The Future of Medical Futility in Ontario

by

Catherine Elizabeth Jane Deans

A thesis submitted in conformity with the requirements for the degree of Master of Laws
Faculty of Law
University of Toronto

© Copyright by Catherine Deans 2014
The Future of Medical Futility in Ontario

Catherine Elizabeth Jane Deans

Master of Laws
Faculty of Law
University of Toronto
2014

Abstract

Medical futility is a topic plagued by controversy. The medico-legal community has long debated the definition of medical futility and whether the concept, however defined, can be used by physicians to justify withholding or withdrawing treatment. In Ontario, the present dominance of patient autonomy in healthcare ethics suggests medical futility has no place in treatment decision-making. In Cuthbertson v Rasouli, the Supreme Court was tasked with deciding whether physicians have unilateral authority to withhold or withdraw futile treatment from an incapacitated patient. The Court concluded that consent must be obtained to withdraw life-sustaining treatment from Mr Rasouli, but in other situations physicians may have unilateral authority to withhold or withdraw treatment. The Supreme Court’s confused and convoluted findings suggest that reform of Ontario’s Health Care Consent Act is necessary to recognize medical futility in a manner that is clear, meaningful and considerate of the views of both patients and physicians.
Acknowledgments

Thank-you:

to my supervisor Colleen Flood for your invaluable guidance and expertise;
to the Canadian Institute of Health Research’s Training Program in Health Law, Ethics and Policy, for all your financial and academic support;
to my family, for your continual love and support, even from afar;
to my grandmothers, for always keeping in touch;
and to Ben, for taking the plunge and coming on this adventure with me.
# Table of Contents

Acknowledgments ........................................................................................................ iii
Abbreviations .................................................................................................................. vii

**INTRODUCTION** ........................................................................................................... 1

**CHAPTER ONE - MEDICAL FUTILITY** ...................................................................... 6

Introduction ...................................................................................................................... 6

1 The Problem of Medical Futility in Canada’s Healthcare System ......................... 7
   1.1 Impact on the patient ................................................................. 7
   1.2 Impact on public healthcare expenditure ..................................... 10
   1.3 Impact on the medical profession .............................................. 13
   1.4 Impact on society ................................................................. 17

2 What is Fueling Futile Treatment? ........................................................................... 19
   2.1 The technologic imperative ....................................................... 19
   2.2 Reimbursement model for services provided by physicians ........... 21
   2.3 The therapeutic illusion and patients’ values .............................. 22
   2.4 Defensive medicine ................................................................. 23
   2.5 Alternate levels of care ............................................................... 25
   2.6 Summary: futility-drivers ......................................................... 26

3 What is Futile Treatment? ......................................................................................... 28
   3.1 Physiological futility ................................................................. 28
   3.2 Goal-driven futility ................................................................. 29
   3.3 Quantitative futility ............................................................... 29
   3.4 Qualitative futility ................................................................. 32
   3.5 An integrated definition ............................................................ 35

4 Futility and the Physician ......................................................................................... 35
   4.1 Physicians are not always right ............................................... 36
   4.2 Reviving medical paternalism .................................................. 38
   4.3 Masking discrimination ............................................................... 39

Evaluation ...................................................................................................................... 40

**CHAPTER TWO - PERSONAL AUTONOMY** ............................................................ 42

Introduction ...................................................................................................................... 42

1 What is Personal Autonomy? ...................................................................................... 44
   1.1 The basics ....................................................................................... 44
   1.2 The value of personal autonomy ...................................................... 45
   1.3 The legal foundations of personal autonomy ................................. 48
       1.3.1 Human dignity ........................................................................ 48
       1.3.2 The right to self-determination and informed consent ............ 50
       1.3.3 Canadian Charter of Rights and Freedoms ........................... 53

2 The Right to Receive All or Any Treatment .............................................................. 56
   2.1 Limitations of personal autonomy ................................................ 59
       2.1.1 Optimal resource allocation .................................................. 59
       2.1.2 Integrity of the medical profession ....................................... 61
       2.1.3 The doctor/patient relationship ............................................ 62
       2.1.4 A physician’s right to freedom of conscience ....................... 63
2.2 Summary: a communitarian approach to personal autonomy ........................................ 66
3 Does Personal Autonomy Survive Incapacity? ................................................................. 68
  3.1 Prior known wishes ........................................................................................................ 69
  3.2 Substitute decision-making .......................................................................................... 71
    3.2.1 The role of a SDM ................................................................................................. 71
    3.2.2 Limits of a SDM ..................................................................................................... 73
Evaluation ............................................................................................................................ 76
CHAPTER THREE - MEDICAL FUTILITY & THE COMMON LAW .................................... 79
Introduction .......................................................................................................................... 79
1 The Unsettled Common Law ............................................................................................. 81
2 Is Medical Futility Considered in the ‘Best Interests’ Test? ........................................... 86
3 Do Physicians have Unilateral Authority to Withhold or Withdraw Treatment? ............. 89
  3.1 Touching vs non-touching dichotomy .......................................................................... 90
  3.2 The role of physicians .................................................................................................. 93
  3.3 The role of the Court ................................................................................................... 95
  3.4 Summary: Physicians’ Unilateral Authority ................................................................. 97
4 Medical Futility in the UK ............................................................................................... 98
  4.1 UK Common law .......................................................................................................... 98
  4.2 Mental Capacity Act 2005 .......................................................................................... 101
  4.3 Contrast between UK and Canadian common law ....................................................... 105
  4.4 Why the difference? ..................................................................................................... 107
  4.5 Is the UK approach preferable? ................................................................................... 110
Evaluation ............................................................................................................................ 112
CHAPTER FOUR - THE RASOULI IMPASSE .................................................................... 118
Introduction .......................................................................................................................... 113
1 The HCCA ........................................................................................................................ 114
  1.1 The meaning of treatment ......................................................................................... 114
  1.2 Incapacitated patients ............................................................................................... 115
  1.3 Challenging the SDM .................................................................................................. 116
2 Rasouli - The Facts ............................................................................................................ 117
3 Decision of the Majority .................................................................................................... 119
4 Decision of the Minority .................................................................................................... 123
5 Impact of Rasouli SCC ..................................................................................................... 126
  5.1 The futility debate is not resolved by the HCCA ......................................................... 126
  5.2 The grey area of medical futility ................................................................................ 128
    5.2.1 Are SDMs required to consider medical futility? ................................................... 128
    5.2.2 Do physicians have unilateral authority to withdraw futile treatment? ................. 129
    5.2.3 What about withholding treatment? ........................................................................ 131
    5.2.4 The minority’s view on medical futility ................................................................. 133
    5.2.5 Summary: medical futility ................................................................................... 134
  5.3 The enduring dominance of personal autonomy ......................................................... 134
    5.3.1 What is personal autonomy? .................................................................................. 134
    5.3.2 How far does the scope of personal autonomy extend? ........................................ 136
# Abbreviations

