in the Courts below to unilaterally withdraw life-sustaining treatment.[1]
2. This case raises fundamental questions about whether doctors should be afforded the unilateral authority to withdraw life-sustaining treatment and impose end of life palliative care without consent of the patient or their substitute decision-maker, without consideration of the principles and processes set out in the Health Care Consent Act ("HCCA"), and where the likely result amounts to non-consensual death of the patient without due process.
3. The HCCA supersedes and replaces the common law in relation to consent to treatment decisions including the withdrawal of life-sustaining treatment and the imposition of end of life palliative care as part of a proposed plan of treatment.
4. In the alternative, if the common law does apply, it must be interpreted in a manner consistent with Charter values and the principles set out in the HCCA and mandates that consent or a court order be required prior to the termination of life-sustaining treatment.
5. Doctors can't rely on their own subjective quality of life assessments of a patient in order to negate medical benefits received from treatment in accordance with a patient's best interests.
6. Assessment of a patient's best interests, both by doctors and substitute decision-makers, encompasses more than just clinical considerations.
7. To the extent that the concept of a standard of care is relevant to end of life decision-making, the HCCA represents the appropriate standard of care in Ontario and implements a

[1] Factum of Respondent at ¶28-33

process that promotes patient autonomy, collaborative and consistent decision-making and access to justice in cases of rare disputes between patients, substitute decision-makers and doctors.

8. In this case, the doctors conflate the assessment of a patient's best interests with the notion of an ill-defined standard of care that assumes no medical benefit is derived by Mr. Rasouli from life-sustaining medical treatment. They do so based on their subjective assessment that his quality of life is so low that he is better off being left to die than to receive life-sustaining treatment.

9. With respect, such an assessment is beyond the medical expertise of the doctors. It is a moral and ethical determination that must be governed by a proper assessment of Mr. Rasouli's best interests, which is best undertaken by the Consent and Capacity Board.

Part II – Issues and the Law

The Scheme Of The HCCA Supports The Requirement of Consent to Withdraw Life-Sustaining Treatment

10. The appellants' proposed plan of treatment including withdrawal of mechanical ventilation and imposition of palliative care requires consent.[2]

11. The HCCA provides for a comprehensive statutory scheme related to consent to treatment in accordance with a patient's prior express wishes and best interests.[3]

12. The HCCA promotes access to justice as it provides for a timely, cost-effective and specialized Tribunal process to resolve disputes related to the refusal of a substitute decision-maker to consent to or withdraw treatment at the end of life in a manner that affords patients and doctors due process and a level of protection against terminal treatment

[2] *Rasouli v. Sunnybrook Health Sciences Centre*, 2011 ONCA 482 ("Rasouli OCA") at ¶ 5
[3] Health Care Consent Act 1996, S.O. 1996, c.2, Sch A ("HCCA") at s. 1, 2, 10, 21

decisions unilaterally imposed by doctors. In Ontario, it is the forum in which such disputes must be resolved.[4]

13. Principles of due process and fundamental justice support the need for oversight when withdrawing life-sustaining treatments without a patient's consent, contrary to their express wishes or best interests, and in a manner likely to result in their death. This principle has been widely recognized and applied in Canada, the USA and the UK.[5]

14. Treatment and a plan of treatment as defined in the HCCA include the withdrawal and withholding of mechanical ventilation as well as the imposition of palliative care.[6]

15. Consent is required to implement palliative care and withdraw life-sustaining treatment because they fall under the definition of treatment under the HCCA and because they impact the physical integrity of the patient. Absent consent, such physical contact with a patient by a physician is an assault.[7]

16. A requirement of consent to withdraw life-sustaining treatment and impose palliative care as part of a plan of treatment promotes the autonomy, dignity and self-determination of vulnerable people at the end of life in a manner consistent with Charter values and the values of the HCCA and is in-keeping with Canada's Constitutional and international obligations.[8]

17. The HCCA supports the requirement of consent to withdraw one treatment (mechanical ventilation) and to replace it with another (end of life palliative care). If the Legislature

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[4] *M. (A.) Benes*, 1999 CarswellOnt 3529 (Ont. CA) at ¶ 46 EPC Tab 5

[5] *Sawatzky v. Riverview Health Centre Inc*., 1998 CarswellMan 515 (Man. QB)at ¶1 at Respondents' Brief of Authorities ("Respondent")Tab 14; *Golubchuk (Committee of) v. Salvation Army Grace General Hospital*, 2008 CarswellMan 57 (Man. QB) at ¶ 1 at Respondents Tab 1; *Airedale NHS Trust v. Bland*, 1993 WL 963744 (House of Lords) at pg. 859, ¶ F at Tab 8 of the Appellants' Brief of Authorities ("Appellants"); *Rasouli (Litigation Guardian of) v. Sunnybrook Health Sciences Centre*, 2011 CarswellOnt 1650 (SCJ) (Rasouli SCJ) at ¶ 64-65, 69-70, 79-80 at EPC Tab 14;

