

CASE COMMENT

THE REQUIREMENT OF CONSENT TO WITHDRAW TREATMENT: A CRITIQUE OF THE *RASOULI* DECISION

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INTRODUCTION

[T]he guiding principle for medical decision-making is not life in itself as an absolute value, but the patient's overall welfare. In most instances, this welfare imposes the maintenance of life, but this is not always the case. It is not the case when the prolonging of life has become purely artificial. It is not the case when the maintenance of life can only be achieved by an undue prolongation of the patient's agony. It is not the case when the maintenance of life results only in the infliction of additional suffering. In other words, it is not the case when the treatment is diverted from its proper end and merely prolongs the dying process rather than life itself.¹

This quotation, from the Law Reform Commission of Canada, highlights a danger inherent to the rapid advancement of life-sustaining medical technologies in our society. Modern hospitals are able to keep some patients alive in a comatose or vegetative state almost indefinitely and to use extraordinary measures to prevent their deaths.² This phenomenon has caused the final stages of life to become an increasingly technical and artificial process.³ Along with our aging population, this type of medical care has led to the emergence of pressing legal and ethical challenges.⁴ Although it may be possible to delay a patient's death through aggressive medical treatment, doing so will not always be the best course of action. There comes a point where life-sustaining measures are no longer serving the purpose of promoting recovery, but are simply extending patient suffering and tying up hospital resources.⁵ However, there has been much contention over who is entitled to decide when withdrawing life support is appropriate.

Historically, a doctor's expertise was highly revered and patients tended to trust their health care practitioners to make even the most vital and personal determinations unilaterally. Over the years, however, an increasing demand from patients for more autonomy and self-determination has resulted in a shift in the Canadian common law of medical consent.⁶ Balancing patient autonomy with physicians' professional and ethical duties illuminates potential conflicts.⁷ On one hand, patients can refuse life-saving treatment and consent to palliative sedation that may hasten death.⁸ On the other hand, physicians' duty to "do no harm" prevents them from actively bringing about death via assisted suicide or euthanasia.⁹ In the recent case of *Cuthbertson v Rasouli* ("*Rasouli*") the

1 The Law Reform Commission of Canada, *Working Paper 28: Euthanasia, Aiding Suicide and Cessation of Treatment* (Ottawa: Minister of Supply and Services Canada, 1982) at 59. Note that the Commission goes on to say that a physician should still continue provision of life support in such a scenario if the patient requests it.

2 *Airedale NHS Trust v Bland*, [1993] AC 789 at 8, 1 All ER 821 [*Airedale*]; Hilary Young, "Why Withdrawing Life-Sustaining Treatment Should Not Require "*Rasouli* Consent"" (2012) 6 McGill JL & Health 54 at 54.

3 Richard I Hall & Graeme M Rocker, "End-of-Life Care in the ICU: Treatments Provided When Life Support Was or Was Not Withdrawn" (2000) 118:5 Chest 1424 at 1429.

4 *Ibid* at 1424; Young, *supra* note 2 at 56.

5 Sharon Kirkey, "Rasouli case may make doctors reluctant to start life support in "borderline" cases" (16 December 2012) online: O Canada <<http://o.canada.com/news/rasouli-case-may-make-doctors-reluctant-to-start-life-support-in-borderline-cases>>; Young, *supra* note 2 at 57.

6 Ian McDowell, "Further Concepts in Medical Ethics", online: Society, the Individual, and Medicine <http://www.med.uottawa.ca/sim/data/Ethics2_e.htm>.

7 Graeme Rocker & Scott Dunbar, "Withholding or Withdrawal of Life Support: The Canadian Critical Care Society Position Paper" (2000) 16 J Palliat Care S53 at S54.

8 *Ibid*; McDowell, *supra* note 6; Young, *supra* note 2 at 57.

9 *Rodriguez v British Columbia (AG)*, [1993] 3 SCR 519 (available on CanLII) [*Rodriguez* cited to SCR]. A new case, *Carter v Canada (AG)*, has recently been heard by the SCC and may overturn the prohibition on assisted suicide, although the judgement will be released post-publication: *Carter*, *infra* note 158.

Supreme Court of Canada (“SCC”) ruled that a substitute decision-maker (“SDM”) was entitled to insist on the continuation of her husband’s life support after multiple physicians concluded that he was in a permanent vegetative state with no hope of recovery.¹⁰

In this paper, I will critically analyze the SCC’s majority decision in *Rasouli*. I agree with the dissent in that the majority erred by interpreting Ontario’s *Health Care Consent Act* (“HCCA”) too broadly and thus concluded that the withdrawal of life support is “treatment” that requires consent.¹¹ The Court’s analysis ought to have considered the common law of consent, *Charter* rights, and policy issues to ultimately find that neither patient nor SDM consent should be required to withdraw medically ineffective life support. In Part I, I will give a brief overview of the facts and court decisions in *Rasouli* and the main legal issues discussed in this paper. In Part II, I will analyze the SCC’s statutory interpretation of the HCCA. I contend that the withdrawal of life support does not have a “health-related purpose” and was not intended to require consent under the HCCA.¹² In Part III, I will argue that the common law of consent does not require consent to withdraw life support. In Part IV, I will assess arguments for a right to refuse withdrawal grounded in the *Canadian Charter of Rights and Freedoms* (“*Charter*”),¹³ finding that these are also likely to fail. In Part V, I will discuss policy considerations and proposals for improving end-of-life care. Ultimately, although physicians should consult with patients’ families and SDMs, the physicians should be able to withdraw patients’ life support without consent, based on their professional expertise regarding whether or not such treatment is beneficial to the patient.

PART I. BACKGROUND

A. Facts

In October 2010, 59-year-old Hassan Rasouli contracted an infection after undergoing brain surgery that caused diffuse brain damage.¹⁴ His physicians, including Dr. Brian Cuthbertson and Dr. Gordon Rubinfeld of Sunnybrook Health Sciences Centre, provided him with artificial nutrition and hydration, and had him on a mechanical ventilator.¹⁵ These treatments could potentially keep him alive for years in a permanent vegetative or minimally conscious state.¹⁶ His physicians had come to believe that the continuation of these life-sustaining treatments was no longer serving its purpose.¹⁷ They believed that Mr. Rasouli had no chance of recovery, and thus there was no medical benefit to continuation. The life support served only to subject Mr. Rasouli to “a long progression of complications as his body deteriorate[d]”.¹⁸

The doctors wished to remove Mr. Rasouli’s life support so that he could die peacefully. This process would entail removing life-sustaining medical therapy or intervention and would usually involve administering palliative care to allow Mr. Rasouli to succumb to

10 *Cuthbertson v Rasouli*, 2013 SCC 53 (available on CanLII) [*Rasouli*]. Please note, the change in Mr. Rasouli’s diagnosis from vegetative state to minimally conscious does not affect the legal arguments and discussion in this paper.

11 *Health Care Consent Act*, SO 1996, c 2 [HCCA].

12 *Ibid*, s 2(1).

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

14 *Rasouli*, *supra* note 10 at para 1.

15 *Ibid* at para 5.

16 *Ibid* at para 1.

17 *Ibid* at para 6.

18 *Ibid* at para 1.

his underlying disease.¹⁹ Dr. Parichehr Salasel,²⁰ Mr. Rasouli's wife and SDM, disagreed with the doctors. She insisted that there was still hope of recovery and that her husband, because of his Shia Muslim religious beliefs, would have wanted his life support continued.²¹ The doctors obtained a concurring second opinion from an independent neurologist, attempted to transfer Mr. Rasouli to another institution, and offered Dr. Salasel the opportunity to obtain a third opinion, which she chose not to do.²² The doctors believed that her consent should not be required in order to proceed with the removal of Mr. Rasouli's life support. Dr. Salasel applied to the Ontario Superior Court for an injunction.²³

B. Court Decisions

The Ontario Superior Court granted Dr. Salasel's injunction, declaring that Mr. Rasouli's physicians were not entitled to withdraw life support without consent.²⁴ The court confirmed that physicians wishing to challenge an SDM's decision must do so via the *HCCA's* Consent and Capacity Board ("the Board") on the grounds of the patient's best interest.²⁵ The physicians appealed this decision in the Ontario Court of Appeal in *Rasouli (Litigation guardian of) v Sunnybrook Health Sciences Centre* ("*Rasouli ONCA*"), but were again unsuccessful.²⁶ The Ontario Court of Appeal concluded that the withdrawal of life support was integrally linked to the administration of palliative care, and was thus a "treatment package"²⁷ falling under the definition of "treatment"²⁸ in the *HCCA*. Section 10(1) of the *HCCA* states that a patient's, or their SDM's, consent must be acquired before a health care practitioner can administer treatment.²⁹ Therefore, consent would be required in order to withdraw life support.

The SCC upheld the lower court's decisions. Chief Justice McLachlin, writing for the majority, found that the withdrawal of life support constituted "treatment" as defined in the *HCCA*.³⁰ She noted that, since it was covered by the statute, there was no need to make a ruling with regard to the common law on this issue.³¹

C. Main Legal Issues

The main issues addressed in this paper are whether or not the SCC erred in interpreting "treatment" to include the withdrawal of life support, and whether or not there is another legal basis for a requirement of consent to withdraw life support. I will argue that a proper interpretation of the *HCCA* does not require consent for the withdrawal of life support. Even though the SCC has already made its decision with respect to Mr. Rasouli, an analysis of the common law and *Charter* regarding consent to withdrawal of life support may still make its way to the Court as provinces other than Ontario, which are

19 Rocker & Dunbar, *supra* note 7 at S53.

20 Dr. Salasel was a physician in Iran before she immigrated to Canada with her family.

21 *Rasouli*, *supra* note 10 at para 7.

22 *Ibid* at para 8.

23 *Rasouli (Litigation Guardian of) v Sunnybrook Health Sciences Centre*, 2011 ONSC 1500 (available on CanLII).

