

Rasouli v Sunnybrook Health Services Centre: End of Life matters reach the Supreme Court of Canada

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Cases Considered:

Rasouli v Sunnybrook Health Services Centre: [2011 ONCA 482](#)

This case involves the issue of consent under Ontario's *Health Care Consent Act*, 1996, SO, 1996 c 2, Schedule "A" (the "Act"). While no similar law exists in Alberta, the case, for its discussion over the continued conflict between the parties of doctors' ability to determine treatment, and the patient's ability to refuse, is an issue that extends beyond the legislative boundaries of Ontario.

Background

On Oct 7, 2010 Mr. Rasouli ("Rasouli") underwent surgery at the Sunnybrook Health Sciences Centre in Toronto (the "Hospital") to remove a benign brain tumor. There were post-operative complications and Rasouli developed bacterial meningitis. The infection spread to and through his brain, leaving him with severe brain damage.

On October 16, 2010 Rasouli was placed on a mechanical ventilator. He is fed through a tube in his stomach. Without these life sustaining measures he would likely die.

Two doctors that treated Rasouli; Cuthbertson and Rubinfeld, are the appellants. They and other doctors who have examined Rasouli agree that Rasouli is in a persistent vegetative state (PVS), which means he will never regain consciousness. At paragraph [4] "...All appropriate treatments have been exhausted, there is no realistic hope of medical recovery, and the respondent is not receiving any medical benefit from being kept on life support."

The appellants acknowledge they require the consent of Ms. Salasel, Rasouli's wife and substitute decision maker (SDM) to administer palliative care, but it is their position that they do not require her consent to withdraw the life-sustaining measures as those measures are not "medically indicated."

Ms. Salasel disagrees with the prognosis and believes that there is hope. She and the family believe that Rasouli is aware of his surroundings. She maintains that her consent is required to withdraw treatment. If the doctors do not wish to follow her wishes they should apply to the Consent and Capacity Board (the "Board") established under the Act, who will decide the appropriate course of action.

The parties turned to the Courts for assistance.

Ms. Salasel sought an order that:

- 1) the doctors be restrained from withdrawing life support.
- 2) the treatment proposal (withdrawal) be referred to the Board for decision.

Drs. Cuthbertson and Rubinfeld cross-applied and sought a declaration that:

- 1) Mr. Rasouli is in a persistent vegetative state
- 2) they can withdraw / withhold further treatments.
- 3) no consent is required under the OHCCA to proceed with the treatment plan.
- 4) the Board has no jurisdiction to decide whether they can proceed with the treatment plan.

The matter was initially heard before Himel, J. at the Superior Court of Justice of Ontario in February/March of 2011. As cited by the Court of Appeal;

[10] The application judge dealt with Ms. Salasel's application and the appellants' cross-application in two separate orders. For present purposes, the key provisions of both orders are the same and read as follows:

1. THIS COURT ORDERS THAT the proposal of the respondent physicians [the appellants] to end life sustaining treatment to the applicant [the respondent] must be referred to the Consent and Capacity Board.
2. THIS COURT ORDERS THAT pending the decision of the Consent and Capacity Board, the respondent physicians are not permitted to withdraw mechanical ventilation and transfer the applicant to palliative care.

The Doctors appealed that ruling.

Positions

The doctors contend that the requirement to obtain consent before withdrawing treatment considered to be of no medical value is counter to the doctor patient relationship. While a patient may refuse treatment, they cannot require a doctor to treat in cases where the doctor regards the treatment as inappropriate or ineffective. They acknowledge that they cannot withdraw or withhold treatment indiscriminately, and that they must act in the best interest of the patient, and certainly not below the requisite standard of care, however, that treatment does not include treatment by a physician that the doctor believes is not medically indicated. The lower court decision, if allowed to stand, would have serious consequences for the medical profession and the health care system.

The doctors acknowledge that they require the consent of Ms. Salasel to provide palliative care to Rasouli. Ms. Salasel believes that "where there is life, there is hope" (para 6) and she and her family do not accept the prognosis given. She maintains her consent is required for the removal of life support and the placement into palliative care. If they disagree, their recourse is to apply to the Consent and Capacity Board ("Board") under the Act.