[6] HCCA s.2; *Rasouli (SCJ)* at ¶ 24 at EPC Tab 14

[7] HCCA s. 2 & 10

[8] *Manitoba (Director of Child & Family Services) v. C.(A) 2009 CarswellMan 293 (SCC)* at ¶¶ 97-108, 153-154 at EPC Tab 7; United Nations, "Convention on the Rights of Persons with Disabilities", at articles 1, 17, 25(a)(d)(f) at EPC Tab 21; *R. v. Jones*, [1986] 2. S.C.R. 284 (SCC) at ¶61 and 76 at EPC Tab 10; *B. (R) v. Children's Aid Society of Metropolitan Toronto*, 1995 CarswellOnt (SC) at ¶¶ at 71, 74-75, 77-78, 83, 107, EPC Tab 1; R. v. Morgentaler, 1988 CarswellOnt 45 (SCC) 19-25, 285-290

intended otherwise, the Legislature would have included the withdrawal of life-sustaining treatment deemed futile by a doctor as an excluded act under the HCCA for which no consent is required and would not expressly require consent for end of life palliative care treatment. They have not done so either expressly in the HCCA or by regulation. [9]

18. Doctors have a positive obligation to assess the risks, benefits and possible outcomes of a proposed treatment and that assessment should take place at the time the proposal is made in order to ensure that the substitute decision-maker is in a position to provide informed consent to the proposed treatment.[10]

19. In the event that consent to withdraw treatment is not obtained at the commencement of a proposed plan of treatment, then it must be obtained for a proposed change to that plan of treatment.[11]

20. The appellants suggest that consent is not required in this case because they are not proposing mechanical ventilation as part of a plan of treatment any longer. They completely ignore the fact that the treatment was proposed as medically appropriate, was consented to, provides a medical benefit to Mr. Rasouli by sustaining his life, and is ongoing. Now, they are seeking to change the plan of treatment to one of palliative care and the permanent removal of mechanical ventilation. Such a change in the plan of treatment clearly requires consent according to the HCCA.[12]

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[9] HCCA s.85(a)(f)(g)
[10] HCCA s. 10 & 11
[11] HCCA s. 2, 10 & 11
[12] HCCA s. 2 & 10

HCCA Supersedes The Common Law

21. Legislative sovereignty renders the HCCA paramount over the common law in respect of the giving and refusing of consent to treatment including the withdrawal of treatment which forms part of a plan of treatment.[13]

22. The Legislature expressly included withholding and withdrawal of treatment in the definition of plan of treatment, and turned its mind specifically to treatments not requiring consent and identified only emergency treatment. It was and remains open to the Legislature to change that if they chose to.[14]

23. The Legislature also specifically turned its mind to which aspects of the common law were not modified by the HCCA and identified only the common law duty of a caregiver to restrain a person at risk of serious bodily harm.[15]

24. The HCCA is a comprehensive code that sets out a full statement of the law in respect of consent to treatment and the withdrawal of treatment and puts in place a process by which to resolve disputes in this regard.[16]

25. Once such a code is in place, subsequent elaboration and enforcement of the law must be carried out within the institutional framework contemplated by the code and is governed by principles and policies derived from the code itself.[17]

26. In the event that it is determined that the HCCA does not represent a comprehensive code that governs disputes in relation to the proposal of a palliative care treatment plan or the withdrawal of life-sustaining treatments, then the common law must be interpreted in a

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[13] HCCA s. 1, 2, 3, 7, 10, 25 & 84; *Manitoba at* ¶¶ 123-126 at EPC Tab 7; Sullivan, Ruth. Driedger on the Construction of Statutes (3rd Edition), "Driedger" pp. 297-316 at EPC Tab 22

[14] HCCA s. 2, 10 & 25

[15] HCCA s. 1& 7

[16] HCCA s. 37; *Manitoba* at ¶¶ 123-126 at EPC at Tab 7

[17] HCCA s. 1, 3, 7 & 25; Driedger pg. 298, 302-304; 307-312 at EPC at Tab 22; *Manitoba* at ¶¶ 123-126 at EPC at Tab 7; *Seneca College of Applied Arts and Technology v. Bhadauria*, 1981 CarswellOnt 17at ¶ 26 at EPC at Tab 18

manner that includes and gives effect to Charter values; a patient's best interests and entitlement to due process.[18]

27. Contrary to the appellants' assertions, this case is not about the right to be treated or the imposition of non-indicated treatment. It is fundamentally about the requirement of consent to impose new treatment and to withdraw a life-sustaining treatment which is already underway in order to replace it with a new plan of treatment.[19]