24 *Ibid*.

25 *HCCA*, *supra* note 11, s 69.

26 *Rasouli (Litigation guardian of) v Sunnybrook Health Sciences Centre*, 2011 ONCA 482 (available on CanLII) [*Rasouli ONCA*].

27 *Ibid* at para 52.

28 *HCCA*, *supra* note 11, s 2(1).

29 *Ibid*, s 10(1).

30 *Rasouli*, *supra* note 10 at para 76.

31 *Ibid* at para 16.

not bound by the *HCCA*, still lack guidance.³² I will argue that the common law does not support a requirement for consent to withdraw life support and *Charter* claims to a right to consent are likely to fail. Furthermore, it is preferable, from a policy standpoint, that physicians have the final say regarding the withdrawal of medically ineffective life support. Concerns about physicians having the final say, such as SDM and family discontentment with end-of-life decisions, can be addressed and reduced through the initiatives I will propose in Part V.

PART II. STATUTORY INTERPRETATION

Under section 10(1) of the *HCCA*, treatment cannot be administered unless “the person has given consent” or “the person’s substitute decision-maker has given consent on the person’s behalf.”³³ Chief Justice McLachlin ruled that the withdrawal of life support constituted “treatment” as defined in the *HCCA* and therefore imposed an obligation on Mr. Rasouli’s physicians to obtain consent before withdrawal. The Chief Justice employed Driedger’s modern approach to statutory interpretation. This contextual approach requires consideration of a term’s ordinary and grammatical sense, the scheme of the act, the purpose of the act, and the intention of the Legislature.³⁴ I will apply this approach to both the definitions of “treatment” and “plan of treatment” within the *HCCA* to illustrate why Chief Justice McLachlin’s interpretation of these terms was inadequate.

A. Treatment

i. Ordinary Meaning

At first blush, the term “treatment” would not ordinarily be thought to include the withdrawal of treatment. In *Child and Family Services (CFS) v RL and SHL* (“*Lavallee*”), the word “treatment” in the *Child and Family Services Act* was ruled not to include withdrawal.³⁵ However, the *HCCA* provides a definition in section 2(1) which Chief Justice McLachlin claims broadens the meaning. “[T]reatment” is defined as “anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan.”³⁶

The requirement that a treatment have a “health-related purpose”³⁷ serves to, in Chief Justice McLachlin’s words, “set limits on when actions taken by health practitioners will require consent.”³⁸ However, her interpretation of a health-related purpose is so broad that it fails to meaningfully limit the definition at all. She states that a health-related purpose should not be restricted to what the doctors believe has medical benefit, or otherwise the Legislature would have used that terminology.³⁹ When withdrawing Mr. Rasouli’s life support, the health-related purpose would be to “ease suffering and prevent indignity at the end of life.”⁴⁰ This could fall under the “therapeutic”, “preventative” or “palliative”

32 Cristin Schmitz, “SCC rules against physicians in end-of-life treatment case”, *The Lawyers Weekly* (1 November 2013) 1; “The Limited Effect of the Decision in Rasouli” (4 November 2013), online: Bull Housser <<http://www.bht.com/resources/limited-effect-decision-rasouli>>.

33 *HCCA*, *supra* note 11, s 10(1).

34 Elmer Driedger, *The Construction of Statutes*, 2nd ed (Toronto: Butterworths, 1983).

35 *Child and Family Services (CFS) v RL and SHL*, [1997] 154 DLR (4th) 409 (available on CanLII) (MBCA) [*Lavallee* cited to DLR].

36 *HCCA*, *supra* note 11, s 2(1).

37 *Ibid*, s 2(1).

38 *Rasouli*, *supra* note 10 at para 37.

39 *Ibid* at para 39.

40 *Ibid* at para 61.

health-related purposes listed in the definition of “treatment”.⁴¹ In the dissenting reasons, however, Justice Karakatsanis contends that the withdrawal of Mr. Rasouli’s life support does not have a health-related purpose. The purpose is simply to “bring treatment to an end.”⁴²

The problem with Chief Justice McLachlin’s broad interpretation of a health-related purpose is that it fails to differentiate between the withdrawal of life support and the withdrawal of other types of treatment.⁴³ Consider a patient receiving a prescription drug to treat a disease. If that patient begins to experience severe side-effects that outweigh its benefits, then ceasing to provide this treatment would certainly prevent the suffering caused by the side-effects. Using Chief Justice McLachlin’s logic, this would be preventative, and thus a health-related purpose. However, the prescribing physician would be under no obligation to continue prescribing the drug, regardless of the patient’s wishes. To continue supplying the drug simply because the patient refused consent to withdraw this treatment would be akin to the doctor poisoning the patient. Chief Justice McLachlin states that it would be absurd for consent to be required in such a scenario but neglects to provide a meaningful way to distinguish it from the withdrawal of life support.⁴⁴ Thus, she draws a vague and arbitrary line, creating uncertainty around when the *HCCA* might be applied in cases of withdrawal of other treatments.

Philippa Foot’s “existing threat” theory of moral responsibility provides a possible solution.⁴⁵ According to Foot, if a victim or, for the purposes of this discussion, a patient is under a pre-existing threat of harm, then the agent, or doctor, merely allowed the harm to occur. On the other hand, if the doctor were to initiate a new threat, he or she would actually be *doing* the harm.⁴⁶ I propose that for the act to have a health-related purpose the doctor must be “doing” rather than simply “allowing.”

Some modifications have been suggested for Foot’s theory. Notably, initiating and sustaining have both been categorized as “doing,” whereas, allowing and enabling have both been considered “allowing.”⁴⁷ When a doctor removes life support, he or she is enabling the existing threat, such as the underlying disease, to harm the patient. The doctor would thus be “allowing” harm rather than “doing” harm. In contrast, where a doctor administers a harmful drug, he or she is initiating a new threat and thus “doing” harm rather than “allowing” it.

This theory has been broadened to also include neutral or beneficial results.⁴⁸ Any benefits, or what Chief Justice McLachlin calls “health-related purposes”, that might result from something that a doctor does could therefore be analyzed from the existing threat theory. This theory examines where the benefits of withdrawing life support, mainly the easing of suffering and prevention of indignity, come from. Is the doctor initiating this benefit, or is the doctor simply enabling it? In more concrete terms, the benefit from removing life support would be that the patient would die more quickly and

41 *Ibid* at para 49; *HCCA*, *supra* note 11, s 2(1).

42 *Rasouli*, *supra* note 10 at para 154.

43 Hilary Young, “Cuthbertson v Rasouli: Continued Confusion Over Consent-Based Entitlements to Life Support” (9 April 2014) at 20, online: Social Science Research Network <<http://ssrn.com/abstract=2463676>> [Young, “Entitlements”].

44 *Rasouli*, *supra* note 10 at para 66.

45 Philippa Foot, “Killing and Letting Die” in Jay L Garfield & Patricia Hennessey, eds, *Abortion: Moral and Legal Perspectives* (Amherst: University of Massachusetts Press, 1984) 177; Fiona Woollard, “Doing and Allowing, Threats and Sequences” (2008) 89 *Pacific Philosophical Quarterly* 261.

46 Foot, *supra* note 45.

47 Woollard, *supra* note 45 at 263; Philippa Foot, “The Problem of Abortion and the Doctrine of Double Effect” (1967) 5 *Trinity* 5 at 12.

48 Woollard, *supra* note 45 at 263.

avoid multiple surgeries, bedsores, infections, organ failure, and other aggressive life-sustaining procedures.⁴⁹ This type of death is not a new possibility introduced by the doctors; it is an existing possibility that has been enabled by the removal of the life support. Thus, withdrawing life support would be “allowing” and should not be categorized as a health-related purpose. If a doctor wishes to further ease a patient’s suffering through palliative care, then the doctor would be introducing a new possibility or benefit and the act of administering palliative care would then have a health-related purpose.

A particularly relevant example by Warren Quinn was discussed by Fiona Woollard in her article “Doing and Allowing: Threats and Sequences”:⁵⁰

Suppose I have always fired up my aged neighbor’s furnace before it runs out of fuel. I haven’t promised to do it, but I have always done it and intend to continue. Now suppose that an emergency arises involving five other equally close and needy friends who live far away, and that I can save them only by going off immediately and letting my neighbor freeze.⁵¹

Woollard uses this case to explain that, even though the threat of harm was not “already in train,” because the agent had been preventing it until that point, it is still an existing possibility and the failure to fire up the furnace would be considered “allowing”. Likewise, the doctors who are consistently preventing a patient from dying through life-sustaining measures are “allowing” when they cease this prevention.⁵²

Initially, Mr. Rasouli’s life support would presumably have had the purpose of keeping him alive so that he could recover. However, once recovery was no longer a possibility, the treatment could not be said to be accomplishing its purpose.⁵³ The true purpose of withdrawal would be to bring the treatment to an end and cease the infliction of unnecessary harm on Mr. Rasouli.⁵⁴ To do so would enable the existing threat of disease to take its course, with the doctors simply allowing this to happen. Similarly, when doctors attempt to resuscitate patients, they may decide, based on medical expertise, that resuscitation is not going to work and cease trying to apply it. It would be completely impractical to require doctors to obtain consent to cease resuscitation because they could potentially be ordered to continue trying to resuscitate indefinitely. At some point the doctors need to be able to make the call that treatments are not performing their purposes and be able to allow the existing threat of death to occur.

49 Laura Hawryluck, “A Response to “Why Withdrawing Life-Sustaining Treatment Should Not Require ‘Rasouli Consent’” (2012) 6 McGill JL & Health 105 at 106; Arthur Schafer, “A win for families, a loss for common sense”, *The Globe and Mail* (21 October 2013) A11.

50 Woollard, *supra* note 45 at 271.

51 Warren Quinn, “Intentions, and Consequences: The Doctrine of Doing and Allowing” (1989) 98:3 *The Philosophical Review* 287 at 298.