The Court reviewed the relevant statutory provisions of the Act (para 19). In particular the definition of “plan of treatment” is critical at section 2;

The Court reviewed the relevant statutory provisions of the Act (para 19). In particular the definition of “plan of treatment” was found critical at section 2;

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;

“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.

(2) A reference in this Act to refusal of consent includes withdrawal of consent.

As were the principles under which refusal or consent to treatment is given; under section 21:

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.

(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.

The Board is established under section 37 of the Act. Ms. Salasel admitted that section 21(1)2 was applicable in this case.

Finding

The Court of Appeal agreed with the lower Court's finding that the definition of "treatment" under the Act includes "plan of treatment." Plan of treatment is defined in section 2(1) and is outlined above. On a plain reading of this text the ordinary meaning is that withholding or withdrawing treatment in accordance with a patient's health condition is included in a plan of treatment (para 28).

At paragraph [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.

In the final assessment, the Court found that the SDM must provide consent to treatment. If that is not forthcoming the recourse for the doctors is to go before the Board. The Court of Appeal unanimously upheld the decision of the Superior Court and dismissed the appeal.

Undeterred, the doctors applied for leave to appeal to the Supreme Court, and on December 22, 2011, the Supreme Court of Canada granted leave to appeal to the doctors of Mr. Rasouli (see [*Brian Cuthbertson and Gordon Rubinfeld v. Hassan Rasouli by his Litigation Guardian and Substitute Decision Maker, Parichehr Salasel*](#), 2011). It remains to be seen whether the Supreme Court will look beyond the applicable legislation, to the question of doctors' discretion, patients' rights and interests, and allocation of resources in the health care system. Some suggest it could provide guidance in end of life cases fraught with uncertainty.

An interesting omission

Prior to the Court of Appeal decision, at the Superior Court (*Rasouli v Sunnybrook Health Sciences Centre*, 2011 ONSC 1500), the hospital spoke to the use of limited resources being allocated to patients with no chance of recovery who are kept alive for extended periods. The Court of Appeal noted that "significantly" the appellants do not pursue a line of argument involving resources. The Court of Appeal analyzed the issue without consideration of cost based on the position of the appellant that "the issue of resources played no part in the appellant's submission, nor did it influence their decision to pursue this appeal" (para 33).

That the economics of the situation are not put forward by the physicians is a curious omission. One could speculate that the physicians sought a declaration concerning their absolute autonomy to determine treatment, not otherwise impeded by cost. A discussion of costs gives rise to arguments of the value of a life, and the very large issue of allocation of finite resources, which

would cloud the matter before the court. Yet, without a discussion of the economics of the extended treatment, the argument is not fully made. If resources were unlimited and a patient desired to be kept alive by whatever means possible, the doctor could oblige; but this is not the case.

It is said that the cost of acute care within a hospital is \$1250-1600/per bed/per day, and for a hospice or out of hospital care, \$100/day (16:9, CTV, Hospital Heartbreak, aired December 31, 2011, as provided by Senator Sharon Carstairs), a striking difference. If a patient were to live for one year in a hospital in acute care the cost is \$456,250. A *Globe and Mail* article on November 29, 2011, *How Much Does Dying Cost Canadians*, indicated that research by Konrad Fassbender, Associate Professor at the University of Alberta's oncology department, put the cost to health care for organ failure at the end of life at \$39,947, terminal illness at \$36,652, frailty at \$31,881, and sudden death at \$10,223. The article admits that the health care system does not often account for the cost of care for end of life procedures, and that data is often lacking. In the case at hand, with life support efforts ongoing since October 2010, it is difficult to fathom that costs play no part in treatment plan decisions.

In Alberta

While Alberta has no legislation governing consent of substitute decision makers and the consent or refusal to a plan of treatment, the *Personal Directives Act* (RSA 2000, c P-6) does provide some guidance on the matter, in particular section 19(1) which states "If a service provider intends to provide personal services with respect to a personal matter to a maker who lacks capacity and a personal directive is in effect, the service provider must

- (a) if the personal directive designates an agent, follow any clear instructions of the agent that are relevant, or
- (b) if the personal directive does not designate an agent or if the agent designated is unable or unwilling to make a personal decision or cannot be contacted after every reasonable effort has been made, follow any clear instructions in the personal directive that are relevant to the decision to be made.