28. To the extent that the common law may apply to these circumstances, it has been modified by the enactment of the HCCA and establishment of the Consent and Capacity Board.[20]

29. It is not appropriate for a Court to put itself in the place of the Legislature and to legislate a new regime that differs from the regime that the Legislature itself has put in place in respect of medical decision-making and consent to treatment.[21]

30. This court should apply the common law in a manner consistent with the recognition of a comprehensive code as determined by the Legislature and not apply common law principles in a manner that derogates from the clear and express intent of the Legislature expressed in the HCCA.[22]

Assessment Of A Patient's Best Interests Is Broader Than Mere Clinical Considerations

31. EPC does not suggest that doctors should be required to propose non-therapeutic or unethical treatment, but where treatment has been proposed and implemented as part of a plan of treatment, consent is required to withdraw that treatment, particularly where death

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[18] HCCA s. 21; *Manitoba* at ¶¶97-108 at EPC at Tab 7; *Pepsi-Cola Canada Beverages (West) Ltd v. R.W.D.S.U., Local 558,* 2002 CarswellSask 22 (SCC). at ¶¶18-20 at EPC at Tab 9; R. v. *Salituro,* 1991 CarswellOnt 124 (SCC) at ¶¶52 at EPC at Tab 13
[19] *Rasouli (OCA)* at ¶ 47
[20] *Machtinger v. HOJ Industries Ltd.*, 1992 CarswellOnt 892 (SCC) at ¶¶23-26 at EPC Tab 6; *Manitoba* at ¶¶123-126 at EPC Tab 7; Driedger at pp. 297-316 at EPC Tab 22
[21] HCCA s. 85 (a)(f)(g); Driedger at pp. 313-315 at EPC Tab 22; *Manitoba* at ¶¶ 123-126 at EPC Tab 7
[22] Driedger at pp. 307-312 at EPC Tab 22

is the anticipated outcome of the withdrawal. The Courts below clearly endorsed this principled approach.[23]

32. The appellants assert that end of life decisions are theirs alone, without regard to the patient's prior express wishes, values and beliefs. They deny that the patient's inherent autonomy entitles them to make any contribution to the definition of their own best interests or well-being, in respect of the withdrawal of life-sustaining treatment.[24]

33. Like a substitute decision-maker, a doctor is not permitted to rely on clinical considerations alone in assessing a patient's best interests in relation to the withdrawal of ongoing treatment under the HCCA, and the requirement of consent in that regard.[25]

34. Principles of fundamental justice require that when a patient is incapable of expressing their own views that the state must require compelling evidence that withdrawal of life-sustaining treatment is in fact what the patient would have requested had they been competent, or that it is in their best interests as defined by s.21 of the HCCA.[26]

35. These principles are fundamental to end of life decision-making and have been widely recognized by actions brought in Ontario under the HCCA and elsewhere in Canada and internationally to restrain doctors from withdrawing life-sustaining treatment.[27]

Doctors Can't Rely On Subjective Quality Of Life Assessments And An Ill-Defined Standard Of Care To Trump A Patient's Best Interests

36. Given economic constraints, an aging population, limited health-care resources, and the objectives of the HCCA to promote dignity, autonomy and self-determination in health-

[23] *Rasouli (SCJ)* at ¶ 24, 52, 103 at EPC Tab 14; Rasouli (OCA) at ¶50-52; Downie at pp. 144-145 at Respondents Tab 16
[24] HCCA s. 21; *Manitoba* at ¶¶ 39-45at EPC Tab 7; Downie at pp. 144-148 at Respondents Tab 16
[25] HCCA s 21; Baylis at pp. 228 -230 at Respondents Tab 7; CPSO Policy at pp. 2-4 at Appellants Tab 26; Downie at pp. 145-147 at Appellants Tab 26; Katz, Meir. "When is Medical Care "Futile"? The Institutional Competence of the Medical Profession Regarding the Provision of Life-Sustaining Medical Care." Nebraska Law Review, July 12, 2011. Pgs. 27, 29, 31-35, 37, 39, 42,44,47-49, 59, 61, 65, 67, 68 at EPC Tab 25
[26] HCCA s. 2, 10, 21; *Manitoba* at ¶¶ 97-108 & 144 at EPC Tab 7
[27] HCCA s 21; *Manitoba at* ¶¶ 39-45 at EPC Tab 7; *Sawatzky* at ¶1 at Respondent Tab 14; *Golubchuk* at ¶ 1at Respondent Tab 1; *W.(D), Re* (2004) CanLii 56526 (Ont. CCB) ¶¶ 30-31at EPC Tab 19; *Scardoni v. Hawryluck,* 2004 Carswell Ont 424 (SCJ) at ¶44, 59-60 at EPC Tab 17; Thaddeus Mason Pope, "Involuntary Passive Euthanasia in U.S. Courts: Reassessing the Judicial Treatment of Medical Futility Cases", (2008) 9 Marquette Elder's Advisor 229 at pp. 235, 243, 247-249 at Appellants Tab 25