52 Woollard qualifies this part of the theory to encompass only the removal of barriers which are not the agent’s own resources and are in use to prevent or delay the possibility in question. Thus, since life support is the hospital’s resource and the doctors are agents of the hospital, they can remove it to “allow” a possibility to occur. In contrast, an outsider who is not affiliated with the hospital would be “doing” harm if they were to remove the life support: Woollard, *supra* note 45 at 274.

53 *Rasouli*, *supra* note 10 at para 154.

54 Kirkey, *supra* note 5; Hawryluck, *supra* note 49 at 110.

ii. Scheme of the Act

Terms in a statute should not be interpreted in isolation, so it is important to assess the scheme of the Act.⁵⁵ Withdrawal of life support is not specifically mentioned in the definition of “treatment” under the *HCCA*. The implied exclusion maxim assumes that such silence is deliberate because the Legislature would have mentioned withdrawal of life support expressly if it were meant to be included.⁵⁶ However, this maxim has strong critiques and should be applied cautiously.⁵⁷

The second part of the definition of “treatment” specifies a few things that are meant to be included as treatment but may not be typically thought of as such; for example, the definition includes a course of treatment, plan of treatment, and community treatment plan.⁵⁸ Withdrawal of life support is not listed. Unless it were something obviously seen to be treatment, the Legislature would have specified. The courts have decided that withdrawal of treatments in general do not constitute treatment. The common law on withdrawal of life support, though unsettled, also indicates a reluctance to view withdrawal as treatment.⁵⁹ Inclusion of it in the definition of treatment in the *HCCA* would be a significant departure from the common law, which should be clearly expressed by the Legislature.⁶⁰ Justice Karakatsanis identifies that the *HCCA* provides no special provisions to deal with end-of-life decisions.⁶¹ The Legislature would have been clearer if it intended to fundamentally alter the common law to create entitlement to treatment by requiring consent to withdraw life support. The *HCCA* specifically states that it does not affect the common law of consent for anything that does not fall under the definition of treatment, which does not include withdrawing life support.⁶²

Chief Justice McLachlin applies a broad interpretation because the *HCCA* specifies actions which are *not* to be included in the definition of treatment. Under the definition, the *HCCA* excludes actions such as “the assessment or examination of a person,” “the taking of a person’s health history,” “the communication of an assessment or diagnosis,” and “a treatment that in the circumstances poses little or no risk of harm to the person.”⁶³ Therefore, Chief Justice McLachlin states that if withdrawal of life support were meant to be excluded as well, it would have been listed in these exceptions.⁶⁴ However, these exclusions actually further support the narrowing, not the broadening, of the definition of treatment. In the *HCCA*, Parliament has excluded trivial acts from the definition of treatment, showing respect to doctors and limiting patient autonomy where it is appropriate.⁶⁵ All of these listed exclusions, if they were to be considered “treatment”, would require what I will hereafter refer to as “Typical Common Law Consent.” The latter allows patients to grant or refuse consent to treatment that the physician is willing

55 *Merk v International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers, Local 711*, 2005 SCC 70 at para 18 (available on CanLII).

56 *R(C) v Children’s Aid Society of Hamilton*, [2004] 70 OR (3d) 618 at para 23 (available on CanLII) (Sup Ct J).

57 *65302 British Columbia Ltd v Canada*, [1999] 3 SCR 804 at para 11 (available on CanLII); *Tetreault-Gadoury v Canada (Employment and Immigration Commission)*, [1991] 2 SCR 22 at para 17 (available on CanLII).

58 *HCCA*, *supra* note 11, s 2(1).

59 *Rasouli*, *supra* note 10 at para 53; *Schmitz*, *supra* note 32.

60 *Young*, *supra* note 2 at 95.

61 *Rasouli*, *supra* note 10 at para 141, Karakatsanis J, dissenting.

62 *HCCA*, *supra* note 11, s 8(2).

63 *Ibid*, s 2(1).

64 *Rasouli*, *supra* note 10 at para 47.

65 *Young*, *supra* note 2 at 68.

to provide, but does not allow patients to demand treatment that has not been offered by the physician.⁶⁶

Withdrawal of life support would require a very different kind of consent, which law professor Hilary Young labeled as, and which I will hereafter refer to as, “Rasouli Consent.” By categorizing withdrawal as treatment, patients and SDMs would be given authority to demand the continuation of treatment.⁶⁷ That is to say, the patients would have the power to force the doctors to treat rather than just the power to stop them from treating. Therefore, the fact that withdrawal of treatment is not listed along with the other exclusions does not mean that it was intended to be included as treatment, but rather that it is a completely different category than those trivial Typical Common Law Consent issues. Parliament’s failure to mention withdrawal of life support in these relevant sections of the *HCCA* is likely because the Act was not intended to apply to that scenario at all.

Chief Justice McLachlin explains that, in finding that the withdrawal of life support is treatment under the *HCCA*, there is still recourse for physicians through the Board created under Part V of the *HCCA*.⁶⁸ Physicians may ask the Board to overturn an SDM’s decision if the SDM is not acting in accordance with the patient’s prior wishes or best interest, or if any change in prognosis has rendered a prior wish inapplicable. Instead of placing the legal burden on the families to take the disagreement to court, it is up to the physician to bring their concerns to the Board.⁶⁹ The Board is then able to take into account medical benefit as part of its analysis.⁷⁰ For the past 17 years, the Board has been utilized to resolve disagreements over end-of-life decisions and has already handled cases dealing with the withdrawal of life support.⁷¹ If needed, the Board is also subject to judicial review to ensure that it has acted within its mandate and in accordance with the *Charter*.⁷²

However, the ability of the Board to deal with the range of considerations and circumstances that arise in decisions to withdraw life support is quite limited.⁷³ For example, the physician’s professional and ethical interests and resource allocation will not be considered by the Board.⁷⁴ Furthermore, the physician has little recourse where the patient has a prior expressed wish to continue life support.⁷⁵ The Board’s ability to consider a best-interest analysis and medical benefit only arises where there is no prior wish, or where the prior wish is no longer applicable and the patient, if capable, would likely consent because the prognosis has significantly improved.⁷⁶ Unfortunately, the relevant cases would usually involve a physician wanting to withdraw life support because the patient’s prognosis has worsened rather than improved. This is not contemplated within the *HCCA*, likely because the *HCCA* was not intended to cover the situation of treatment withdrawal.

66 *Lavallee, supra* note 35. In *Lavallee*, the word “treatment” in the *Child and Family Services Act* was only applied to Typical Common Law Consent.

67 Young, *supra* note 2 at 54.

68 *HCCA, supra* note 11, s 37(1).

69 *Rasouli, supra* note 10 at para 114.

70 *Ibid* at para 27; Daphne Jarvis, “Canada: The Impact of the SCC Decision in the “Rasouli” Case” (28 October 2013), online: Mondaq Ltd <<http://www.mondaq.com/canada/x/271154/trials+appeals+compensation/The+Impact+Of+The+SCC+Decision+In+The+Rasouli+Case>>.

71 *Rasouli, supra* note 10 at para 102, McLachlin CJ.

72 *Ibid* at para 100.

73 Schafer, *supra* note 49.

74 Young, *supra* note 2 at 93.

75 *Ibid* at 94.

76 *HCCA, supra* note 11, s 36(3).

Other concerns with leaving disputes over withdrawal of life support to the Board include the following:

- The only medical specialists on the Board are psychiatrists and not medical doctors;
- The process is not quick and efficient despite misconceptions to the contrary; and
- There is no corresponding body to resolve disputes in other provinces.⁷⁷

It is unclear how this will apply to provinces like British Columbia, which has very similar legislation to the *HCCA* but does not have the Board to resolve disputes that arise.⁷⁸ The Board was not created to handle disputes over the withdrawal of medically ineffective treatment. It is ill-equipped to do so, and the language of the *HCCA* does not support such an interpretation.

Finally, the *HCCA* articulates when consent is required and outlines the role of SDMs with regard to consent. However, it does not create new causes of action or remedies for failure to obtain consent.⁷⁹ Presumably, a failure to respect Typical Common Law Consent would be subject to common law recourses, such as battery.⁸⁰ Those recourses, though, would not be applicable to Rasouli Consent.⁸¹ Thus, patients and SDMs would have no cause of action if a doctor withdrew life support without consent. This would be true even if withdrawal were considered treatment as there is no common law remedy for simply breaching a statute.⁸²

iii. Purpose of the Act/Intention of Parliament

The *HCCA* and similar statutes arose because many provinces found the common law unsatisfactory with respects to medical decision-making for incapable patients.⁸³ The intention was to codify and modify the common law on this issue.⁸⁴ However, the intention was not to override the common law of consent as a comprehensive scheme, only to provide clarity and a way to acknowledge patient autonomy even when dealing with incapacity.⁸⁵ It is clear that respect for autonomy is an important legislative goal; however, there is no reason to believe that Parliament intended to create a new right for patients to demand treatment. If the *HCCA* was intended to go beyond the typical common law right to refuse treatment by granting a right to insist on continuation of medically ineffective treatment, it would have done so in clearer terms. Justice Karakatsanis points out that there is no evidence in the legislative history that Parliament intended to require consent for procedures the physician was not willing to provide.⁸⁶ If Parliament wanted to create such entitlements, the issue would have most likely been specifically addressed and been present in legislative debate.

Chief Justice McLachlin states that the inclusion of withdrawal of life support as “treatment” is in line with these purposes as it impacts autonomy “in the most fundamental

77 *Jarvis, supra* note 70.

78 *Schmitz, supra* note 32.

79 *Young, supra* note 2 at 80.

80 *Ibid* at 61.

81 See Part III for a common law analysis of Rasouli Consent.

82 *The Queen (Can) v Saskatchewan Wheat Pool*, [1983] 1 SCR 205 (available on CanLII) [cited to SCR].

83 *Rasouli, supra* note 10 at para 133.

84 *Ibid* at para 17.