<table>
<thead>
<tr>
<th>Abbr.</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALC</td>
<td>Alternate Level of Care stays</td>
</tr>
<tr>
<td>CCB</td>
<td>Consent and Capacity Board</td>
</tr>
<tr>
<td>CHA</td>
<td>Canadian Health Act 1984</td>
</tr>
<tr>
<td>CIHI</td>
<td>Canadian Information for Health Information</td>
</tr>
<tr>
<td>CMA</td>
<td>Canadian Medical Association</td>
</tr>
<tr>
<td>CMPA</td>
<td>Canadian Medical Protective Association</td>
</tr>
<tr>
<td>CPR</td>
<td>Cardiopulmonary Resuscitation</td>
</tr>
<tr>
<td>CPSO</td>
<td>College of Physicians and Surgeons of Ontario</td>
</tr>
<tr>
<td>HCCA</td>
<td>Health Care Consent Act 1996</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>MCA</td>
<td>Mental Capacity Act 2005 (UK)</td>
</tr>
<tr>
<td>PVS</td>
<td>Permanent Vegetative State</td>
</tr>
<tr>
<td>SPPA</td>
<td>Statutory Powers Procedures Act 1971</td>
</tr>
<tr>
<td>SDM</td>
<td>Substitute Decision-Maker</td>
</tr>
<tr>
<td>TDB</td>
<td>Treatment Disputes Board</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>US</td>
<td>United States of America</td>
</tr>
<tr>
<td>WMA</td>
<td>World Medical Association</td>
</tr>
</tbody>
</table>
Introduction

Is there a future for medical futility in Ontario’s law? Routinely, incapacitated patients, unable to speak for themselves, are being prescribed aggressive and expensive life-sustaining treatment. These procedures often fail to cure or ameliorate the patient’s condition; rather, they sustain biological functions while the patient’s body breaks down and dignity wastes away. Has the time come, then, for society to condemn the administration of medical treatment in inappropriate - and sometimes grossly inappropriate - situations? This query is not simply legal in nature; it is a moral and an emotional inquiry. In an age where a miracle cure is not a matter of divine intervention, but possible through rapid scientific advancements, is it cruel for society to deprive a patient of medical attention? Even if it is not, how do we translate the ends of medicine into legal verse?

The medical futility debate is “fraught with confusion, inconsistency, and controversy.”

Futility disputes broadly, disagreements about whether the patient will benefit from further treatment - are increasing in numbers in the end-of-life context involving incapacitated patients. Traditionally, physicians have used the term ‘medically futile’ to justify withholding or withdrawing clinically ineffective treatment. The term is appealing in the medical profession as it grants physicians authority to define the ends of medicine according to strict clinical criteria.

At the same time, the term ‘medically futile’ frequently causes alarm in patients and their loved ones that death is inevitable and the medical profession is soon to abandon them. This fear is heightened in the Canadian context where patients have no option to access treatment outside the public healthcare system. It is therefore unsurprising that there is fierce resistance to the notion of medical futility, with some arguing that an incapacitated patient’s substitute decision-maker (SDM) should have the final authority to decide whether life-sustaining

---


3 Paula Chidwick, Robert Sibbald & Laura Hawryluck, "Best interests at end of life: an updated review of decisions made by the Consent and Capacity Board of Ontario (2013) 28 J Critical Care 22 (end-of-life disagreements brought before the Consent and Capacity Board have risen from 2 per year between 2003 and 2008 to 5 per year between 2009 and 2012, at 23).
treatment is in the patient’s best interests.\textsuperscript{4} Indeed, some commentators have argued the term ‘futile’ should be expunged from the bioethics arena because its provocative nature discourages amicable and constructive decision-making.\textsuperscript{5}

In Ontario, there is no explicit legislative regime for resolving futility disputes. The Health Care Consent Act 1996 (\textbf{HCCA}) directs that a SDM is entitled to give or refuse consent to a proposed treatment on behalf of an incapacitated patient based on the patient’s prior known wishes or, absent such wishes, the patient’s best interests.\textsuperscript{6} It is unclear, however, whether an SDM has authority to consent to the withholding or withdrawal of medical care that the treating physician believes is futile. This uncertainty was brought to the attention of Canada’s Supreme Court in \textit{Cuthbertson v Rasouli}.\textsuperscript{7} The Supreme Court’s decision marked the end of a three-year court battle in which the wife and SDM of a patient, Mr Rasouli, sought a court order restraining Mr Rasouli’s treating physicians from withdrawing his life-sustaining treatment. In a split decision (5-2) the Court reasoned that under the HCCA a physician must obtain the consent of a SDM before withdrawing life-support. Any disagreement about whether consent was appropriately given or refused could be resolved by a hearing before Ontario’s Consent and Capacity Board (\textbf{CCB}). While the decision has been championed by patient rights advocates, it has been equally lamented by the medical profession, which argues that the decision compels health practitioners to indefinitely prescribe futile and potentially harmful treatment in conflict with their ethical and professional obligations and at a great expense to the public healthcare purse.

In \textbf{Chapter One}, I will unpack the debate surrounding medical futility occurring in Ontario and throughout Canada. I will show that futile treatment can have a negative impact on patients, the medical profession, the healthcare budget and the availability of healthcare resources. However, five factors influence the healthcare system in a way that motivates

\begin{itemize}
  \item \textsuperscript{4} Jocelyn Downie, "Unilateral Withholding and Withdrawal of Potentially Life-sustaining Treatment: A Violation of Dignity Under the law in Canada" (2004) 20 Journal Palliative Care 143 (if a physician wants to withhold or withdraw treatment against the wishes of a SDM then she must seek a court order to that effect. Absent such an order the SDM’s decision stands, at 148-149).
  \item \textsuperscript{6} \textit{Health Care Consent Act}, 1996, SO c 2, Sched A, ss 20-21.
  \item \textsuperscript{7} \textit{Cuthbertson v Rasouli}, 2013 SCC 53, [2013] 3 SCR 341.
\end{itemize}
physicians to supply futile treatment and encourages patients, or their SDMs, to demand it. Hence, in my view, legal intervention is necessary to stymy the proliferation of futile treatment in Canada’s healthcare system. The development of a legal standard of medical futility is complicated, however, because it is such a value-laden concept; whether a particular treatment is futile will rest on the beliefs and values of the decision-maker. Therefore, drawing on aspects of four commonly-cited definitions of medical futility, I will propose a legal definition of medical futility which encapsulates both the values of patients and those of the medical profession. Finally, I will discuss why medical futility should be uprooted from its traditional foundations. I will demonstrate that physician-driven futility - futility based on clinical criteria and medical values - increases the risk of an adverse medical event, promotes medical paternalism and allows for discriminatory medical practices.