care decision-making, making doctors the sole gatekeepers for withdrawal of life-sustaining treatment could permit medical treatment decisions to be made in a manner contrary to the values and rights set out in the Charter and HCCA without the opportunity to subject such decisions to Charter scrutiny or due process. It would also place doctors in an untenable conflict of interest.[28]

37. Erroneously assuming that there is a right to unilaterally withdraw life-sustaining treatment and that there is no medical or other benefit to keeping Mr. Rasouli alive, the Appellants ask this Court to give them sole power to determine when they may legitimately exercise such a right. They want this Court to create a mechanism by which doctors can single-handedly determine when ongoing treatment falls outside the standard of care and, with legal immunity, withdraw life-sustaining treatment over the objection of the patient and/or his family. In essence, Appellants want this Court to appoint the fox to guard the henhouse.[29]

38. The nature of the fiduciary obligations of doctors mandate that there be an appropriate process of oversight and adjudication in respect of contested treatment decisions. The HCCA assigns the Consent and Capacity Board this primary jurisdiction.

39. Requiring application to a Court is a costly, lengthy and adversarial process that would deprive most patients and their families of access to justice, including access to a lawyer which is available under the HCCA to represent a patient's best interests in hearings at the Board.[30]

40. EPC submits that the HCCA itself represents the appropriate standard of care by which physicians must be guided in Ontario in respect of disputes in relation to medical treatment

[28] Downie pp. 144-149 at Respondents Tab 16; Council on Ethical and Judicial Affairs, American Medical Association, "Medical Futility in End-of-Life Care, "Journal of the American Medical Association (1999: 281:10) 937-41 at Respondents Tab 18; See Katz at noted 25

[29] Downie at pp. 144-145 at Respondents Tab 16

decisions, including with respect to the withdrawal and withholding of treatment and the implementation of palliative care at the end of life.[31]

41. There has not been an adequately developed or defined standard of care with regard to treatment that is considered futile so as to justify the position advanced by the Appellants with regard to medical standard of care. This is particularly true where diagnosis is disputed, or found to be incorrect, as in this case.[32]

42. If medical treatment can keep the patient alive, such care is not medically or physiologically futile. In this case, mechanical ventilation was ***effective***. The dispute in this case concerns not medicine, but ethics: whether Mr. Rasouli's quality of life is such that effective treatment is ***worthwhile***.[33]

43. It would be improper and contrary to the purpose and principles of the HCCA to allow such an ill-defined standard to trump patient autonomy and security interests as protected by the HCCA and the Charter.

44. This case illustrates the fundamental flaw with such an approach as if the Appellants did proceed in the manner by which they proposed, Mr. Rasouli would have died. This determination would have been based on an inaccurate diagnosis, an ill-defined standard of care, without the benefit of an adjudication of his best interests and without any oversight. This clearly falls below any reasonable standard of procedural fairness or natural justice and is contrary to the doctors' fiduciary duty under the HCCA and otherwise at law.[34]

45. In assessing whether or not life-sustaining treatment should be withheld or withdrawn, it would be inappropriate for this court to accept that it is possible for one person, including a physician, to assess another person's life and to determine whether or not that other

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[30] HCCA s. 37 at EPC Tab 19
[31] *Benes* at ¶ 46 at EPC Tab 5; CPSO Policy at pp. 1 at Appellants Tab 26
[32] Baylis at pp. 227-228 at Respondent Tab 7; see Katz at Note 25
[33] Baylis at pp. 228-230 at Respondents Tab 7; Council on Ethical and Judicial Affairs pp. 227-228 at Respondents Tab 18
[34] *Norberg v. Wynrib*, 1992 CarswellBC 155 (SCC) at ¶64-66 at EPC Tab 8; *Benes* at ¶ 46 of EPC Tab 5

person's life is of sufficient quality to warrant his or her continued existence. Arguments based on quality of life necessarily assume that there is an objective standard against which one is able to make comparisons. There is not. There is only subjective assessment based on the values of the assessor. [35]

46. Doctors should not be permitted to substitute their own values and beliefs about dignity and autonomy to trump those of a patient who does not share those values and beliefs. [36]

47. Justice MacKenzie highlights the problem of submitting vulnerable people to best interest assessments based on quality of life judgments made by third parties:

> *If it is to be decided that "it is in the best interests of Stephen Dawson that his existence cease", then it must be decided that, for him, non-existence is the better alternative. This would mean regarding the life of a handicapped child as not only less valuable than the life of a normal child, but so much less valuable that it is not worth preserving. I tremble at contemplating the consequences if the lives of disabled persons are dependent upon such judgments...It is not appropriate for an external decision maker to apply his standards of what constitutes a livable life and exercise the right to impose death if that standard is not met in his estimation."*[37]

Part III-Order and Costs

48. EPC seeks leave to present oral argument and asks that the appeal be dismissed. EPC does not seek costs and asks that no costs be awarded against it.