85 *Ibid* at para 164.

86 *Ibid* at para 165.

way” and goes to the heart of the *HCCA*.⁸⁷ However, the purpose of promoting autonomy is not absolute. The *HCCA* was not meant to give complete control to patients and their SDMs. There is still value in ensuring adequate medical treatment.⁸⁸ The purpose of the *HCCA* is not to allow patients to demand whatever treatment they like. Even Chief Justice McLachlin concedes that it was not intended to impose a requirement to obtain consent for all types of withholding or withdrawal of treatment.⁸⁹ This would be absurd and go against the strong presumption that the Legislature is rational and competent. Any interpretation that results in absurdity should be abandoned. Thus, if the withdrawal of life support is treatment, it must be an exception. It is unlikely that the Legislature would create such an exception without expressly indicating that it was doing so.

The *HCCA* was not intended to overturn basic principles of the common law, and a requirement for consent to withdraw treatment generally has not been recognized in the jurisprudence.⁹⁰ To infer that the withdrawal of life support is treatment brings up complications regarding whether other types of withdrawal should be included, or whether the type of life support could change whether or not consent is required.⁹¹ To make a fundamental change to the common law without specifying the details is against the purposes of the *HCCA*. The *HCCA* should serve to clarify and provide guidance with regard to consent, rather than overturn and complicate it.

B. Plan of Treatment

i. Ordinary Meaning

An argument can be made that withdrawal of life support is included in the definition of “plan of treatment,” which is considered treatment under the *HCCA*. The definition in section 2(1) says that a plan of treatment is “the administration [...] of various treatments or courses of treatment and may, in addition, provide for the *withholding or withdrawal of treatment*.”⁹² At first glance, this definition seems like it could encompass withdrawal of life support. However, Chief Justice McLachlin’s reasoning for withdrawal of life support being a plan of treatment is insufficient and very similar to the flawed “treatment package” approach advanced by the Court of Appeal.

As laid out by the Ontario Court of Appeal in *Rasouli* ONCA, it could be argued that withdrawal of life-support is ‘integrally linked’ to the administration of palliative care, and is thus part of a “treatment package.”⁹³ Withdrawal of life support is generally followed by palliative care, and since, in one physician’s opinion, it would be “barbaric” to remove life support without supplying palliative care, what the physicians are really proposing is to replace one treatment (life support) with another (palliative care).⁹⁴ Since the administration of palliative care is clearly treatment under the *HCCA* and requires consent, the withdrawal of life support would therefore similarly require consent.

This argument, however, has been criticized.⁹⁵ Chief Justice McLachlin briefly acknowledges that the treatment package argument is overly broad and then proceeds to offer her own reasons for why the withdrawal of life support would be part of a plan

87 *Ibid* at para 68.

88 *Ibid* at para 87.

89 *Ibid* at para 48.

90 *Ibid* at para 53.

91 *Ibid* at para 160, Karakatsanis J, dissenting.

92 *HCCA*, *supra* note 11, s 2(1) [emphasis added].

93 *Rasouli* ONCA, *supra* note 26 at para 52.

94 Andrew B Cooper, Paula Chidwick & Robert Sibbald, “Court Rules that Withdrawal of Life Support is a Plan of Treatment Requiring Consent” (2011) 183:8 CMAJ E467.

95 Young, *supra* note 2.

of treatment.⁹⁶ Unfortunately, her supposedly new rationale is simply a reworded version of the treatment package argument and is subject to the same weaknesses. Chief Justice McLachlin explains that the withdrawal of life support is closely tied to palliative care and that palliative care will inevitably be administered in a case like *Rasouli*, thereby creating a “plan of treatment.”⁹⁷ However, the link between withdrawal of life support and the administration of palliative care is purely a statistical connection and the two are not always bound together.⁹⁸ Justice Karakatsanis acknowledges that the relationship between withdrawal of life support and the administration of palliative care depends on the specific circumstances of each patient.⁹⁹ Palliative care may already have begun before contemplating the withdrawal of life support, and patients or their SDMs may still refuse palliative care regardless of whether their life support is removed.¹⁰⁰ The decision to withdraw life support and the decision to begin palliative care are two separate decisions and consenting to one does not necessitate consenting to the other. It would be arbitrary to say that the requirement for consent to the withdrawal of life support depends on whether or not palliative care preceded the decision.

Another issue with the treatment package approach is that it does not provide a meaningful distinction between the withdrawal of life support and other withdrawals that may be statistically connected to palliative care. An example of this would be when physicians determine that a patient’s chemotherapy is no longer working and they feel that continuing would only cause the patient unnecessary suffering without any therapeutic benefit.¹⁰¹ After ceasing the chemotherapy treatments, the patient will often be provided with palliative care. The Court of Appeal in *Rasouli* decided that the distinction between withdrawal of life support and withdrawal of other treatments, like chemotherapy, is whether or not palliative care and death would follow *imminently*.¹⁰² This is an arbitrary distinction that has no basis in ethics or in medicine.

Whether or not the patient is entitled to demand continuation of ineffective and possibly harmful treatment should not rest on the gap of time between the withdrawal and the administration of palliative care.¹⁰³ The Court also did not address how much time is allowed in order to qualify as “imminent.”¹⁰⁴ Withdrawal of life support does not necessarily lead to death, and when it does, the time it takes can vary.¹⁰⁵ Removal of certain types of life support can result in longer wait times than others. For instance, the removal of a respirator could lead to death quite quickly, whereas the removal of artificial nutrition and hydration could take much longer for death to occur.¹⁰⁶ It would be absurd to require consent for the removal of a respirator and not for the removal of artificial nutrition.

ii. Scheme of the Act

The definition of “plan of treatment” not only includes the “withdrawal,” but also “withholding,” of treatment. Specifically, the definition says that a plan of treatment “may,

96 *Rasouli*, *supra* note 10 at para 66.

97 *Ibid* at para 68.

98 *Ibid* at para 161, Karakatsanis J, dissenting; Young, *supra* note 2 at 75.

99 *Rasouli*, *supra* note 10 at para 161.

100 Young, *supra* note 2 at 75.

101 *Rasouli* ONCA, *supra* note 26 at para 53.

102 *Ibid*.

103 Young, *supra* note 2 at 77.

104 *Rasouli* ONCA, *supra* note 26 at para 53.

105 Deborah Cook et al, “Withdrawal of Mechanical Ventilation in Anticipation of Death in the Intensive Care Unit” (2003) 349 N Engl J Med 1123.

106 Young, *supra* note 2 at 78.

in addition, provide for the withholding or withdrawal of treatment.”¹⁰⁷ As these terms are presented together, it can be assumed that they should be interpreted consistently. If withdrawal of life support can be included in an interpretation of “treatment plan”, then the withholding of life support should be included in the same way. It is clear that withholding life support can be just as integrally linked to palliative care as its withdrawal is. There can also be varying gaps of time between the decision to withhold life support, the administration of palliative care, and death, likely even more so than between life support withdrawal and the administration of palliative care.¹⁰⁸ Surely the Legislature is not saying that physicians would be required to obtain consent in the decision to withhold life support. This would be an absurd result as it would mean that patients or their SDMs would be granted the right to demand life support even when it is not needed and it would not be considered medically useful. By the same logic, consent would be required for “withholding” a kidney transplant, regardless of wait lists or the availability of a suitable kidney.¹⁰⁹ Thus, whether or not withholding life support would be considered part of a plan of treatment must rest on another distinction, and so too should its withdrawal.

iii. Purpose of the Act/Intention of Parliament

Chief Justice McLachlin expresses a concern that, if the withdrawal of life support is not necessarily a “treatment” or a “plan of treatment,” then physicians would have too much discretion to decide whether they want to present the option of withdrawing life support to the patient as a plan of treatment or not. She says this would result in arbitrariness as to when the withdrawal would require consent as physicians could simply change their wording and present elements of a plan of treatment separately in order to avoid the consent requirement.¹¹⁰ This would fundamentally undermine patient autonomy and would not be in line with the purpose of the *HCCA*.

However, the *HCCA* need not be interpreted in such a way as to give physicians such broad discretion. When a physician is taking multiple steps, the overall purpose of the plan, rather than the physician’s whim, should determine whether or not any given withdrawal should be a plan of treatment or part of one. If the overall plan has a health-related purpose, then any withholding or withdrawal included within that plan would be considered part of a plan of treatment requiring consent for the purposes of the *HCCA*. If the plan does not have a health-related purpose, then it would not be considered a plan of treatment for the purposes of the *HCCA* and, thus, those withholdings and withdrawals would not require consent. The purpose of the withdrawal of life support in cases like *Rasouli* is *not* a “health-related purpose,” but rather the purpose is to cease the prolongation of the dying process and the suffering caused by the physician intervention through administering the life support in the first place. Whether or not palliative care is administered afterwards is a separate decision and does not change the purpose of the withdrawal. On the other hand, if a physician wanted to try a new aggressive treatment that was meant to aid in recovery but was incompatible with the patient’s life support, there would be a health-related purpose. The physician would be proposing a plan with the therapeutic purpose of curing the patient and withdrawal of life support could be considered as part of this plan of treatment.

107 *HCCA*, *supra* note 11, s 2(1).

108 John M Luce & Ann Alpers, “Legal Aspects of Withholding and Withdrawing Life Support from Critically Ill Patients in the United States and Providing Palliative Care to Them” (2000) 162 *Am J Respir Crit Care Med* 2029 at 2031.

109 Kirkey, *supra* note 5; Young, *supra* note 2 at 78.

110 *Rasouli*, *supra* note 10 at para 57.