The law has resisted formally recognizing medical futility chiefly due to the concept of personal autonomy, which is currently recognized as the dominant principle in medical decision-making. Personal autonomy protects a patient’s right to make reasoned decisions based on personal values, beliefs and wishes. The principle is strongly rooted in human rights norms - including human dignity, the right to self-determination, and the doctrine of informed consent - which serve to protect patients from perverse or overly paternalistic medical practice. In this sense, a patient’s autonomous desire to continue treatment may override concerns that further treatment is futile. However, I will argue in Chapter Two that personal autonomy should not enjoy unrestrained dominance in the healthcare context. Rather, I suggest, a communitarian approach to personal autonomy is preferable, whereby a patient’s autonomy is measured against other relevant and material interests such as the fiscal well being of the healthcare system, resource allocation issues, and the ethical and professional obligations of health practitioners. Crucially, I argue that personal autonomy cannot be understood in a way that creates an entitlement to receive futile treatment within the public healthcare system.

The Canadian common law prior to Rasouli SCC serves to illuminate, but not resolve, the tension between medical futility and personal autonomy. The futility debate at common law asks two questions: first, does medical futility justify treatment being withheld or withdrawn? Second, do physicians have unilateral authority to determine when treatment is futile such that it should be withheld or withdrawn? My review of the Canadian common law in Chapter Three reveals a piecemeal line of cases regarding the futility debate. Generally, the
courts have elevated the values, beliefs and wishes of the patient above concerns about the ineffectiveness of treatment in assessing what is in the patient’s best interests. Nevertheless, within the Canadian jurisprudence exist pockets of judicial sentiment that save medical futility from being completely ejected as a consideration in medical decision-making. The unsettled nature of the Canadian common law on this issue stands in marked contrast to the United Kingdom’s law, which I will also consider in Chapter Three, where the judiciary and legislature have both defined futility and weighted physicians’ futility concerns heavily in determining whether it is in the patient’s best interests to withdraw or withhold treatment. My conclusion that the UK has developed coherent legal principles for resolving futility disputes supports my argument that law reform to clarify the law regarding medical futility is both possible and desirable in Ontario.

In Chapter Four, I will argue Rasouli SCC did not settle the law surrounding medical futility in Ontario. The majority decision - penned by McLachlin CJ - heavily relied on the principle of personal autonomy to reach the conclusion that consent was required to withdraw Mr Rasouli’s life-support. Despite this finding, McLachlin CJ also recognized that the medical implications of a treatment, particularly the harmful implications, will sometimes justify a physician unilaterally withdrawing treatment, “but not always.”\(^8\) McLachlin CJ’s reasoning reveals some recognition of a legal standard of medical futility but, as will be discussed, she gave very little detail about the circumstances where the standard could be applied. By contrast, the minority decision - delivered by Karakatsanis J - relied too heavily on the clinical view of medical futility as a justification to withdraw or withhold treatment. The judgment did little to protect patient rights against the dangers of physician-driven futility. Thus, I will argue that, rather than clarify the law, both judgments illuminate that the current law relating to futility disputes – found in the HCCA and the common law - is inadequate.

To remedy this gap in the law, in Chapter Five I will propose a number of amendments to the HCCA to settle the law of medical futility in Ontario. I will suggest that the meaning of “treatment” in the HCCA should be amended to exclude:

any intervention that is withheld or withdrawn in circumstances where there is no reasonable probability it will create an effect that patient is able to experience as a health benefit.

\(^8\) Ibid at para 58.
This recommendation creates a standard that takes into account both physicians’ concerns that medically ineffective treatment is being provided and the views of patients regarding treatment. If there is any dispute about whether a treatment should be withheld or withdrawn in light of this definition, I will suggest that the dispute is automatically transferred to a newly created Treatment Dispute Board (TDB). The TDB will have a specific mandate to resolve futility disputes and its members will have the necessary expertise to do the same. I envisage these recommendations will create a legal standard of medical futility that balances the concepts of medical futility and personal autonomy. Critically, my amendments are designed to encourage constructive discussions and agreement between physicians and SDMs about treatment decisions.
Chapter One

Medical Futility

Introduction

Ronald Cranford and Lawrence Gostin once described medical futility as “[a] concept in search of a definition.”¹ Medical futility has eluded concrete definition because it requires value-laden judgments about whether a particular treatment will benefit a patient. One may claim that maintaining only the biological functions of a patient through life-support is not producing a benefit; yet, another may hold that the benefit lies in simply keeping the patient alive. Given these polarizing positions with regard to futile treatment, both the Canadian courts and provincial legislatures have resisted recognizing medical futility as a legal justification to withhold or withdraw treatment.

The purpose of this chapter is to explore the concept of medical futility and its surrounding controversy. The chapter is split into four parts. In Part One, I will provide background as to why medical futility is a problem in Canada’s public healthcare system, and I will show how the provision of futile treatment negatively impacts: public healthcare expenditure, patients receiving the treatment, patients waiting for treatment, and the medical profession.

But why is futile treatment being prescribed at all if indeed it causes such diffuse harms as described in Part One? In Part Two, I will examine five ‘futility-drivers’ that are responsible for fueling the provision of futile treatment within the healthcare system: the technologic imperative, the reimbursement model for services provided by physicians, the therapeutic illusion and patient values, the practice of defensive medicine, and alternate levels of care.

In light of my discussion in Part’s One and Two, I will suggest that legal intervention is desirable to counter the influence of these futility drivers, and to root out harmful and futile treatment in the healthcare system. Legal recognition of a standard of medical futility is controversial because it is such a value-laden concept. Therefore, in Part Three, I will discuss four oft-cited definitions of medical futility and drawing from this discussion I will

propose a legal standard of medical futility that encapsulates both the values of patients and the medical profession.

Finally, in Part Four, I will argue that if medical futility is to have any value in law it must discard its clinical roots. Physician driven-futility is undesirable as a legal standard because it promotes medical paternalism, increases the probability of discriminatory medical practices, and risks harm to the patient, or even death, if a physician makes a false-positive finding of futility. This discussion will reinforce my view that a legal standard of medical futility must account for the views of both the medical profession and patients.

1 The Problem of Medical Futility in Canada’s Healthcare System

1.1 Impact on the patient

Medical treatment is usually intended to have some physical or mental impact on the patient, and in some cases a patient will experience pain or discomfort as a side effect of treatment. The invasive and aggressive nature of life-sustaining treatment makes it particularly likely patients will experience pain or at least a high degree of discomfort. For example, lung suctioning has been likened to a hot-poker being inserted down the throat. Even if life-sustaining procedures do not cause direct harm, the patient may still suffer complications caused by the artificial extension of their life, including bedsores, infections, bloating, and organ damage.

---

2 Sweiss v Alberta Health Services, 2009 ABQB 691 (available on CanLII) [Sweiss] (here, the court acknowledged any form of resuscitative treatment would cause substantial harm to the patient, at para 69); London Health Science Centre v RK (1997), 152 DLR (4th) 724 (available on CanLII) (Ont SC) [London Health] (the patient’s treating physician argued that attempting resuscitation would result in “broken ribs, laceration of RKs lungs and liver and massive internal bleeding” at para 8); the harms caused by continued drug treatment were discussed in Rotaru v Vancouver General Hospital Intensive Care Unit, 2008 BCSC 318 (CanLII) [Rotaru] (“in particular digoxin and simvastatin were discontinued on February 1…due to concerns about potential toxicity”, “albumin” was discontinued because it was “resulting in fluid overload” and TPN (Total Parenteral Nutrition) was withdrawn because it was “…contributing to progressive renal failure given the urea load” at para 18).