Dated: July 24, 2012

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Hugh R. Scher

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[35] HCCA s. 21; Sobsey D., (1993) "Disability Discrimination and the Law" Health Law Review, 2(1) 6-10 at pg. 4 at EPC Tab 26; *Re S.D.* [1983] B.C.J. No.38 (BC Supreme Court) at p.9 ¶38 at EPC Tab 15; Baylis at pp. 228-230 at Respondents Tab 7; Wolbring, Gregor. "The Triangle of Enhancement Medicine, Disabled People, and the Concept of Health: A new challenge for HTA, Health Research and Health Policy." Alberta Heritage Foundation for Medical Research, December 2005. pp. 2-3 at EPC Tab 27; Endicott, Oliver R., "Legalizing Physician – Assisted Death: Can Safeguards Protect the Interests of Vulnerable Person?" July 2000. Prepare under sponsorship of the Canadian Bar Association "Law for the Future Fund" for Council of Canadians with Disabilities at pp. 10-12 at EPC Tab 24; See Katz at Note 25; Rodriquez v. British Columbia, 1993 CarswellBC 228 (SCC) at ¶¶14-15, 19 at EPC Tab 16; Burgdorf, Robert L. "Assisted Suicide: A Disability Perspective." National Council on Disability Position Paper, March 24, 1997. Pgs. 204-207 at EPC Tab 23

[36] *Re S.D.* [1983] B.C.J. No.38 (BC Supreme Court) at p. 9, ¶ 38, p. 11 ¶ 43 at EPC Tab 15; Baylis at pp. 226-230 at Respondent Tab 7; Downie at pp. 147-149 at Respondents at Tab 16, Endicott at pp. 10, 12, 36 at EPC Tab 24

[37] *Re S.D.* [1983] B.C.J. No.38 (BC Supreme Court) at p. 9, ¶ 38, p. 11 ¶43; at EPC Tab 15; B*attlefords and District Co-operative Ltd, v. Gibbs*, 1994 CanLii 4550 (SCC) at pg. 12-13 at EPC Tab 2; *Eldridge v. British Columbia (Attorney General)*, 1997 CarswellBC 1939 (SCC) at ¶56 at EPC Tab 4; R. Latimer, 1995 CarswellSask 88 (Sask-CA) at ¶ 74-79 at EPC Tab 11

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PART V – STATUTES

Health Care Consent Act, 1996
S.O. 1996, CHAPTER 2
SCHEDULE A

Purposes

1. The purposes of this Act are,

(a) to provide rules with respect to consent to treatment that apply consistently in all settings;

(b) to facilitate treatment, admission to care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters;

(c) to enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed and persons who are to receive personal assistance services by,

(i) allowing those who have been found to be incapable to apply to a tribunal for a review of the finding,

(ii) allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on their behalf concerning treatment, admission to a care facility or personal assistance services, and

(iii) requiring that wishes with respect to treatment, admission to a care facility or personal assistance services, expressed by persons while capable and after attaining 16 years of age, be adhered to;

(d) to promote communication and understanding between health practitioners and their patients or clients;

(e) to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment, admission to a care facility or a personal assistance service; and

(f) to permit intervention by the Public Guardian and Trustee only as a last resort in decisions on behalf of incapable persons concerning treatment, admission to a care facility or personal assistance services. 1996, c. 2, Sched. A, s. 1.

Interpretation

2. (1) In this Act,

"attorney for personal care" means an attorney under a power of attorney for personal care given under the *Substitute Decisions Act, 1992*; ("procureur au soin de la personne")

"Board" means the Consent and Capacity Board; ("Commission")

"capable" means mentally capable, and "capacity" has a corresponding meaning; ("capable", "capacité")

"care facility" means,

(a) a long-term care home as defined in the *Long-Term Care Homes Act, 2007*, or

(b) a facility prescribed by the regulations as a care facility; ("établissement de soins")

"community treatment plan" has the same meaning as in the *Mental Health Act*; ("plan de traitement en milieu communautaire")

"course of treatment" means a series or sequence of similar treatments administered to a person over a period of time for a particular health problem; ("série de traitements")