C. Conclusion on Statutory Interpretation

If the *HCCA* was intended to apply to the withdrawal of life support it would have expressly said so. Judging by the ordinary meaning, scheme of the act, purpose of the act, and intention of Parliament, withdrawal of life support should not be included within the definition of treatment or plan of treatment. By inferring otherwise, Chief Justice McLachlin only created unnecessary confusion and arbitrariness. For the above reasons, I submit that the majority decision in *Rasouli* erred in interpreting the definition of “treatment” under the *HCCA* in an overly broad manner. The Court should have determined that the *HCCA* did not apply and whether Mr. Rasouli’s physicians were required to obtain consent before withdrawal ought to have been decided through the common law. Since the ruling currently only applies in Ontario, the rest of Canada may still seek guidance through the common law or the *Charter*.

PART III. COMMON LAW

In this section, I will analyze the common law of consent. The narrow formulation of the SCC decision in *Rasouli* left many unanswered questions for the rest of the country. In a recent article, Professor Young canvasses how *Rasouli* might be applied outside Ontario. She examines those areas that would be the least influenced by the decision and thus most likely to require a common law determination regarding withdrawal of life support.¹¹¹ British Columbia,¹¹² Prince Edward Island,¹¹³ and the Yukon¹¹⁴ have statutes similar to the *HCCA* that require consent for “treatment” or “health care.” It is likely that *Rasouli* would be persuasive in interpreting the law in those jurisdictions.¹¹⁵ However, the connection is less clear elsewhere in Canada. In Manitoba,¹¹⁶ Newfoundland,¹¹⁷ and the Northwest Territories¹¹⁸ the statutes define “treatment” and “health care” in a similar manner but do not require consent for such acts. Conversely, Quebec’s Civil Code¹¹⁹ requires consent for “treatment” but does not define “treatment”. Finally, the statutes in Alberta,¹²⁰ New Brunswick,¹²¹ Nova Scotia,¹²² Saskatchewan,¹²³ and Nunavut¹²⁴ have neither a definition of “treatment” nor a requirement for consent to it. Presumably, the common law of consent would apply in such jurisdictions.¹²⁵

Chief Justice McLachlin did not make a ruling in *Rasouli* with regard to the common law, as her judgment was restricted to the application of the *HCCA*. Justice Karakatsanis, on the other hand, claimed that the *HCCA* did not apply and thus *Rasouli* should be decided in common law. I believe that she correctly concluded that the common law would not place an obligation on Mr. Rasouli’s doctors to obtain consent before

111 Young, “Entitlements”, *supra* note 43.

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

113 *Consent to Treatment and Health Care Directives Act*, RSPEI 1988, c C-17.2, s 1.

114 *Care Consent Act*, s 3, being Schedule B to the *Decision-Making Support and Protection to Adults Act*, SY 2003, c 21.

115 Young, “Entitlements”, *supra* note 43 at 11.

116 *Health Care Directives Act*, SM 1992, c 33 CCSM c H27, ss 1, 7.

117 *Advance Health Care Directives Act*, SNL 1995, c A-4.1.

118 *Personal Directives Act*, SNWT 2005, c 16.

119 *Civil Code of Quebec*, LRQ, c C-1991, art 11.

120 *Adult Guardian and Trusteeship Act*, SA 2008, c A-4.2; *Personal Directives Act*, RSA 2000, c P-6.

121 *Infirm Persons Act*, RSNB 1973, c I-8.

122 *Personal Directives Act*, SNS 2008, c 8.

123 *Health Care Directives and Substitute Health Care Decision Makers Act*, SS 1997, c H-0.001, as amended by the Statutes of Saskatchewan, 2000, c A-5.3 and 2004, c 65.

124 Nunavut has no relevant legislation.

125 Young, “Entitlements”, *supra* note 43 at 12-14.

removing life support. First, the origin of the common law of consent in the tort of battery does not ground entitlement to treatment.¹²⁶ Second, the more contemporary principle of informed consent does not ground entitlement to treatment either.¹²⁷ Third, Rasouli Consent is fundamentally distinct from Typical Common Law Consent as it is dependent on the evaluation of patient reasoning. Fourth, the jurisprudence dealing with life support has not authoritatively created an exception for Rasouli Consent. Fifth, Rasouli Consent would mark a radical change to the common law notion of consent that should be left to Parliament, rather than an incremental change that the courts would be permitted to make.

A. Battery

The common law of consent to medical treatment originated in the tort of battery, or unwanted touching.¹²⁸ For a physician to administer any treatment that required touching, as most do, consent would be required for it not to constitute battery.¹²⁹ A patient may refuse to consent under almost any circumstances and for any reason, even if doing so would result in his or her death.¹³⁰ This tort only provides patients with the ability to refuse treatment and cannot ground any right to demand treatment that the physician is unwilling to provide (meaning a patient cannot demand to be touched).

One argument for requiring consent for the withdrawal of life support is that doing so would require touching and therefore invoke the tort of battery.¹³¹ In *Golubchuk v Salvation Army Grace General Hospital et al* (“*Golubchuk*”), the Manitoba Court of Queen’s Bench found that consent is not required for withdrawal generally, but since the removal of life support would require touching, consent is required.¹³² If the physicians were asking to simply turn off the machines or cease to supply the required nutrients, there would be no touching. However, presumably, they would want to remove the tubes from the patient’s body and likely administer palliative care to reduce discomfort, all of which would involve touching. Thus, consent should be required to withdraw life support.

The extubation argument seems to be more of a technicality, rather than a meaningful distinction. The withdrawal of other types of treatment would similarly engage this sort of battery. As mentioned earlier, it seems to be widely accepted that a patient cannot demand continuation of a prescription drug if the prescribing physician deems the harms of the drug to outweigh its benefits.¹³³ Patient consent is not required for a physician to withdraw treatment in that case, so should it be required where the drug is being administered intravenously? Technically, the physicians could stop the flow of the drug without touching the patient and leave in the empty IV. The physical interference is not necessary to accomplish the goal, but is used to improve patient comfort and respect patient dignity.¹³⁴ Similarly, when stopping a respirator, extubation is not always performed and there is a lack of consensus on whether it is in the patient’s best interest to do so.

126 *Rasouli*, *supra* note 10 at para 185.

127 *Young*, *supra* note 2 at 63.

128 *Ibid* at 62; Daniel E Hall, Allan V Prochazka & Aaron S Fink, “Informed Consent for Clinical Treatment” (2012) 184 CMAJ 533 at 533.

129 *Rasouli*, *supra* note 10.

130 *Malette v Shulman* (1990), 72 OR (2d) 417 at para 14 (available on CanLII) (CA) [*Shulman*].

131 *Young*, *supra* note 2 at 61.

132 *Golubchuk v Salvation Army Grace General Hospital*, 2008 MBQB 49 (available on CanLII) [*Golubchuk*].

133 *Rasouli*, *supra* note 10 at para 58.

134 *Ibid* at para 162.

Mr. Rasouli's ventilator could be turned off and his nutrition supply cut off without touching him. However, to enhance his comfort and dignity, the physicians could perform other activities that would involve touching, such as extubation and the provision of palliative care. Theoretically, Dr. Salasel, as his SDM, could refuse consent to these further steps, subject to her duties under the *HCCA* to act in her husband's best interests.¹³⁵

Trying to understand withdrawal of treatment solely through the tort of battery leads to arbitrariness.¹³⁶ Consent would be required to withdraw a treatment when touching is involved, but would not be required to withdraw the same treatment if done without touching. Consent would not be required to withhold treatment, but would be required to withdraw the same treatment if to do so would require touching. Although the common law of consent originated with battery, this tort is no longer the primary focus of the common law of consent.¹³⁷ The common law has since evolved to be more patient-centered, focused on promoting patient autonomy and self-determination with a cause of action rooted in negligence.¹³⁸

B. Informed Consent

At the heart of the current common law of consent is the idea that "every human being of adult years and sound mind has a right to determine what shall be done with his own body."¹³⁹ Rather than simply ensuring that they avoid battery, physicians are now required to obtain "informed consent" before administering treatment.¹⁴⁰ This means that they are required to provide a patient or the patient's SDM with all the relevant information concerning a proposed treatment, its risks, the likely outcomes, and any practical alternatives so that the patient can make an informed decision about his or her medical care.¹⁴¹ Failure to do so in accordance with the standard of a reasonable physician opens up a medical caregiver to liability in negligence.¹⁴² Founded on the principles of autonomy and self-determination, a patient's right to decide what happens to his or her body prevails over all other interests when dealing with Typical Common Law Consent.¹⁴³ Therefore, it is said to be very patient-centered, one-sided, and absolute.¹⁴⁴

Under the law of informed consent, a patient may refuse or withdraw consent to treatment for almost any reason.¹⁴⁵ Even if the physicians feel that the refusal would not be in the patient's best interest, the physician cannot override the patient's wishes. The Court has established that this principle extends even when the patient's refusal would almost certainly result in death.¹⁴⁶ Thus, a patient or the SDM may refuse consent to the commencement or continuation of life support, even if death would imminently follow.

135 *HCCA*, *supra* note 11. The physicians would be able to bring it to the Consent and Capacity Board, who would be able to overrule her decision if it was not in accordance with a prior expressed wish. If there was no prior wish, the Board could overturn her decision if it was not in the patient's best interest. Mr. Rasouli did not have an Advanced Directive.

136 Jocelyn Downie, "Unilateral Withholding and Withdrawal of Potentially Life-Sustaining Treatment: a Violation of Dignity Under the Law in Canada" (2004) 20 *J Palliat Care* 143 at 145.

137 *Ibid.*

138 *Ibid*; *Reibl v Hughes*, [1980] 2 SCR 880 (available on CanLII) [*Reibl* cited to SCR].

139 *Ibid* at para 11.

140 *Cojocar v British Columbia Women's Hospital & Health Centre*, 2013 SCC 30 (available on CanLII).

141 Hall, Prochazka & Fink, *supra* note 128.

142 *Reibl*, *supra* note 138.

143 Downie, *supra* note 136 at 146.

144 Young, *supra* note 2 at 57.

145 Shulman, *supra* note 130.

146 *Ibid.*

However, this still does not ground an obligation for physicians to provide ineffective treatment simply because the patient has not consented to not being treated.