A recent case in Alberta to consider this section was *Sweiss v Alberta Health Services*, 2009 ABQB 691. The patient, in a PVS, had provided instructions provide in a signed declaration that Sharia Law be followed, his family wished to continue life support until death occurred naturally. The Court looked to the *Personal Directives Act*, which could not fully inform the Court, as the declaration did not meet the test for a personal directive. It was the common law that guided its decision regarding the request for an injunction to stop the hospital from withdrawing life support from Mr. Sweiss.

While the applicant sought an injunction under the principles of *RJR MacDonald...*, the Court rejected the approach per the reasoning in *Re: J (Re J. (A Minor) (A Wardship: Medical Treatment)*, [1992] 3 WLR 507 (CA)), and proposed:

[63] In my opinion, the proper test to be applied in this type of case in what is in the patient's best interest. This inquiry requires that several matters be considered and weighed. Some of the pertinent considerations include: (i) the medical condition of the patient; (ii) the recommended medical treatment, including doing something, nothing or very little; (iii) the wishes and beliefs of the patient, if they are known; and (iv) what is just and equitable in all of the

circumstances of the case. This list does not exhaust the factors which may be considered in such applications, but rather reflects some of the issues to be considered in determining what is in a patient's best interest. In addition, I wish to emphasize that no factor should be considered paramount and all considerations ought to receive equal weight.

And in conclusion:

[72] I am of the opinion that the proper test to be applied in determining whether an injunction should be granted in these types of applications is what is in the patient's best interest. In coming to this conclusion, I adopted the reasoning set out in *Re J.* that the three-part test contained in *R.J.R. MacDonald* is not appropriate for this type of application. However, I wish to highlight that I do not agree with the idea that the overriding consideration ought to be what treatment is being recommended by physicians.

...

[74] Although I have held that no one factor should be treated as paramount, this conclusion may not apply where a valid personal directive exists which runs contrary to the proposed medical treatment program. In cases where a personal directive is found to exist, it would appear that, pursuant to the authority in the Personal Directives Act, the wishes, beliefs and values of the patient "must" be followed.

A temporary injunction was granted, and the parties eventually resolved the matter. Mr. Sweiss passed away prior to the issuance of the decision.

A more recent case, *May v Alberta Health Services*, 2010 ABQB 213, faced a similar situation on a different set of facts, and as the patient was an infant, no personal directive could exist. Further, the issue was a matter of procedure. *Sweiss* was considered and applied, with the Court maintaining that "I agree with Ouellette J. in *Sweiss* (at para 63) that medical opinions are one of several factors to be considered in determining what is in the patient's best interests. No one factor is necessarily determinative on its own" (para 26).

There appears to be some desire for balance between the professional autonomy of a physician, a patient's best interests and the patient's wishes and beliefs. From a practical perspective, in most cases, where a patient is close to the end of life, the parties would work collaboratively to ensure a dignified and comfortable end that affords with the wishes and beliefs of the patient. That these cases are so rare is tribute to that reality. However, the common sense of the parties could be overshadowed by the confusion between statute and policy.

A review of the current [Alberta Health Services regional policy on Advance Care Planning: Goals of Care Designation \(Inc. Resuscitation\) – Adult](#) (accessed January 9, 2012), provides a startling pronouncement:

4.4 Where the provisions of a Personal Directive or a Patient gives clear and relevant instructions requesting interventions that Certainly will not Benefit, those interventions are not provided. (emphasis original)

But as outlined in the [Calgary Health Region, Personal Directive Policy guidelines, #1407](#) (retrieved on January 9, 2012):

4.DUTY TO COMPLY WITH PERSONAL DIRECTIVES
Calgary Health Region staff shall comply with the wishes of patients/clients regarding their care and treatment as specified in a Personal Directive, or at the request of an authorized Agent, unless the provision of such services is deemed to be unwarranted or illegal. Calgary Health Region shall not require the existence of a Personal Directive as a pre-condition to receiving care.

The use of the terms “Certainly will not benefit” and “unwarranted” are not defined, and are unclear. The acknowledgement that the staff shall comply with a Personal Directive is not an absolute without knowing who determines what benefits, and what is unwarranted.

It would be a significant development for the Supreme Court to provide clarity and guidance on end of life conflicts between doctors and patients that will become more common as the population ages.