"evaluator" means, in the circumstances prescribed by the regulations,

(a) a member of the College of Audiologists and Speech-Language Pathologists of Ontario,

(b) a member of the College of Dietitians of Ontario,

(c) a member of the College of Nurses of Ontario,

(d) a member of the College of Occupational Therapists of Ontario,

(e) a member of the College of Physicians and Surgeons of Ontario,

(f) a member of the College of Physiotherapists of Ontario,

(g) a member of the College of Psychologists of Ontario, or

(h) a member of a category of persons prescribed by the regulations as evaluators; ("appréciateur")

"guardian of the person" means a guardian of the person appointed under the *Substitute Decisions Act, 1992*; ("tuteur à la personne")

"health practitioner" means a member of a College under the *Regulated Health Professions Act, 1991*, a naturopath registered as a drugless therapist under the *Drugless Practitioners Act* or a member of a category of persons prescribed by the regulations as health practitioners; ("praticien de la santé")

Note: On a day to be named by proclamation of the Lieutenant Governor, the definition of "health practitioner" is amended by striking out "a naturopath registered as a drugless therapist under the *Drugless Practitioners Act*". See: 2009, c. 26, ss. 10 (2), 27 (2).

"hospital" means a private hospital as defined in the *Private Hospitals Act* or a hospital as defined in the *Public Hospitals Act*; ("hôpital")

"incapable" means mentally incapable, and "incapacity" has a corresponding meaning; ("incapable", "incapacité")

"mental disorder" has the same meaning as in the *Mental Health Act*; ("trouble mental")

"personal assistance service" means assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning or any other routine activity of living, and includes a group of personal assistance services or a plan setting out personal assistance services to be provided to a person, but does not include anything prescribed by the regulations as not constituting a personal assistance service; ("service d'aide personnelle")

"plan of treatment" means a plan that,

(a) is developed by one or more health practitioners,

(b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and

(c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition; ("plan de traitement")

"psychiatric facility" has the same meaning as in the *Mental Health Act*; ("établissement psychiatrique")

"recipient" means a person who is to be provided with one or more personal assistance services,

(a) in a long-term care home as defined in the *Long-Term Care Homes Act, 2007*,

(b) in a place prescribed by the regulations in the circumstances prescribed by the regulations,

(c) under a program prescribed by the regulations in the circumstances prescribed by the regulations, or

(d) by a provider prescribed by the regulations in the circumstances prescribed by the regulations; ("bénéficiaire")

"regulations" means the regulations made under this Act; ("règlements")

"treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include,

(a) the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the *Substitute Decisions Act, 1992* of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,

(b) the assessment or examination of a person to determine the general nature of the person's condition,

(c) the taking of a person's health history,

(d) the communication of an assessment or diagnosis,

(e) the admission of a person to a hospital or other facility,

(f) a personal assistance service,

(g) a treatment that in the circumstances poses little or no risk of harm to the person,

(h) anything prescribed by the regulations as not constituting treatment. ("traitement") 1996, c. 2, Sched. A, s. 2 (1); 2000, c. 9, s. 31; 2007, c. 8, s. 207 (1); 2009, c. 26, s. 10 (1); 2009, c. 33, Sched. 18, s. 10 (1).

Refusal of consent

(2) A reference in this Act to refusal of consent includes withdrawal of consent. 1996, c. 2, Sched. A, s. 2 (2).

Meaning of "excluded act"

3. (1) In this section,

"excluded act" means,

(a) anything described in clause (b) or (g) of the definition of "treatment" in subsection 2 (1), or

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

Excluded act considered treatment

(2) If a health practitioner decides to proceed as if an excluded act were a treatment for the purpose of this Act, this Act and the regulations apply as if the excluded act were a treatment within the meaning of this Act. 1996, c. 2, Sched. A, s. 3 (2).

Wishes

5. (1) A person may, while capable, express wishes with respect to treatment, admission to a care facility or a personal assistance service. 1996, c. 2, Sched. A, s. 5 (1).

Manner of expression

(2) Wishes may be expressed in a power of attorney, in a form prescribed by the regulations, in any other written form, orally or in any other manner. 1996, c. 2, Sched. A, s. 5 (2).

Later wishes prevail

(3) Later wishes expressed while capable prevail over earlier wishes. 1996, c. 2, Sched. A, s. 5 (3).

Restraint, confinement

7. This Act does not affect the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others. 1996, c. 2, Sched. A, s. 7.

No treatment without consent

10. (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

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

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

Opinion of Board or court governs

(2) If the health practitioner is of the opinion that the person is incapable with respect to the treatment, but the person is found to be capable with respect to the treatment by the Board on an application for review of the health practitioner's finding, or by a court on an appeal of the Board's decision, the health practitioner shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless the person has given consent. 1996, c. 2, Sched. A, s. 10 (2).