If a treatment that a patient wishes to have, including life support, has a reasonable expectation of providing benefit, then the physician may be required under the broader duties in negligence and fiduciary duties to provide the treatment as a reasonable physician would.¹⁴⁷ As Justice Karakatsanis explains in the *Rasouli* dissent, physicians still must act in accordance with their standard of care and fiduciary duties.¹⁴⁸ However, this does not extend to cases where the treatment is deemed to be medically unnecessary and ineffective. When considering withholding and withdrawing of treatment, there are many other interests aside from just the patient's choice that must be considered.¹⁴⁹ The Court recognized in *R v Big M Drug Mart Ltd* that autonomy can sometimes be limited by other interests, such as “public safety, order, health or morals or the fundamental rights and freedoms of others.”¹⁵⁰ In cases like *Rasouli*, patient autonomy must be balanced with the professional obligation of physicians and the impact on the broader health care system.

However, a further issue with extending the common law of consent to withdrawal of life support is that the common law presupposes capacity.¹⁵¹ While Typical Common Law Consent can sometimes involve SDMs as well, the fact is that most often *Rasouli* Consent is given by SDMs rather than the patient simply because of the nature of life support. This is a step away from patients exerting their own autonomy.¹⁵² Consider the following statement by Dr. Kumar, an intensive care physician:

I speak to patients about end-of-life issues all the time, and I've never seen anybody, of any faith, ever say, 'If I'm going to die, let it be long and drawn out and painful [...]. It's only ever family members who say, 'This [aggressive care] is what they would have wanted.'¹⁵³

Dr. Kumar's point is that the person making the decision to continue the life support is not the one who has to go through the aggressive treatment and agony of constant surgeries, failing organs, bedsores, and recurring infections.¹⁵⁴

A patient or SDM cannot demand that a physician treat outside his or her professional medical standards of care.¹⁵⁵ This is reflected in the Canadian Medical Association's policy statement that declares “[t]here is no obligation to offer a person medically futile or non-beneficial interventions.” Specifically, with regard to life-sustaining interventions, the policy statement says that, “[f]or situations where there will not be any medical benefit, the intervention is not only generally unsuccessful but also inappropriate, as it may serve only to increase pain and suffering and prolong dying.”¹⁵⁶

147 Young, *supra* note 2 at 63.

148 *Rasouli*, *supra* note 10.

149 Rocker & Dunbar, *supra* note 7 at S54.

150 *R v Big M Drug Mart Ltd*, [1985] 1 SCR 295 at para 95 (available on CanLII).

151 *Ibid.*

152 Young, “Entitlements”, *supra* note 43 at 21.

153 Kirkey, *supra* note 5; Dr. Kumar resigned after being ordered by the court in *Golubchuk* to continue provision of life support, *supra* note 132. See section D in Part III for further discussion of *Golubchuk*.

154 Kirkey, *supra* note 5.

155 Schafer, *supra* note 49; Rocker & Dunbar, *supra* note 7 at S55.

156 Canadian Medical Association, “CMA Statement on Life-Saving and -Sustaining Interventions”, CMA Policy Statement (December 2013), online: Canadian Medical Association <<http://policybase.cma.ca/dbtw-wpd/Polycypdf/PD14-01.pdf>>.

Doctors have taken an oath to “do no harm” and thus should not administer treatments that are harmful and confer no medical benefit to the patient.¹⁵⁷ For example, physician-assisted suicide is illegal, and even though the Court may soon reconsider this in *Carter v Canada (AG)*, there is no argument that physicians would ever be obligated to assist patients to commit suicide if they did not believe it was in the patients’ best interests.¹⁵⁸ It would be undesirable to require doctors to treat patients against their personal and professional ethics and contrary to the standards of the medical profession.

Nonetheless, Chief Justice McLachlin finds that ethical tensions are inherent to medical practice, as doctors cannot paternally impose life-saving treatment if a patient refuses consent.¹⁵⁹ However, this highlights the distinction between doing and allowing harm. As discussed above, being required to refrain from carrying out one’s professional duties and “allowing” harm to occur is quite different from being required to actively “do” harm to someone in a way that is completely contrary to those duties.

C. Evaluation of Patient Reasoning

Another flaw in extending the common law of consent to Rasouli Consent arises from the absolute nature of Typical Common Law Consent. It is fundamental to the common law of consent, and to respect for patient autonomy, that physicians are not entitled to judge a patient’s reasons for giving or refusing consent.¹⁶⁰ Be it religious, political, superstitious, or even irrational, the patient’s decision, if competent and informed, is final. Even where the patient’s decision would not be in his or her best interest, or would lead to death, a physician must respect it. It would be seen to be paternalistic and would undermine patient autonomy if doctors were only made to respect a patient’s decision when the doctor felt that the patient had a legitimate reason for giving or withholding consent.

On the other hand, making an exception in withdrawal of treatment for Rasouli Consent inherently undermines this key component of patient autonomy. In distinguishing cases of withdrawal of life support from withdrawal of other treatments, it seems to come down to the fact that decisions with respect to life support are exceptionally difficult and laden with emotion.¹⁶¹ Religious and personal values seem to have heightened importance when death is imminent.¹⁶² It is easy to understand and identify with Dr. Salasel’s reasons for demanding that her husband’s life support be continued. We are sympathetic to her situation and find the idea of wishing to hold on to a loved one to be logical. In contrast, if a patient demanded that a physician continue supplying harmful pills simply because he or she liked the taste, the courts would dismiss the demand right away.

Allowing physicians and courts to judge a patient’s reasons for giving or refusing consent does not respect patient autonomy. Although the majority decision in *Rasouli* may have been intended to respect autonomy since Dr. Salasel received the decision she wanted, in fact it was not about what she wanted. The decision was based on what the Court deemed it was *acceptable* for her to want. Would the outcome have been different if Dr. Salasel had

157 Schafer, *supra* note 49.

158 *Carter v Canada (AG)*, 2013 BCCA 435 (available on CanLII) [*Carter*]. In *Carter*, the ruling that physician-assisted suicide is illegal may change, but nonetheless this case does not contain an argument for patients to demand physician-assisted suicide where the physician is unwilling to provide it. In fact, there is push from both sides that many safeguards should be in place to ensure that physician-assisted suicide is used only as a last resort when several physicians concur that the patient is in sufficient pain that suicide would be in his or her best interest.

159 *Shulman*, *supra* note 130.

160 *Ibid.*

161 *Rasouli*, *supra* note 10 at para 174.

162 *Ibid* at 196.

given different reasons for wanting her husband's life support continued? If Mr. Rasouli had previously expressed a wish to continue life support simply because he knew it would torment the doctors, would the case have even gone to the SCC? Extending Rasouli Consent to the common law would create far too much uncertainty. It would create a situation where consent would be required for withdrawal of some treatments and not others, or even for some patients and not others who were receiving the same treatment, based purely on the patients' reasons. The requirement of consent should not depend on how good or reasonable the decision-maker views the patient's reasons to be.¹⁶³

As Young explains, Rasouli Consent under common law would not grant a right to consent, but would grant simply an opportunity to propose a rational argument for why one should be allowed a treatment that is not recommended.¹⁶⁴ Patients are already afforded this, as doctors should and do consult with families and SDMs before withdrawing life support.¹⁶⁵ However, physicians' practice of consulting with loved ones should not go so far as to become part of the common law of consent. Whereas refusing consent to treatment is an absolute principle, demanding treatment should require justification. Both refusing consent and demanding treatment should not fall under informed consent.¹⁶⁶ Allowing an opportunity for treatment that should require justification to be treated the same as the definitive legal principle that treatment can be refused would cause a lack of certainty and predictability in the common law of consent.

D. Cases on Life Support

Although the general application of the common law of consent does not ground Rasouli Consent, courts have struggled when specifically considering withholding and withdrawing life support and life-saving measures. There is no clear consensus; however, there seems to be a reluctance on the part of the courts to acknowledge a right for patients and their SDMs to demand life support to continue once physicians have determined that it is no longer beneficial to the patient. Even the SCC's majority decision in *Rasouli* confined itself to legislation and refused to extend Rasouli Consent to the common law.

Canadian courts appear to find it within a physician's decision-making capacity to withhold life-support through the issuance of a do-not-resuscitate ("DNR") order without consent. In *Lavallee*, the Manitoba Court of Appeal ruled that a physician does not require consent to place a DNR order on a patient's file.¹⁶⁷ This case involved an infant who had no hope of meaningful recovery, but the mother refused to accept the physician's recommendation for the DNR order. The Court clearly summarized its position refusing to require consent for DNR orders:

[N]either 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 the case.¹⁶⁸

Several decisions regarding withdrawal of life support have expressed similar reasoning. In *Sweiss v Alberta Health Services*, the Alberta Court of Queen's Bench ruled that a

163 Young, *supra* note 2 at 89.

164 *Ibid.*

165 Jarvis, *supra* note 70; Schafer, *supra* note 49; Hall & Rocker, *supra* note 3 at 1429.

166 Young, *supra* note 2 at 70.

167 *Lavallee*, *supra* note 35.

168 *Ibid.*

physician acting within his duty for the best interest of his patient does not need to acquire consent to withdraw life support.¹⁶⁹ However, an injunction was granted so that the family could obtain a second opinion as to whether the life support was in fact useless and that withdrawal would be in the patient's best interest.¹⁷⁰ Likewise, in *Rotaru v Vancouver General Hospital Intensive Care Unit*, the British Columbia Supreme Court did not allow the patient's daughter to demand continuation of life support when the physicians had determined that withdrawal was in the patient's best interest.¹⁷¹ The court stated that "the love for her mother [...] is not enough to ground an order to treat Ms. Priboi in a manner which is contrary to [the physician's] clinical judgment."¹⁷² The SCC in *Children's Aid Society of Ottawa-Carleton v MC* also determined that consent was not required for medical practitioners to withdraw life support. This case involved an infant with severe birth defects and no chance of survival. However, the court recommended that, until the law is clarified on the issue, physicians first seek a court order.¹⁷³

Unfortunately, the suggested approach of first seeking a court order may not be effective. *London Health Sciences Centre v K(R)* involved a wife who initially disagreed with her husband's physicians' plan to withdraw life support.¹⁷⁴ The physicians went to the Ontario Court of Justice to ask to be granted immunity from all liability for withdrawing the treatment. The court refused to grant immunity, but did not make a ruling as to whether the wife's consent was required under common law.