4 See for example: Re N, 2009 CanLII 42576 (ON CCB) (“[a]fter surgery, N was transferred to ICU. She had a complicated course during hospitalization and was unable to improve. She
Therefore many physicians believe that providing life-sustaining treatment is in some instances “tantamount to torture.”\(^5\) Physicians frequently argue in futility disputes that life-sustaining treatment should not be provided because it serves only to increase or prolong the patient’s suffering without a compensatory improvement in the patient’s prognosis.\(^6\) Rather than prolonging the patient’s life, the treatment is simply prolonging the dying process. It is questionable then whether terminally ill or permanently unconscious patients should be exposed to life-sustaining procedures if the interventions do not provide a cure or improve their quality of life, but do increase suffering at the end of life.

The argument that life-sustaining treatment is harmful is debatable, however, in cases involving patients in a permanent vegetative-state (PVS). A diagnosis of PVS requires the absence of sufficient cerebral cortical function to indicate the patient has awareness of the self and the environment.\(^7\) A patient in a PVS may show some reflexive movement in response to noxious substances, but these do not indicate conscious experience of pain and

---


\(^6\) For example: *Rotaru, supra* note 2 (the treating physician in the case gave evidence “[t]o continue life support, in my opinion, is unethical, as it has no chance of changing the prognosis, and it does do harm in that it is prolonging Mrs Priboi’s suffering” at para 6); *London Health, supra* note 2 (the treating physician submitted there was no medical justification for continuing life-support for the patient whose chance of recovery was “highly unlikely”, and who continuously suffered from bedsores, extreme fluctuations in blood pressures, the gradual weakening of bones, renal failure and was “swollen and puffy all over from broken blood vessels” at para 7).

are generally non-purposeful and involuntary. Although a patient diagnosed as being in a PVS may not experience any pain from life-sustaining treatment, but, such treatment may still be futile.

Nevertheless, prolonged exposure to life-sustaining treatment may erode the dignity of both PVS and non-PVS patients. An incapacitated patient, like any other individual, is entitled to die with dignity. Whilst there will be many different views about what a dignified death entails, many would agree it requires minimal interference with the patient’s bodily integrity. Yet, life-sustaining procedures necessitate that health practitioners aggressively invade the patient’s body to maintain biological functions. During this time the patient’s body will deteriorate due, in large part, to the unnatural state of permanent bed-confinedment. In most cases - although not all - death is imminent and inevitable for terminal or permanently unconscious patients, but rather than a swift and dignified death the patient is left to “die by millimeters.”

---


9 *London Health, supra* note 2 (“[d]ue to the almost complete absence of brain stem activity, [the patient] is not likely experiencing any pain” at para 7).


11 *London Health, supra* note 2 (“[t]he patient’s body is gradually breaking down despite the best efforts of the medical professionals attending him. He is becoming ‘swollen and puffy all over from broken blood vessels’. His liver function is abnormal and his bones are breaking down” at para 7).

12 Whilst death is almost always imminent for terminal patients suffering from illnesses such as end-stage cancer or Alzheimer’s Disease who have been admitted into intensive care units (ICUs), patients in a PVS have been known to survive in such a state for as long as 37 years and 111 days: David Smith, “Legal Recognition of Neocortical Death” (1985-86) 71 Cornell L Rev 850 at 858.

13 Alicia Ouellette, “When vitalism is dead wrong: the discrimination against and torture of incompetent patients by compulsory life-sustaining treatment” (2004) 79 Ind LJ 1 at 13-22; Family Decisions Coalition, “Personal Stories”, online: Family Decisions Coalition <http://wings.buffalo.edu/bioethics/fheda/sheila.html> (the tragic case of Shelia Pouliot illustrates how sustained exposure to life-sustaining treatment can cause both physical harm and lose of dignity. Ms Pouliot suffered from a severe blood infection and multi-organ malfunction, and was kept alive by artificial nutrition and hydration. Her family and treating physicians both wished to withdraw life-support to give her a more dignified death but a New York court overruled this decision. Despite the courts directive that nutrition and hydration should be maintained all she could tolerate was sugar water. For the two months she was being sustained on sugar water alone her skin broke down, she swelled to grotesque
1.2 Impact on public healthcare expenditure

The cost of Canada’s public healthcare system rises annually. Between 1975 and 2012 real per capita public healthcare spending increased at an average annual rate of 2.3%. This figure exceeded the average annual growth in real per capita GDP of 1.3% for the same period. Against these growth trends, it has been estimated that by the late 2020s - after adjustments for inflation - roughly 17% of Canada’s GDP will be spent on healthcare, 6% more than in 2013. If economic growth continues to be outpaced by the increase in healthcare expenditure, it is questionable whether Canada can sustain its current levels of healthcare spending in the long-term.

The upward trend in healthcare spending is troublesome at a provincial level too, with average public healthcare expenditure accounting for almost 40% of all spending by provincial and territorial governments. Ontario’s government has predicted that the share of provincial expenditure absorbed by healthcare costs will increase to 55% by 2025 and has cited healthcare as being the greatest fiscal challenge to the province over the next 20 years.

Sustainability is a contested concept, but nonetheless the trajectory of health care spending suggests at a minimum that governments will face challenges in maintaining a robust publicly funded healthcare system. Whilst one may disagree with the extent of the sustainability proportions, her body began to eat its own organs, her muscles rotted and her heart deteriorated. After two months of witnessing Ms Pouliot ‘die by millimeters’ her family and physicians again petitioned the court to reconsider the order, which it did and once hydration was removed she died two days later).


David Dodge & Richard Dion, Chronic Healthcare Spending Disease: A Macro Diagnosis and Prognosis (Toronto: C D Howe Institute, 2011) at 8.


problem, many agree that there are problems with how the healthcare system is utilized.\textsuperscript{22} As far back as 1994 it was argued “it is not the policy of medicare \textit{per se} that is no longer affordable, but the inefficient manner in which medicare has been implemented.”\textsuperscript{23} More recently, a 2010 report from the Canadian Institute for Health Information (CIHI) proposed significantly improving the healthcare system by “ensur[ing] the care provided is appropriate.”\textsuperscript{24} The report was highly critical of instances of “inefficient resource use” within the healthcare system where there was “evidence of little benefit” to the patient\textsuperscript{25} – that is, where treatment is futile.