Elements of consent

11. (1) The following are the elements required for consent to treatment:

1. The consent must relate to the treatment.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not be obtained through misrepresentation or fraud. 1996, c. 2, Sched. A, s. 11 (1).

Informed consent

(2) A consent to treatment is informed if, before giving it,

(a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and

(b) the person received responses to his or her requests for additional information about those matters. 1996, c. 2, Sched. A, s. 11 (2).

Same

(3) The matters referred to in subsection (2) are:

1. The nature of the treatment.
2. The expected benefits of the treatment.
3. The material risks of the treatment.
4. The material side effects of the treatment.
5. Alternative courses of action.
6. The likely consequences of not having the treatment. 1996, c. 2, Sched. A, s. 11 (3).

Express or implied

(4) Consent to treatment may be express or implied. 1996, c. 2, Sched. A, s. 11 (4)

Principles for giving or refusing consent

21. (1) A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles:

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.
2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests. 1996, c. 2, Sched. A, s. 21 (1).

Best interests

(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;

(b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and

(c) the following factors:

1. Whether the treatment is likely to,

i. improve the incapable person's condition or well-being,

ii. prevent the incapable person's condition or well-being from deteriorating, or

iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.

2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.

3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.

4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed. 1996, c. 2, Sched. A, s. 21 (2).

Emergency treatment
Meaning of "emergency"

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

Emergency treatment without consent: incapable person

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

(a) there is an emergency; and

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

Emergency treatment without consent: capable person

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

(a) there is an emergency;

(b) the communication required in order for the person to give or refuse consent to the treatment cannot take place because of a language barrier or because the person has a disability that prevents the communication from taking place;

(c) steps that are reasonable in the circumstances have been taken to find a practical means of enabling the communication to take place, but no such means has been found;

(d) the delay required to find a practical means of enabling the communication to take place will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm; and

(e) there is no reason to believe that the person does not want the treatment. 1996, c. 2, Sched. A, s. 25 (3).

Examination without consent

(4) Despite section 10, an examination or diagnostic procedure that constitutes treatment may be conducted by a health practitioner without consent if,

(a) the examination or diagnostic procedure is reasonably necessary in order to determine whether there is an emergency; and

(b) in the opinion of the health practitioner,

(i) the person is incapable with respect to the examination or diagnostic procedure, or

(ii) clauses (3) (b) and (c) apply to the examination or diagnostic procedure. 1996, c. 2, Sched. A, s. 25 (4).

Record

(5) After administering a treatment in reliance on subsection (2) or (3), the health practitioner shall promptly note in the person's record the opinions held by the health practitioner that are required by the subsection on which he or she relied. 1996, c. 2, Sched. A, s. 25 (5).

Continuing treatment

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

Same

(7) Treatment under subsection (3) may be continued only for as long as is reasonably necessary to find a practical means of enabling the communication to take place so that the person can give or refuse consent to the continuation of the treatment. 1996, c. 2, Sched. A, s. 25 (7).

Search

(8) When a treatment is begun under subsection (2) or (3), the health practitioner shall ensure that reasonable efforts are made for the purpose of finding the substitute decision-maker, or a means of enabling the communication to take place, as the case may be. 1996, c. 2, Sched. A, s. 25 (8).

Return of capacity

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

Application to determine compliance with s. 21

37. (1) If consent to a treatment is given or refused on an incapable person's behalf by his or her substitute decision-maker, and if the health practitioner who proposed the treatment is of the opinion that the substitute decision-maker did not comply with section 21, the health practitioner may apply to the Board for a determination as to whether the substitute decision-maker complied with section 21. 1996, c. 2, Sched. A, s. 37 (1).

Parties

(2) The parties to the application are:

1. The health practitioner who proposed the treatment.
2. The incapable person.
3. The substitute decision-maker.
4. Any other person whom the Board specifies. 1996, c. 2, Sched. A, s. 37 (2).

Power of Board

(3) In determining whether the substitute decision-maker complied with section 21, the Board may substitute its opinion for that of the substitute decision-maker. 1996, c. 2, Sched. A, s. 37 (3).

Directions

(4) If the Board determines that the substitute decision-maker did not comply with section 21, it may give him or her directions and, in doing so, shall apply section 21. 1996, c. 2, Sched. A, s. 37 (4).

Time for compliance

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

Deemed not authorized

(6) If the substitute decision-maker does not comply with the Board's directions within the time specified by the Board, he or she shall be deemed not to meet the requirements of subsection 20 (2). 1996, c. 2, Sched. A, s. 37 (6).