Golubchuk is the only Canadian case where the court definitively stated that consent to withdraw life support was required under the common law because it involves touching.¹⁷⁵ As a result of this ruling by the Manitoba Court of Queen's Bench, three intensive care physicians who were working with Mr. Golubchuk resigned from the hospital. They did so because they felt that continuing to subject a patient to life support once it no longer conferred a benefit was "tantamount to torture" and that forcing doctors to do so violated their ethical and professional duties.¹⁷⁶

It is noteworthy that the United Kingdom has authoritatively denied an obligation for physicians to obtain consent for the withdrawal of life support. The leading United Kingdom case is *Airedale NHS Trust v Bland*, in which the House of Lords ruled that the withdrawal of life support from a patient in a persistent vegetative state with no prospect of recovery did not require consent. The court found that the principle of sanctity of life was not absolute, as it does not allow treatment where patients refuse life-saving treatment, forcible feeding of inmates on hunger strikes, or life-sustaining treatment that would only prolong suffering. The House of Lords specifically acknowledged that withdrawal would involve touching the patient, but that this does not negate the physician's legal ability to do so.¹⁷⁷

169 *Sweiss v Alberta Health Services*, 2009 ABQB 691 (available on CanLII).

170 *Ibid.*

171 *Rotaru v Vancouver General Hospital Intensive Care Unit*, 2008 BCSC 318 (available on CanLII) [*Rotaru*].

172 *Ibid* at para 18.

173 *B (R) v Children's Aid Society of Metropolitan Toronto*, [1995] 1 SCR 315 (available on CanLII) [cited to SCR].

174 *London Health Sciences Centre v K(R)* (1997), 152 DLR (4th) 724 (available on CanLII) (ONSC) [cited to DLR].

175 *Golubchuk*, *supra* note 132. Flaws in the treatment package and battery arguments used by this court have already been addressed.

176 Jamie Komarnicki, "Two more doctors resign over life-support case", *The Globe and Mail* (17 June 2008) online: <<http://www.theglobeandmail.com/news/national/two-more-doctors-resign-over-life-support-case/article674697>>.

177 *Airedale*, *supra* note 2.

The law around life support in Canada remains unsettled. As the Canadian cases discussed above were not decided by the SCC, they are not authoritative outside of their respective jurisdictions. These cases do, however, show a tendency among judges across the country to respect a physician's judgment with regard to withholding and withdrawing life support.

E. Incremental Changes

Courts are able to make incremental changes to the common law; however, significant expansion to the law should be left to the Legislature.¹⁷⁸ This is especially true where there are complex and significant implications and ramifications to changes. In a democratic country, it is proper for the elected officials to make such decisions after consultation and debate with the public. Changing the common law so as to include a requirement for consent to withdraw life support should not be within the authority of the courts. Doing so would be a significant departure from how the common law of consent is currently viewed, not an incremental change.¹⁷⁹ The amount of inconsistency and uncertainty that would arise from such a ruling would be problematic.

This may explain why the court in *Rasouli* decided to determine the case based on the legislation. The problem, however, was that the statutory interpretation was flawed and the Legislature did not intend to implicate the withdrawal of life support in the *HCCA*. Without the issue being clearly presented by the Legislature, Canadian citizens are deprived of the necessary debate, public consultation, and overall legislative process that forms the basis of democracy. As it is a relatively modern issue because of the development of medical technologies and the shifted focus towards patients' roles in end-of-life decisions, there has yet to be sufficient debate and research on the implications of allowing patients to remain on life support indefinitely when it is ineffective or even harmful.¹⁸⁰ Ideally, Parliament should take initiative and address this issue through public debate. Then, once a democratic decision has been made, it should state so *clearly* in the legislation.¹⁸¹

PART IV. CHARTER

Charter challenges present another avenue that may be pursued in the courts to create a requirement for consent prior to withdrawal of life support. This approach has been advanced by counsel in prior cases, in several different ways, but has yet to be fully addressed by judges. Thus, there is no precedent that excludes the possibility that withdrawing life support without consent could violate a patient's *Charter* rights.¹⁸²

Regardless of the particular *Charter* right that has been allegedly infringed, there are certain initial barriers to overcome in order to bring such a claim. Only Parliament, legislatures, governments, and government actors who have been given delegated authority are subject to *Charter* scrutiny, and, therefore, anyone advancing a claim must show that doctors fall into one of these categories.¹⁸³ The *Charter* likely does not apply to doctors because they are independent contractors who owe an individual duty of care to a patient, unlike hospitals, which are government agents. This was touched upon in

178 Young, *supra* note 2 at 69.

179 As discussed above in Part III.

180 Young, *supra* note 2 at 61.

181 *Ibid* at 71.

182 Glen Rutland provides a useful overview of some possible approaches to a *Charter* claim with respect to withdrawing life support. See Glen Rutland, "Futile or Fruitful: The *Charter* and the Decision to Withhold or Withdraw Life-Sustaining Treatment" (2009) 17 Health LJ 81 at 82.

183 *Ibid* at 96; *Charter*, *supra* note 13.

Eldridge v British Columbia (“*Eldridge*”), where the court stated that the *Charter* applied to the hospital’s decision, but the question of whether the *Charter* applies to the decisions of individual doctors providing medical care was not considered.¹⁸⁴

Other case law in the medical field has presented further challenges for anyone hoping to place a *Charter* obligation on doctors. In *Chaoulli v Quebec (AG)*, the SCC ruled that there is no constitutionally protected right to health care.¹⁸⁵ This has been qualified somewhat in later cases which assert that a “core” treatment can be a *Charter* right. In *Auton (Guardian ad litem of) v British Columbia (AG)*, a new treatment for autism was not considered important enough to create a constitutional obligation to provide it.¹⁸⁶ On the other hand, a successful *Charter* claim was advanced in *Eldridge* to require sign language interpreters for medical visits.¹⁸⁷ It was determined that it was medically necessary for patients to understand their doctors in order for them to receive proper care. It remains vague as to what is necessary and what is not. Whether life support can be successfully argued to be necessary remains to be seen. In *Rodriguez v British Columbia (AG)*, the SCC ruled that there were no *Charter* violations in the prohibition of assisted suicide.¹⁸⁸ As both of these cases deal with a claimed right to control the way one dies by artificial means, it may be difficult for the court to assert that one is not a *Charter* right, while the other is.

On a more practical note, the time and money required to follow through with *Charter* litigation could be particularly burdensome on the type of plaintiffs involved in these cases. Glen Rutland, author of “Futile or Fruitful: The *Charter* and the Decision to Withhold or Withdraw Life-Sustaining Treatment”, points out that the majority of relevant situations would likely be time-sensitive because the individual in question is facing the withdrawal of life-sustaining interventions.¹⁸⁹ The patient or their SDM would have to be granted an injunction to prevent the doctors from acting before the litigation has completed. Even if that is accomplished, the patient may succumb to his or her underlying illness, despite the life support, before the termination of the lengthy multi-year litigation process. At such time, the motivation for SDMs and family members to continue spending money advancing the claim may significantly decline. Many people faced with the burdens of caring for a critically ill loved one may not be financially capable of pursuing this type of litigation.

PART V. POLICY CONSIDERATIONS AND PROPOSALS

SDM consent is not often an issue because SDMs and doctors will usually reach a consensus. However, when a dispute does arise, many policy reasons exist for leaving the decision to withdraw life support in the hands of doctors rather than SDMs. These reasons include decreased conservatism and objective consideration of patient’s best interests. Furthermore, many of the concerns over doctors making such an important decision can be addressed by simple proposals to improve end-of-life care in hospitals, such as consideration of patient’s wishes and adequate consultation and communication with the patient’s family and loved ones.

184 *Eldridge v British Columbia*, [1997] 3 SCR 624 (available on CanLII) [*Eldridge* cited to SCR].

185 *Chaoulli v Quebec (AG)*, 2005 SCC 35 (available on CanLII).

186 *Auton (Guardian ad litem of) v British Columbia (AG)*, 2004 SCC 78 (available on CanLII).

187 *Eldridge*, *supra* note 184.

188 *Rodriguez*, *supra* note 9.

189 Rutland, *supra* note 182 at 95.

A. Decreased Conservatism

Before *Rasouli*, it was typical practice for physicians to err on the side of caution when considering commencement of life support for a patient.¹⁹⁰ If there was a chance of recovery, even a very slim one, the physician would begin administering life support knowing that he could later withdraw the treatment if there turned out to be no hope of recovery. There is concern that by limiting a physician's ability to withdraw life support once it has commenced, physicians will be less likely to begin life support in borderline cases.¹⁹¹ Not only are there issues with resource allocation, but the physician may feel that the chance of recovery is so slim that it would not be in the patient's best interests to risk making him suffer on life support for years if the SDM refuses consent to withdraw.

B. Objective Consideration of Patient's Best Interests

Where a patient is not in a position to exercise his or her autonomy, in the common law the focus shifts from the patient's wishes to his or her best interests. For example, in an emergency a patient may be treated without consent. In some situations, the physician may be authorized by the court or by parents to treat a patient without consent even where there is no emergency.¹⁹² When continuing life support only serves to prolong a painful dying process, the focus should likewise shift to the best interests of the patient, rather than to the family's interest of holding on to false hope¹⁹³ or the SDM's wish to avoid the guilt associated with having to choose to end or withhold life support for a loved one.¹⁹⁴ Not only do doctors possess the medical expertise required to determine the likelihood of a treatment's success, but they also are less likely to be conflicted by complicated emotions during end-of-life decisions.¹⁹⁵ Thus, having the doctor make the decision can take some of the moral pressure off of the SDM and allows the doctor to make a more objective decision that is in the best interest of the patient.

