

***Rasouli* and Consent to Withdraw  
Treatment**

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In *Rasouli v. Sunnybrook Health Sciences Centre*, 2011 ONCA 482, the Court of Appeal held that a physician's obligation to obtain consent to treatment under the *Health Care Consent Act* includes an obligation to obtain a patient or Substitute Decision Maker's consent to the withdrawal of life support when this withdrawal medically necessitates the provision of palliative care.

## **Background**

In October 2010, after undergoing an operation to remove a benign brain tumor at Sunnybrook, Mr. Rasouli developed bacterial meningitis and ventriculitis, suffered severe brain damage, and fell into a coma. Mr. Rasouli was placed on a mechanical ventilator and a gastric feeding tube. His treating physicians and a staff neurologist diagnosed Mr. Rasouli as being in a persistent vegetative state, such that there was no realistic hope of medical recovery, and that ongoing mechanical intervention would not be of medical benefit and might be of harm to him. On this basis, the physicians advised Mr. Rasouli's wife, substitute decision maker, and legal guardian of their plan to withdraw life support and transfer Mr. Rasouli to palliative care. His wife, Ms. Salasel disagreed with this plan, on the basis that she and her family do not accept that Mr. Rasouli is in a state of permanent and irreversible unconsciousness.

Ms. Salasel successfully applied to the Ontario Superior Court for an order preventing Mr. Rasouli's physicians, Drs. Cuthbertson and Rubinfeld, from withdrawing life-sustaining treatment without her consent. The application judge ordered that the proposal of end of life sustaining treatment must be referred to the Consent and Capacity Board ("the Board"), and that pending the Board's decision, Mr. Rasouli's physicians are not permitted to withdraw mechanical ventilation and transfer Mr. Rasouli to palliative care.

The physicians responsible for Mr. Rasouli's care and treatment appealed the decision on the basis that a proper interpretation of "treatment" under the *Health Care Consent Act* does not include the withholding or withdrawal of treatment that had no medical value to the patient. By the time this matter came before the Ontario Court of Appeal in May 2011, Mr. Rasouli had already been sustained by a mechanical ventilator and G-tube for 7 months, despite the position of his physicians that these measures were futile or harmful.

## **The Court of Appeal decision**

The Court of Appeal upheld the application judge, and held that the plan of care that the appellants wished to implement constitutes treatment under the *Health Care Consent Act*, and thus required

consent. However, Moldaver, Simmons, and Doherty J.J.A., reasoned differently from Justice Himel. Their reasoning significantly narrows the application of their holding, but arguably not enough.

Whereas the application judge reviewed the jurisprudence in this area, the Court of Appeal justices side-stepped the common law and held that in their view, “the Act provides a complete answer” (para. 36)<sup>1</sup>. It seems like a bold move to base the decision solely on the interpretation of the ambiguous provisions and circular definitions in the *Health Care Consent Act*—nevertheless, that was the court’s focus, and it will be the focus of this presentation as well.

### **The relevant provisions of the *Health Care Consent Act***

Pursuant to the Act, a physician cannot administer **treatment** without obtaining the consent of the capable patient, or, where the patient is incapable of consent to treatment, without obtaining the consent of that person’s substitute decision maker (s. 10).

A substitute decision maker must make treatment decisions in accordance with the prior wishes of the incapable person made when that person was at least 16 years old. If they do not know or cannot comply with that person’s wish, they must make the decision in accordance with the incapable person’s best interests. The best wishes take into consideration the person’s values, wishes, and whether the treatment will improve the person’s condition and do more good than harm (s. 21).

Where consent to a proposed treatment is not forthcoming, and the proposing physician is not satisfied that the substitute decision maker has complied with his or her obligation under s. 21 of the Act, the physician may refer the matter to the Consent and Capacity Board to determine whether the substitute decision maker complied with their statutory obligations (s. 37).

Under the Act, “**treatment**” is defined anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a ... **plan of treatment** ... .” (s. 2).

“**Plan of treatment**” is then defined as a plan that, (a) is developed by one or more health practitioners; (b) deals with one or more health problems that a person has [or] is likely to have; and (c) may... provide for the withholding or withdrawal of treatment in light of the person’s current health condition.

### **Interpretation of the provisions of the *Health Care Consent Act***

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<sup>1</sup> For a discussion of the Canadian common law in this area, see *Rasouli v. Health Sciences Centre and Cuthbertson*, 2011 ONCA 1500 (S.C.) at paras. 21-23, 71-83. For prior decisions of the Consent and Capacity Board in this area, see para. 50.

The application judge found that “treatment” includes the withdrawal of life support. She reasoned that the goal of life support is to “prevent suffering and premature death” and treat “reversible illness.” These purposes fall within the definition of “treatment” under the Act, which includes anything done for a “preventative” or “therapeutic” purpose (*Rasouli v. Health Sciences Centre and Cuthbertson*, 2011 ONCA 1500 (S.C.) at paras. 16-20, 30-33; reviewed on appeal at paras. 24-27).