Subsequent substitute decision-maker

(6.1) If, under subsection (6), the substitute decision-maker is deemed not to meet the requirements of subsection 20 (2), any subsequent substitute decision-maker shall, subject to subsections (6.2) and (6.3), comply with the directions given by the Board on the application within the time specified by the Board. 2000, c. 9, s. 35.

Application for directions

(6.2) If a subsequent substitute decision-maker knows of a wish expressed by the incapable person with respect to the treatment, the substitute decision-maker may, with leave of the Board, apply to the Board for directions under section 35. 2000, c. 9, s. 35.

Inconsistent directions

(6.3) Directions given by the Board under section 35 on a subsequent substitute decision-maker's application brought with leave under subsection (6.2) prevail over inconsistent directions given under subsection (4) to the extent of the inconsistency. 2000, c. 9, s. 35.

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(7) If the substitute decision-maker who is given directions is the Public Guardian and Trustee, he or she is required to comply with the directions, and subsection (6) does not apply to him or her. 1996, c. 2, Sched. A, s. 37 (7).

Deemed application concerning capacity

37.1 An application to the Board under section 33, 34, 35, 36 or 37 shall be deemed to include an application to the Board under section 32 with respect to the person's capacity to consent to treatment proposed by a health practitioner unless the person's capacity to consent to such treatment has been determined by the Board within the previous six months. 2000, c. 9, s. 36.

Application hearings

Board to fix time and place of hearing

75. (1) When the Board receives an application, it shall promptly fix a time and place for a hearing. 1996, c. 2, Sched. A, s. 75 (1).

Hearing to begin within seven days

(2) The hearing shall begin within seven days after the day the Board receives the application, unless the parties agree to a postponement. 1996, c. 2, Sched. A, s. 75 (2).

Exception

(2.1) Despite subsection (2), the hearing of an application under section 39.2 of the *Mental Health Act* shall begin within 30 days after the day the Board receives the application, unless the parties agree to a postponement. 2010, c. 1, Sched. 9, s. 1.

Decision

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

Reasons

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

(a) issue written reasons for its decision; and

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

Notice of right to request reasons

(5) The Board shall advise all parties to the application that each party has a right to request reasons for the Board's decision. 1996, c. 2, Sched. A, s. 75 (5).

Method of sending decision and reasons

(6) Despite subsection 18 (1) of the *Statutory Powers Procedure Act*, the Board shall send the copy of the decision and, if reasons are required to be issued under subsection (4), the copy of the reasons,

(a) by electronic transmission;

(b) by telephone transmission of a facsimile; or

(c) by some other method that allows proof of receipt, in accordance with the tribunal's rules made under section 25.1 of the *Statutory Powers Procedure Act*. 1996, c. 2, Sched. A, s. 75 (6).

Deemed day of receipt

(7) Despite subsection 18 (3) of the *Statutory Powers Procedure Act*, if the copy is sent by electronic transmission or by telephone transmission of a facsimile, it shall be deemed to be received on the day that it was sent, unless that day is a holiday, in which case the copy shall be deemed to be received on the next day that is not a holiday. 1996, c. 2, Sched. A, s. 75 (7).

Exception

(8) If a party that acts in good faith does not, through absence, accident, illness or other cause beyond the party's control, receive the copy until a date that is later than the deemed day of receipt, the actual date of receipt governs. 1996, c. 2, Sched. A, s. 75 (8).

Meaning of "business day"

(9) In subsection (4),

"business day" means any day other than Saturday or a holiday. 1996, c. 2, Sched. A, s. 75 (9).

Offence: decision contrary to wishes

84. (1) A person who knowingly contravenes paragraph 1 of subsection 21 (1), paragraph 1 of subsection 42 (1) or paragraph 1 of subsection 59 (1) is guilty of an offence and is liable, on conviction, to a fine not exceeding $10,000. 1996, c. 2, Sched. A, s. 84 (1).

Exception

(2) Subsection (1) does not apply if the person acts in accordance with permission given under section 36, 53 or 68 or in accordance with directions given under section 35, 37, 52, 54, 67 or 69. 1996, c. 2, Sched. A, s. 84 (2).

Regulations

85. (1)The Lieutenant Governor in Council may make regulations,

(a) prescribing facilities as care facilities for the purpose of clause (b) of the definition of "care facility" in subsection 2 (1) and providing transitional rules for the application of the Act to such facilities;

(f) prescribing things that do not constitute treatment for the purpose of the definition of "treatment" in subsection 2 (1);

(g) prescribing excluded acts for the purpose of clause 3 (1) (b);

United Nations A/Res/61/106

GENERAL ASSEMBLY

Distr.: General

24 JANUARY 2007

61/106. CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

Article 1 – Purpose:

The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Article 17 – Protecting the integrity of the person:

Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others

Article 25 – Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

a. Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

d. Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

f. Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.