Thus, it would be logical for doctors to make objective decisions using a best-interest analysis about the end of life, just as they do about the beginning of life. A fetus at the beginning of life is dependent on its mother to sustain itself; whereas a patient at the end of life may be dependent on medical devices. The law concerning what stage a fetus becomes a living human being remains murky and, consequently, there is no clear legal limit on when a woman can have an abortion.¹⁹⁶ By refusing to decide when life begins, the courts have essentially left it open to the doctors to decide when to perform an abortion on an individual basis. Women have a legal right to seek an abortion at any time, but doctors can, and often do, refuse on medical grounds.¹⁹⁷ When it comes to

190 Kirkey, *supra* note 5.

191 *Ibid.*

192 Judith Areen, "The Legal Status of Consent Obtained from Families of Adult Patients to Withhold or Withdraw Treatment" (1987) 258:2 JAMA 229.

193 Rotaru, *supra* note 171.

194 Jenny Way, Anthony L Back & J Randall Curtis, "Withdrawing Life Support and Resolution of Conflict with Families" (2002) 325 BMJ 1342 at 1345.

195 Douglas B White et al, "Are Physicians' Recommendations to Limit Life Support Beneficial or Burdensome?" (2009) 180 Am J Respir Crit Care Med 320 at 323 [White et al, "Physicians' Recommendations"].

196 The legal restrictions on abortion were struck down in 1988: *R v Morgentaler*, [1988] 1 SCR 30 (available on CanLII) [cited to SCR].

197 Chris Kaposy, "Improving Abortion Access in Canada, Health Care Analysis" (2008) 18:1 Health Care Anal 17.

end-of-life decisions, the law has also neglected to provide a definition of “death” and leaves determining “death” to doctors.¹⁹⁸

C. Patient’s Wishes

Although patients and their SDMs should not be entitled to demand the continuation of life support, the interests and wishes of the patient and his or her family should indisputably be taken into account.¹⁹⁹ Justice Karakatsanis suggests physicians employ certain processes, such as providing notice, ensuring reasonable accommodation, and exploring alternative institutions that may be willing to provide the treatment.²⁰⁰ These improvements should not be seen as a burden to the health care system because reductions in patient-physician conflict improve both quality and efficiency of decision-making. Less conflict leads to compliance with doctor recommendations, shorter ICU times, and less use of some life support measures.²⁰¹ Also, there is less chance of the physician’s decision being challenged in court if the patient’s wishes are taken into account.

Unfortunately, critically ill patients are often reluctant to discuss end-of-life care, as they find it threatening to contemplate such situations.²⁰² Doctors can provide an impartial analysis of the condition and prognosis of the patient but have limited insight into the personal and emotional aspects of end-of-life decisions. Advance Directives or Living Wills are seen as valuable tools to determine what the patient would have wanted, but many patients do not have them.²⁰³ Furthermore, when Advance Directives are present, they are still subject to interpretation and cannot cover all situations that might occur. Also, wishes can change as one approaches death. Studies show that enhancing relationships between physicians, patients and families may be a better solution.²⁰⁴

D. Family Consultation & Communication

One of the main fears of allowing doctors to withdraw life support without consent is that they will make such decisions unilaterally without consulting family members. This is a legitimate concern, since the requirement of informed consent would inherently require more communication than its counterpart.²⁰⁵ Doctors may be less motivated to explain the situation or ask for the family’s input if consent is not required. This would be an undesirable result because a patient’s loved ones often feel that they are more familiar with the patient’s values and beliefs, and thus better able to determine the patient’s best interests.²⁰⁶

198 *The Canadian Bioethics Companion*, “Chapter 3: End of Life Issues”, online: An Online Textbook for Canadian Ethicists and Health Care Workers <<http://canadianbioethicscompanion.ca/the-canadian-bioethics-companion/chapter-3-end-of-life-issues>>. There are few exceptions to this. In Manitoba, death is defined by its Vital Statistics Legislation as cessation of brain function: *Vital Statistics Act*, CCSM c V60.

199 Jarvis, *supra* note 70; Schafer, *supra* note 49; Hall & Rocker, *supra* note 3 at 1429.

200 Rasouli, *supra* note 10 at para 201.

201 Richard I Hall, Graeme M Rocker & Dawnelda Murray, “Simple Changes can Improve Conduct of End-of-Life Care in the Intensive Care Unit” (2004) 6 Can J Anesth 631 at 634.

202 Thomas J Prendergast & Kathleen A Puntillo, “Withdrawal of Life Support” (2002) 288 JAMA 2732 at 2734.

203 Douglas B White et al, “Life Support for Patients without a Surrogate Decision Maker: Who Decides?” (2007) 147 Ann Intern Med 34 at 37 [White et al, “Life Support”].

204 Daren K Heyland et al, “What Matters Most in End-of-life Care: Perceptions of Seriously Ill Patients and their Family Members” (2006) 174:5 CMAJ 1 at 6.

205 Franco A Carnevale et al, “The Moral Experience of Parents Regarding Life-Support Decisions for their Critically-Ill Children: A Preliminary Study in France” (2006) 10:1 JCHC 69 at 78.

206 White et al, “Physicians’ Recommendations”, *supra* note 195 at 322.

In France, it is common that the physician, rather than the family, maintains authority over life-support decisions for children. In 2006, a study titled “The Moral Experience of Parents Regarding Life-Support Decisions for their Critically-Ill Children: A Preliminary Study in France” found that the most fundamental shortcoming that interviewed parents identified regarding their child’s medical care was the lack of information given to those parents about their dying child.²⁰⁷ Many were unhappy with the doctors’ insufficient communication and indicated that this was an important consideration they would like to see improved. This concern was rated as being even more important to them than the doctors’ clinical skills. Although this study was preliminary and more research is needed, it does highlight doctor-family communications as an area that could be targeted in order to avoid possible problems associated with doctors making important end-of-life decisions.

There are already recommended safeguards and procedures in place to ensure life support is not withdrawn without taking steps to reach a consensus with the patient’s family and SDM. For example, the Canadian Critical Care Society recommends several steps when considering withdrawing life support, including: establishing consensus with medical colleagues that continuation would be inappropriate, erring on the side of continuation if there is any uncertainty, recognition of non-medical facts (such as patient hopes and fears, attitudes to life and death, religious beliefs), extended discussion with family members, attempts to transfer the patient to another institution, and mediation.²⁰⁸ Ultimately, however, the Canadian Critical Care Society asserts that the reasonable physician has no obligation to comply with a patient or SDM’s desire to continue life support that confers no benefit to the patient.²⁰⁹

Reasonable accommodation should be made prior to withdrawal of life support to address family members’ concerns, such as delays for social, personal, or spiritual closure, or if a relative is traveling to say goodbye. Families are more directly impacted by the outcome of withdrawal than the doctors or hospitals,²¹⁰ and the families are the ones who will experience the emotional and practical consequences of the decision.²¹¹ Physicians should be better trained to inform patients and SDMs of the patient’s condition and prognosis, as well as the rationale and timing of the withdrawal of life support. Without explanation, withdrawal can come across as abandonment, or families might suspect that the motives have more to do with money than the patients’ best interests.²¹² In the 2006 study of parents of critically ill children, the parents who received proper information felt more respected and better prepared for the withdrawal than parents who received little information.²¹³

For any proposed improvement of end-of-life care to be successful, research needs to be done in order to better understand where care is lacking and how to get physicians to comply with recommendations. Studies show that the current recommendations are not always complied with. Increasing accountability, implementing review panels, or establishing ethics committees could be helpful in addressing this concern.²¹⁴

207 Carnevale et al, *supra* note 205 at 74.

208 Rocker & Dunbar, *supra* note 7.

209 *Ibid* at 557.

210 White et al, “Physicians’ Recommendations”, *supra* note 195 at 322.

211 J M Appel, “Mixed Motives, Mixed Outcomes: When Accused Parents Won’t Agree to Withdraw Care” (2009) 35 J Med Ethics 635 at 635.

212 E Gedge, M Giacomini & D Cook, “Withholding and Withdrawing Life Support in Critical Care Settings: Ethical Issues Concerning Consent” (2007) 33 J Med Ethics 215 at 216.

213 Carnevale et al, *supra* note 205 at 75.

214 White et al, “Life Support”, *supra* note 203 at 38; Areen, *supra* note 192 at 234.

CONCLUSION

The Supreme Court of Canada's majority decision in *Rasouli* found that the withdrawal of life support constituted treatment as defined under the *HCCA* and thus required doctors to obtain consent before withdrawing. I believe that this was a mistaken interpretation of the *HCCA* and that the requirement for Rasouli Consent is not currently supported through legislation or through the common law in Canada. The Driedger approach to statutory interpretation of the *HCCA* and the current common law of consent only provide for refusal of proposed treatments, rather than demand of treatments that are not recommended. There are potential *Charter* claims, but historically the Court has been reluctant to grant *Charter* rights to demand health care.

There is still uncertainty as to how *Rasouli* will affect provinces outside of Ontario that have different legislation and lack Ontario's Consent and Capacity Board to resolve disputes. However, I contend that it would be undesirable for the courts to attempt to extend this ruling to such provinces through further statutory interpretation or through the common law. When life support is no longer serving its intended purpose and only prolonging the dying process, it is appropriate for physicians to be able to withdraw the treatment. Respect for patient autonomy should not extend so far as to allow patients and SDMs to demand continuation of an ineffective and potentially harmful treatment that their physician is no longer willing to provide. Patients should be able to seek life support, and possibly other end-of-life care options, but doctors need to be able to place realistic limits on those requests based on their medical expertise.