End-of-life medical care is a particular fiscal burden on the public healthcare system, raising the question of whether end-of-life treatments are being appropriately provided. A longitudinal study examining the effects of age and time to death on healthcare costs revealed costs roughly quadrupled during the last year of life compared to two years prior to death.\textsuperscript{26} Healthcare costs at five years prior to death were roughly ten times less that the year preceding death.\textsuperscript{27} Dying, it seems, is an expensive process.\textsuperscript{28}

End-of-life medical costs are especially high when life-sustaining measures are involved. In a recent study commissioned by Toronto’s Sunnybrook Hospital, the authors conclude: “the provision of care at the end of life, often including aggressive diagnostic care, technology assisted monitoring and treatment in [intensive care units (ICUs)], is among the most expensive; consuming up to 0.5-1\% of the GDP (or 10-20\% of the healthcare budget).”\textsuperscript{29} An array of complex machinery is used in ICUs to provide life-sustaining treatment to critically ill patients, including intracranial pressure catheters, inotropes, dialysis machines, and

\begin{itemize}
\item \textsuperscript{22} Pran Magna, "Health Care in Canada: A Crisis of Affordability or Inefficiency" [1994] CA Business Economics 56 at 56.
\item \textsuperscript{23} Ibid at 56 [emphasis in original].
\item \textsuperscript{24} Canadian Institute for Health Information, \textit{Health Care in Canada, 2010} (December 2010), online: <https://secure.cihi.ca/free_products/HCIC_2010_Web_e.pdf> at 22.
\item \textsuperscript{25} Ibid at 24.
\item \textsuperscript{26} Meena Seshamani & Alastair Gray, “A longitudinal study of the effects of age and time to death on hospitals costs” (2004) 23 J Health Eco 217.
\item \textsuperscript{27} Ibid at 224.
\item \textsuperscript{28} Evelyn Forget et al, “Variations in Lifetime Healthcare Costs across a Population” (2008) 4:1 Healthc Policy (“a typical individual might anticipate many years of increasingly costly disability before dying an expensive death at an advanced age”, at e150).
\item \textsuperscript{29} Robert Fowler & Michael Hammer, "End-of-life Care in Canada” (2013) 36:3 Clin Invest Med E127 at E130.
\end{itemize}
mechanical ventilators. ICUs are also staffed by a large interdisciplinary team, which includes physicians and nurses, respiratory therapists, physical therapists, ethicists, nutritionists, pharmacists, bio-technicians, radiologists and often, social workers and physiatrists. With these components in mind it is estimated that the cost of a single ICU bed is on average CAD$3000 a day, which amounts to more than CAD$1 million per ICU bed per year.

The high cost of ICU treatment is concerning in light of evidence suggesting ICU resources are not being optimally utilized. In a Canadian-wide survey measuring whether futile treatment was provided in ICUs, 87% of physicians and 95% of nurses surveyed believed that medically futile treatment was administered in ICUs. A survey from the United States examining physicians’ attitudes to providing ICU care to patients in a PVS revealed that roughly 91% of respondents believed that treatment should be withheld for respiratory failure, cardiac arrest, acute renal failure or cancer, and 89% believed that it was ethical to withdraw aggressive life-sustaining treatment that was already being provided. Moreover, while many patients do not want to be inflicted with aggressive and invasive hospital treatment at the end of life, 70% of Canadians are admitted to hospital at the end of life and between 10-15% of those people are further admitted into ICUs. It seems that, absent a prior known wish to the contrary, institutionalized and technologically-supported care is being provided as the default end-of-life medical care, even though such care may be undesired by patients and deemed clinically unbenevolent by physicians.

31 Ibid at 1339.
34 Payne, supra note 8 at 104.
35 Fowler & Hammer, supra note 29 (“up to 70% of elderly patients say they would prefer a less aggressive treatment plan focusing on providing comfort rather than technologically supported, institutionalized death” at E127).
36 Ibid at E127-E128.
Canada has an aging population, and the baby-boom cohort - “Canada’s largest population group in recent history” – is beginning to turn 65. It can be expected then that as Canada undergoes a demographic shift towards old age there will be increased demands for expensive end-of-life care. This will strain the public healthcare purse, particularly if end-of-life care is delivered in an inefficient and futile manner.

1.3 Impact on the medical profession

Physicians are required to practice medicine in accordance with well-established ethical and professional obligations. In Ontario, these obligations are largely contained in policy published by the Canadian Medical Association (CMA) and College of Physicians and Surgeons of Ontario (CPSO), including the CMA Code of Ethics and the CPSO Practice Guide. Together these policy documents dictate both the underlying values and principles of the medical professional (i.e. compassion, beneficence, non-maleficence, respect for persons, justice and accountability), and a physician’s fundamental responsibilities when carrying out medical duties.

Ethical and professional obligations are vital to inspire public faith in the healthcare system. The obligations exist to protect the patient from untoward or inexpert medical practices, to maintain the integrity of the medical profession, and to ensure the practice of medicine promotes the public good. A violation of ethical or professional duties may result in medical malpractice liability if the patient suffers harm, and/or disciplinary action from the CPSO. It is unsurprising then that physicians vehemently oppose the provision of futile care.

---

37 Canadian Institute of Health Information, National Health Expenditure Trends, 1975 to 2013, online: <https://secure.cihi.ca/free_products/NHEXTrendsReport_EN.pdf> at 53.
41 CMA Code of Ethics, supra note 39 at 1.
42 CPSO Practice Guide, supra note 40 (“in return for the privilege of self-regulation, the profession makes a commitment to promote the public good” at 7.)
treatment if to do so conflicts with the physician’s obligations and exposes them to professional liability.\textsuperscript{44}

Whilst the provision of futile treatment infringes a number of ethical and professional obligations,\textsuperscript{45} physicians commonly assert it causes three paramount violations. First, a physician has no professional obligation to administer treatment where it is not in the patient’s best interests to receive such treatment.\textsuperscript{46} Indeed, the patient’s best interests must be the physician’s first and foremost consideration when proposing to implement or discontinue a course of treatment.\textsuperscript{47} Treatment that is invasive and harmful but does not benefit the patient will be contrary to the patient’s best interests.

The Canadian courts have recognized that a physician should not be compelled to provide treatment contrary to the patient’s best interests.\textsuperscript{48} The courts have not, however, accepted that physicians have the final authority to determine what is in the patient’s best interests.\textsuperscript{49} Calculating the patient’s best interests requires consideration of the patient’s diagnosis and prognosis, the clinical implications of the proposed treatment, and the patient’s beliefs, wishes and values.\textsuperscript{50} The last criterion demands insight into the patient’s personality, and so it

\textsuperscript{44}See: Rotaru, supra note 2 at para 4; Sweiss supra note 2 at para 24.
\textsuperscript{45}See for example: CMA Code of Ethics, supra note 39 (physicians must “refuse to participate in or support practices that violate basic human rights” at 2); Mary Ann Bailey, "Futility, Autonomy, And Cost in End-of-life Care" (2011) 39:2 JL Med & Ethics 172 ("[p]hysicians and other individual and organizational providers of treatment are the stewards of [healthcare funds] and have a duty to use them only for uses that are consistent with the understandings that underlie the formation of the pools” at 175).
\textsuperscript{46}CMA Policy, CMA Statement on Life-saving and –sustaining Interventions (December 2013), online: Canadian Medical Association <http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD14-01.pdf> [CMA Statement on Life-saving and –sustaining Interventions] ("[t]here is no obligation to offer a person medically futile or non-beneficial interventions” at 3); Picard & Robertson, supra note 43 at 345-346.
\textsuperscript{48}Sweiss, supra note 2 at para 73.
\textsuperscript{49}Ibid. C.f. Airedale NHS Trust v Bland, [1992] UKHL 5, [1993] AC 789 [Bland] (“[t]he decision whether or not the continued treatment and care of a PVS patient confers any benefit on him is essentially one for the practitioners in charge of his case” at 862).
\textsuperscript{50}Ibid.
is beyond the physician’s expertise to make a determination alone.\textsuperscript{51} As will be discussed in Chapter Three, the courts have yet to determine whom, if not the physician, has the final authority to determine an incapacitated patient’s best interests.