As the courts in this proceeding noted, the definitions of “treatment” and “plan of treatment” are circular. The definition of “treatment” includes “plan of treatment”, and thereby includes the “withholding or withdrawal of treatment.” The “treatment” being withheld or withdrawn must meet the criteria of being done for a “therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose.”

In appealing her decision, the appellant physicians argued that whereas in some circumstances life support measures *can* serve a therapeutic or preventative purpose, in the case of Mr. Rasouli, the life support measures are of no medical benefit and may lead to harmful side effects. In his case, because the life support measures served no purpose, they were not treatment.

On one hand, the Court of Appeal justices stated that it was unnecessary for them to finally decide whether treatment is defined as treatment that a treating physician opines has some medical value. However, in the same breath, they stated at para. 41:

[W]e have difficulty accepting that the legislature intended to include within the definition of treatment measures that attending physicians consider to be of no medical value and therefore worthless. More to the point, if the legislature intended that consent was required to the withholding or withdrawal of life support measures that are considered to be medically ineffective or inappropriate, we would have expected clearer language to that effect. ...

The respondents’ posited that the life support measures could be of medical value, because the doctors may be wrong in their diagnosis; they submitted that life support measures are keeping Mr. Rasouli alive, and he is entitled to remain alive until his wife feels that there is no hope for his recovery.

Rather than decide whether Mr. Rasouli’s life support was treatment, the court stated as follows (para. 46):

[W]e need not resolve the metaphysical debate over whether life saving measures in cases such as the respondent’s are of no medical value because they are futile, or of high medical value because they are keeping him alive while his family continues to hold out hope for his recovery. For present purposes, we are prepared to accept that the Act does not require doctors to obtain consent from a patient or substitute decision-maker to withhold or withdraw “treatment” that they view as medically ineffective or inappropriate.

Despite the court's acceptance (if not decision) that physicians are not required to obtain consent for treatment they view as medically ineffective or inappropriate, the court appeal found that the appellants' proposal to remove Mr. Rasouli from a ventilator and place him on a program of palliative care constitutes treatment under the Act. However, in contrast to the application judge's reasoning, the Court of Appeal did not base its conclusion on a finding that the withdrawal of life support is treatment under the Act. Rather, the court based its conclusion on its finding that 1) the administration of palliative care which they deemed in paragraph 48 as "end-of-life care provided to a patient to keep the patient comfortable pending his or her imminent death, upon removal of a life-sustaining mechanical ventilator." constitutes treatment under the act; and 2) the removal of the ventilator is a pre-condition to and integrally linked with the administration of palliative care. In circumstances such as Mr. Rasouli's, where palliative care is recommended as an adjunct to the withdrawal of life support, the withdrawal of life support and the administration of palliative care are a "treatment package" for purposes of the Act, and this treatment package cannot be provided without consent (paras. 47-52).

The Court further held that if Ms. Salasel's consent was not forthcoming, the appellants' proposal must be referred to the Consent and Capacity Board (paras. 58-62, 65). If the Board finds that Mr. Rasouli expressed a prior wish to be sustained on life support, the physicians cannot withdraw this support, even if the support is medically futile. However, where the Board finds that no prior wish has been expressed, the Board has the jurisdiction to determine whether the proposed treatment is in his best interests.

***Obiter*: No consent required to withhold medically futile treatment**

Just as critical as what the court held about Mr. Rasouli is the discussion in *obiter* about situations unlike Mr. Rasouli's. The court distinguished Mr. Rasouli's situation from circumstances where there is a temporal gap between 1) withdrawing treatment that physicians deem medically futile or inappropriate, and 2) the patient's death and requirement for end-of-life palliative care. In such circumstances, the court suggested that physicians can withhold or withdraw medically futile treatment without obtaining the patient's consent. They gave the example of discontinuing chemotherapy treatment that physicians have determined is ineffective and that will result in death in a week, a month, or six months. Because death is not immediate, ending the chemotherapy treatment does not trigger the requirement for a particular form of palliative care and does not require consent (paras. 53).

Further, the court accepted that patients cannot demand treatment that their doctors consider medically futile. Similarly, physicians can withhold from the outset life-support that they consider of no medical

value. Withholding life support, unlike withdrawing life support, is not integrally linked with end of life palliative care, and therefore does not require consent (paras. 54 - 56).

## **Analysis**

There is some logic to these distinctions. Where the physician withholds life support from a dying patient, the patient's death is caused by the patient's medical condition. Similarly, where chemotherapy is no longer effective for a dying patient, and chemotherapy is medically futile, their death is not being triggered by the cessation of the therapy (presumably if the therapy was sustaining their life, the therapy would not be futile). Rather, their death is caused by their disease. However, where a mechanical ventilator is sustaining the person's life, removing the ventilator will trigger the person's death, and, in cases such as Mr. Rasouli's, the need for palliative care.