Nor have the Canadian courts resolved whether it is in the best interests of a patient in a PVS or who is terminally ill to receive life-sustaining treatment. In the infamous UK case \textit{Airedale NHS Trust v Bland}, the House of Lords concluded that life-sustaining treatment should be withdrawn from a patient in a PVS “whose condition is in reality no more than a living death, and for whom such treatment or care would in medical terms, be futile.”\textsuperscript{52} In some cases, the Canadian courts have appropriated this sentiment to find it is not in the best interests of patients who are in a PVS or terminally ill to have their lives artificially extended.\textsuperscript{53} In other cases, an order has been made that life-sustaining treatment must be continued - at least temporarily - despite the patient’s dire prognosis.\textsuperscript{54} Ultimately, a physician’s obligation to provide treatment will depend on a case-by-case assessment of what is in the patient’s best interests, and this assessment will not rest solely on clinical evidence. However, if a physician’s opinion that treatment is futile is disputed, this \textit{prima facie} undermines the physician’s obligation to treat the patient in accordance with her best clinical judgment.

The second major way futile treatment will breach a physician’s obligations is if it is contrary to the primary ethical principle of non-maleficence (i.e. do no harm).\textsuperscript{55} As discussed above, futile treatments - and particularly futile life-sustaining treatments - can cause harm to the patient’s physical body and dignity. Obviously, however, many medical interventions, from resetting a dislocated shoulder to open heart surgery, will cause the patient some degree of pain and discomfort. Therefore, the principle is recognized in a more nuanced manner,

\textsuperscript{52} Bland, \textit{supra} note 49 at 870.
\textsuperscript{53} See Child and Family Services of Central Manitoba v Lavallee et al (1997), 123 Man R (2d) 135, 154 DLR (4th) 409 (Man CA); \textit{Re IHV}, 2008 ABQB 250 (CanLII), 449 AR 211.
\textsuperscript{54} See Jin (Next friend of) v Calgary Health Region, 2007 ABQB 593 (CanLII), 428 AR 161; \textit{Sweiss}, \textit{supra} note 2; Sawatzky v Riverview Health Centre Inc, [1998] MJ No 506, 167 DLR (4\textsuperscript{th}) 359.
\textsuperscript{55} \textit{Sweiss}, \textit{ibid}, at para 69.
whereby a physician has no ethical obligation to provide treatment that is both clinically harmful and ineffective, or where the harms of the treatment outweigh its benefit.\textsuperscript{56}

The ethical duty to do no harm can also be understood more expansively as serving to protect the emotional well-being of other stakeholders involved in the treatment of a patient, such as health practitioners, the patient’s family, and even the wider community. Michael Ardagh aptly discussed the harms caused by inappropriate use of treatment, specifically resuscitative measures, as follows:

Harms to the family include unfulfilled hope, loss of control of loved one’s destiny, a cost of lost earning while at the bedside and the cost of supporting a disabled survivor. The harms to the health care workers include frustration and sadness at lack of success, guilt at inflicting harm and the opportunity cost of being unable to treat others waiting for resources. The harms to the community include the loss of resources to treat others, the false perception that resuscitation offered hope and the worry that death must be preceded by a loss of dignity.\textsuperscript{57}

Given the potential for these diffuse harms caused by the provision of futile treatment, it is reasonable that physicians would not want to be responsible for instigating such treatment, even in situations where they are legally compelled to do so.

The third reason why futile treatment infringes a physician’s duties is that such treatment conflicts with the duty to use a “degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing.”\textsuperscript{58} Part of this standard of care obliges physicians to provide, or not to provide, treatment according to reasonable medical judgment.\textsuperscript{59} A physician who provides, or is compelled to provide, treatment which she knows, or ought to know, is contra-indicated will violate this professional obligation.\textsuperscript{60}

This duty of care is purposed to protect patients from negligent medical practices, as well as

\begin{flushright}
\textsuperscript{56} Steven H Miles, "Medical Futility" (1992) 20 L Med & Health Care 310 at 311. \textit{CMA Statement on Life-saving and –sustaining Interventions}, supra note 46 (“[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” at 1-2).

\textsuperscript{57} Michael Ardagh, "Futility Has No Utility in Resuscitation Medicine" (2000) 26 J Med Ethics 396 at 398; Brennan, supra note 5 (“continued intensive care for an insentient terminally ill patient is offensive to most people, and physicians can reasonably claim that a rational person would not request it” at 337).

\textsuperscript{58} \textit{Crits v Sylvester} [1956] OJ No 536, 1 DLR (2d) 502 at 508.

\textsuperscript{59} Edward R Grant, "Medical Futility: Legal and Ethical Aspects" (1992) 20 L Med & Health Care 330 at 332; \textit{CMA Code of Ethics}, supra note 39 (“[p]ractise the art and science of medicine competently, with integrity and without impairment” at 1).

\textsuperscript{60} Picard & Robertson, \textit{supra} note 43 at 346.
\end{flushright}
ensure the art of medicine is cemented in scientific evidence. Thus, futile treatment subverts the scientific and ethical foundations upon which the integrity of the medical profession is based.

Futile treatment undoubtedly undermines the ethical and professional obligations that regulate the medical profession. But ethical and professional obligations are fluid ideals, and the extent to which any one duty is recognized by the law will depend on the circumstances at issue and whether the duty conflicts with another duty. Nonetheless, to maintain the integrity of the medical profession the law should, at the very least, consider physicians’ ethical and professional concerns regarding futile treatment.

1.4 Impact on society

Canada has finite healthcare resources. It follows that provincial governments cannot be expected to provide all forms of medical care desired by their citizens, nor can medical care be provided for an indefinite period of time. In an ideal healthcare system, resources would be distributed in a way that is optimally fair and productive. Precise realization of optimal resource allocation may be an impossible goal, because medical decisions are frequently made in high-pressure and mercurial environments; nonetheless, healthcare providers and funders should strive to achieve greater efficiency within the healthcare system. The fair allocation of resources is particularly important in Canada because it operates a single-payer healthcare system, meaning patients cannot access healthcare privately. Therefore, if one patient disproportionately absorbs resources this will limit the resources available to treat another patient.

Futile end-of-life care is an example of sub-optimal resource allocation. It creates an opportunity cost by directing resources away from patients who could properly benefit from medical attention. This opportunity cost was highlighted in the case of London Health

---


63 This opportunity cost is less obvious in countries that have a mixed private/public healthcare model because if the treatment is unavailable or delayed in the public system, the patient can seek treatment through the private system (assuming the patient can pay for it and there is a health practitioner willing to provide it).
Science Centre v RK, which involved a patient (RK) in a PVS being kept alive on life-support. 64 A neurosurgeon consulted on RK’s condition gave evidence that: “since RK has been supported by the ventilator in the ICU, the hospital has had to cancel 8 cases of cardiac surgery that could if been performed if RK ‘were not occupying that bed’.” 65 The indefinite provision of life-support could not prevent the inevitability of RK’s death, 66 but the delay in his death directly jeopardized the lives of other people.

The issue of optimal resource allocation is further complicated by the question of who is responsible for making allocation decisions. Both provincial governments and physicians have a role to play in such decisions. On the one hand, provincial health insurance legislation defines the scope of insured services provided by health practitioners and hospitals. 67 On the other hand, physicians make decisions about which patients get priority, which tests to order, the type of treatment given and so on. 68 This decision-making role has earned physicians the unofficial title of the ‘gate-keepers’ 69 or ‘stewards’ 70 of healthcare resources. This stewardship role is supported by the Canada Health Act 1985 (CHA), which requires physicians to decide and certify whether an intervention is ‘medically necessary’ 71 or ‘medically required’. 72 Given this unofficial ‘stewardship’ role, it has been argued that physicians have an ethical and professional duty to consider other patients, or the general population, when proposing or providing treatment. 73 Nonetheless, this argument has been dismissed by judicial authority which states that treatment decisions cannot be influenced by resource allocation issues where there is uncertainty about whether a treatment will benefit a patient. 74

---

64 London Health, supra note 2.
65 Ibid (RK was an 83 year old man diagnosed as being in a PVS with a “highly unlikely” chance of recovery, at para 8).
66 Ibid at para 9.
69 Koche, supra note 61 at 323.
70 Bailey, supra note 45 at 175.
71 Canada Health Act, RSC, 1985, c C-6, s 2 (meaning of ‘hospital services’).
72 Ibid (meaning of ‘physician services’).
73 Bailey, supra note 45 at 175.
74 Law Estate v Simice, 1994 CanLII 3068 (BCSC) (“if it comes to a choice between a physician’s responsibility to his or her individual patient and his or her responsibility to the
Therefore, it should be left to policymakers (as the voice of society) to direct how the interests of patients should be balanced against each other. Statutory guidelines about how scarce resources should be allocated would equip physicians with both the moral authority and medical expertise to direct whether a patient should have continued access to end-of-life healthcare resources, such as mechanical ventilators. But no provincial or territorial government has created any robust policy to this effect. It follows there is currently no solid legal foundation in Ontario, or throughout Canada, to withdraw or withhold futile life-sustaining treatment from a patient in order to make a bed available for another patient with a more hopeful prognosis. This legal lacuna allows individual patients to absorb a disproportionate amount of resources, even if use of the resources do not create a clinical health benefit, and in doing so, deny other patients access to healthcare resources, causing further detriment to their health or even death.

2 What is Fueling Futile Treatment?

If futile treatment is harmful in the ways is described above, why is it being provided? Futile treatment is not the product of any individual factor within Canada’s healthcare system. I venture instead that futile treatment is a product of five factors, which will be discussed below. In any given situation futile treatment may be provided as a result of one or more of the futility-drivers identified.

2.1 The technologic imperative

Over the last half-century advances in modern medicine have improved human health and allowed more people to live longer than at any other point in human history. Modern medical advances have also contributed to the escalating cost of healthcare. One study suggests that the development of new medical technology contributes 1.1% to the total growth rate of real medicare system overall, the former must take precedence in a case such as this. The severity of the harm that may occur to the patient who is permitted to do undiagnosed is far greater than the financial harm that will occur to the medicare system if one more CT scan procedure only shows the patient is not suffering from a serious medical condition” at para 18) [Simice].

Schulkenkm, supra note 38 (the authors argue that the legality of unilateral withholding or withdrawal of potentially life-sustaining treatment is “very unclear and very controversial” in Canada, at 32-33).

per capita healthcare spending, thus accounting for approximately one-quarter of the growth in real per capita healthcare spending from 1996 to 2009.\footnote{78 \textnormal{Dodge & Dion, supra note 16 at 7.}}

Nevertheless, it is not medical technology \textit{per se} that is the cause of healthcare cost escalation; rather it is the ineffective utilization of medical technology that is cause for concern. Lawrence Schneiderman and Michael De Ridder argue that the healthcare system is infected by a ‘technologic imperative’ whereby “if a means or instrument or medication exists that can produce an effect on the body, then medicine is obligated to use it.”\footnote{79 \textnormal{Lawrence Schneiderman & Michel De Ridder, “Medical Futility” in James L Bernat & Richard Beresford, eds, \textit{Handbook of Clinical Neurology}, 3:118 (BV: Elsevier, 2013) at 168.}} For example, if a patient cannot breathe on her own she should be attached to a mechanical ventilator simply because it will allow her to breathe.

The problem with the technologic imperative is that it shifts the focus of medicine away from the patient’s best interests and onto the effectiveness of treatment.\footnote{80 \textnormal{Ibid.}} The question becomes whether medical technology can be used in the circumstances to create an effect on the body, rather than whether it will actually have any beneficial outcome for the patient.\footnote{81 \textnormal{Ibid.}} In the end-of-life context, the technologic imperative holds that because physicians can prolong life by means of a mechanical ventilator or feeding tube, they ought to provide it.

The judiciary has recognized that the technologic imperative interferes with a physician’s duty to first and foremost consider whether treatment is in the patient’s best interests. In \textit{Sweiss v Alberta Health Services}, Ouellette J cautioned “that simply because a medical procedure can be done does not mean that it should be done.”\footnote{82 \textnormal{Sweiss, supra note 2 at para 64.}} Despite this judicial sentiment, the creeping influence of the technologic imperative was evident in a 2005 survey where the most common answer given by health practitioners when asked “Any other reasons for providing futile care?” was that physicians felt death was avoidable or could be “put off” through the use of medical advancements.\footnote{83 \textnormal{Palda, supra note 33 at 209-210.}} This finding suggests that the technologic imperative is cultivating within the medical profession so that physicians are
perceiving that heroic and aggressive life-sustaining measures must be applied by default, regardless of whether it is in the patient’s best interests.

2.2 Reimbursement model for services provided by physicians

The second factor driving the futile use of life-sustaining treatment is Canada’s single-payer fee-for-service payment structure for healthcare services. Under this payment structure provincial governments are the payer-sole for public healthcare services and physicians are reimbursed for each service provided.\textsuperscript{84} Whether or not this payment structure is a desirable form of physician reimbursement is beyond the scope of this paper. Suffice for the current purposes, the fee-for-service compensation model reinforces the potential for cost escalation in the healthcare system “since it creates an incentive for physicians to provide more rather than less units of their services in order to increase their incomes.”\textsuperscript{85} While, the fee-for-service reimbursement model encourages physicians to provide more medical care, this may not reflect an increase in health benefits to patients if treatment is unnecessary.