The decision that a physician requires consent to withdraw treatment that will result in the need for palliative care is not consistent with the court's acceptance that physicians are not obligated, or ought not to be obligated, to provide or continue with a treatment that is medically futile. (It also appears to contradict the court's opinion, above, that (para. 41): "[I]f the legislature intended that consent was required to the withholding or withdrawal of life support measures that are considered to be medically ineffective or inappropriate, we would have expected clearer language to that effect.") Further, it is incongruous with the definition of "treatment" as done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose.

Although the withdrawal of Mr. Rasouli's ventilator will result in palliative care being medically indicated, the appellants did not propose withdrawing the ventilator in order to provide Mr. Rasouli palliative care. Rather, they proposed withdrawing the ventilator in order to end an artificially sustained life. In my view, the provision of the ventilator is in and of itself not "treatment" and its withdrawal should not fall under the ambit of the Act. Tacking the withdrawal of life support to palliative care as a "treatment package" may be to be a results-oriented means for the court to absolve itself of the responsibility to decide that the withdrawal of life-support is not treatment, and thereby avoid confronting the complex social, political, religious, moral, and conscientious issues the accompany such a decision. Although the court may think that this is a matter better left to the legislature, it is then curious for the court to advise that "the Act provides a complete answer". Clearly, both the Act and the court's decision leave us with many questions.

(An additional issue, which was likely not dealt with because the appeal did not address fiscal concerns, is that continuing to provide life support where medically unnecessary as an insured service

is inconsistent with the *Health Insurance Act*. A substitute decision maker should not be making the call of whether the hospital/physician ought to keep on providing futile treatment.)

## Recap

Some of the salient points that come out of *Rasouli* are:

- The legislature has not signaled an intention to require consent to the withholding or withdrawal of life support measures that are considered to be medically ineffective or inappropriate (*obiter*, para. 41)
- The court accepts that physicians can withhold life support that they believe is medically futile without consent (*obiter*);
- Physicians can withdraw treatment that they believe is medically futile without consent, so long as there is a temporal gap between withdrawing the treatment and administering palliative care (*obiter*) (paras. 53-56);
- Presumably, physicians can withdraw life support without consent, if the withdrawal does not result in a requirement to provide end-of life palliative care;
- On the other hand, where withdrawing medically futile treatment kick-starts the requirement for palliative care, physicians require consent to withdraw treatment;
  - If consent for the latter is not forthcoming, the physician can apply to the Consent and Capacity Board to make a determination of whether the substitute decision maker has complied with his or her obligations under the Act.
  - If the Board finds that the incapable person expressed a prior wish to be sustained on life support, the physician cannot withdraw this support, even if the support is medically futile;
  - However, where the Board finds that no prior wish has been expressed, the Board has the jurisdiction to determine whether or not the proposed treatment is in the incapable person's best interests (paras. 58-62) (For example, where the incapable person is an infant, who will not have expressed former wishes, the Board's determination of whether the treatment is in the best interest the patient will likely turn on a decision of the

treatment's medical efficacy, such as in *E.J.G. (Re)*, 2007 CanLII 44704 (ON CCB), a case referred to in the application decision).

**If the decision was mine to make!**

Perhaps a more logical and principled approach that is consistent with the definition of "treatment" would be to hold that where the cessation of medically futile treatment results in palliative care being medically indicated, the physician does not require the consent to withdraw treatment, but does require consent to provide palliative care. The physician can advise the substitute decision maker that she intends to withdraw treatment because it is medically futile, and that as a result, palliative care is indicated. In the unlikely event that the substitute decision maker refuses the provision of palliative care, the physician can challenge that refusal to the Consent and Capacity Board. It is less likely that the incapable person will have expressed end of life wishes respecting the refusal of palliative care than that they have expressed wishes regarding life support. Where wishes have not been expressed, the Board will then be adjudicating whether the substitute decision maker's refusal to consent to the provision of palliative care is in accordance with the patient's best interests. This task seems more appropriate than saddling the Board (made up of the general public, lawyers, and psychiatrists) with determining the medical and "metaphysical" issues of whether withdrawing life support is in a person's best interests.

**Some additional eyebrow raising quotes from *Rasouli* (Does audience agree?):**

[57] Patients need not fear that this distinction between withholding life support measures from the outset and withdrawing them after they have been put in place will cause doctors to choose the former over the latter. Doctors must act in their patients' best interests, and if they fall below the requisite standard of care in withholding treatment from the outset, they can be held accountable.

[64] We do not believe that by interpreting palliative care to include the withdrawal of life support measures, the floodgates will open and intensive care units will be deluged with patients who have no chance of improvement but who require life-sustaining measures to survive. If that proves to be the case, then the legislature can, and no doubt will review the situation.

**Appendix: Select provisions of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A**

2. (1) In this Act,

“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”)

“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).

### **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).

### **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).

**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

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