Conversely, it has been argued that controlling physician incomes through other methods of reimbursement will help stem rising healthcare costs by removing any financial incentive to inappropriately prescribe healthcare services.\textsuperscript{86} One study found that compared to salary and capitation (payment is made per patient for whom care is provided) methods of reimbursement, physicians provide a greater quantity of primary care services under the fee-for-service method.\textsuperscript{87} However, it must be acknowledged too that many factors discourage physician-generated demand” including a physicians’ ethical obligation to always act in the patient’s best interests,\textsuperscript{88} discussed above. Nevertheless, physicians are still left with wide discretion to choose which course of treatment to propose and may “choose ones that are more income beneficial, even if only of marginal clinical value.”\textsuperscript{89}

\textsuperscript{84} See: Lahey, \textit{supra} note 67 at 1.
\textsuperscript{85} Ibid at 22-23. See also Magna, \textit{supra} note 22 at 62.
\textsuperscript{86} Magna, \textit{ibid}, at 61. It is not my argument that countries will not have a problem with the provision of futile treatment where physicians are paid on a salary basis. Instead, I suggest that the fee-for-service reimbursement model is just one of five influences in Canada’s healthcare system that encourage, or at least do not discourage, the provision of futile treatment.
\textsuperscript{88} Lahey, \textit{supra} note 67 at 22.
\textsuperscript{89} Ibid at 23.
Moreover, the single-payer component of the payment structure directs that Canadians do not pay out-of-pocket medical expenses.\(^\text{90}\) Full public coverage leaves patients without awareness of the cost of medical treatment and so patients, or SDMs, may be inclined to seek treatment even if it is of questionable necessity. In turn, physicians may not discourage patient or SDM demand due to the fiscal incentive driving them to provide excessive levels of care. Overall, Canada’s current payment structure for healthcare services invites the over-exploitation of healthcare resources.

2.3 The therapeutic illusion and patients’ values

The third factor driving the provision of medically futile treatment is hope that continued medical attention, however unbefitting, will nonetheless make the patient well again. Thaddeus Pope describes this as the ‘therapeutic illusion’ where a SDM or patient believes in miraculous recovery or that a new cure will soon be found.\(^\text{91}\) Of course, it is exceedingly difficult for most people to accept that a loved one is sick or dying, and it is unsurprising that most people would want to explore all avenues of treatment that could extend a patient’s life. Indeed, there are some cases where patients have ‘beaten the odds’ and recovered from illnesses where the probability of doing so was almost negligible.\(^\text{92}\) These medical success stories fuel public expectations about the power of medicine.

Further, the beliefs and values of a patient or patient’s family may direct that a full and aggressive course of treatment be provided. A desire for treatment arising from a deep-rooted personal, cultural or religious belief is particularly intractable.\(^\text{93}\) In disputes regarding the withdrawal of life-support it is frequently argued by families that the patient’s religious beliefs require that life be sustained at all costs.\(^\text{94}\) A 2008 survey revealed that 60% of the

\(^{90}\) Ibid.


\(^{92}\) For example, in 1984 Terry Wallis was diagnosed as being in a PVS following a severe car crash. His physicians opined that his condition would not improve, however his family refused to give up hope and moved him to a specialized rehabilitation center. Nineteen years later he ‘woke-up’ and began speaking and interacting fully with those around him: Francie Grace, “Man awakes after 19 years in coma”, CBS (9 July 2003), online: <http://www.cbsnews.com/news/man-awakes-after-19-years-in-coma/>.

\(^{93}\) Pope, supra note 91 at 202.

\(^{94}\) Rasouli v Sunnybrook Health Sciences Centre, 2011 ONSC 1500, 105 OR (3d) 761 [Rasouli ONSC] (Mr Raosuli’s SDM asserted that because Mr Rasouli was a Shia Muslim he believed that “access to health care is a fundamental right and that a person is entitled to
general public believed that a patient in a PVS could experience a miraculous recovery.\(^{95}\) The same survey showed that even though the public generally trusted physicians’ recommendations, 72.4% of people surveyed believed that patients should have a right to demand care even where it is contrary to medical opinion.\(^{96}\)

In other disputes regarding the withdrawal of life-support it has been argued that although further treatment may be invasive and undignified “pain [is] the price of living”\(^{97}\) and “where there is life there’s hope.”\(^{98}\) In this sense arguments about the quality of life are redundant in light of a patient’s or their loved ones’ uncompromising belief in the sanctity of life. Where the patient or family clings to hope for recovery or improvement it will be a difficult task for a physician - both logically and emotionally - to convincingly argue that treatment is not effective. Thus, the therapeutic illusion together with intractable personal beliefs and values are factors driving the demand for treatment of questionable value.

### 2.4 Defensive medicine

‘Defensive medicine’ is the phenomenon whereby physicians over-prescribe treatment to avoid accusations of medical negligence.\(^{99}\) A study from the United States reported 96% of physician respondents were worried or altered their practice based on their perceived legal vulnerability regarding the treatment of terminal patients.\(^{100}\) In the same study 25% of physicians reported extreme legal defensiveness to a degree that it inhibited rational decision-making.\(^{101}\)

---

95 Lenworth M Jacobs et al, “Trauma Death: Views of the Public and Trauma Professionals on Death and Dying from Injuries” (2008) 143 Archives Surgery 730 at 734.

96 Ibid at 732-733 (interestingly, a relatively high proportion of physicians surveyed (44.3%) also thought that patients have a right to demand contra-indicated treatment, at 733).

97 Re HJ, 2003 CanLII 49837 (ON CCB) at 8.

98 Ibid at 8; Scardoni, supra note 94 at para 80; Re E, 2009 CanLII 28625 (ON CCB) at 32.


101 McCrary, ibid, at 371.
The practice of defensive medicine in the US is unsurprising given its excessively high volume of medical malpractice cases. The extent to which ‘defensive medicine’ influences the practice of medicine in Canada is unclear. The Canadian Medical Protective Association (CMPA) provides full medical liability protection to 95% of physicians in Canada, including providing compensation to patients proven to have been harmed by the negligence of physicians. Thus, physicians in Canada do not personally pay damages awards ordered against them. Moreover, although an estimated 23,750 people die annually from medical errors, the CMPA report that newly filed legal suits against physicians were just under 900 in 2012. It would seem then that Canadian physicians have little to fear from the threat of malpractice litigation.

Nevertheless, the fear of being accused of acting negligently and the resulting stress of having the accusation investigated and even eventually litigated, may be driving Canadian physicians to practice defensively. The CMPA report that physicians who have been accused of malpractice “may feel their whole life is falling apart, leading to extreme distress, burnout, depression, and even suicide.” Even if a physician has not suffered the distress of such an accusation herself, she may be exposed to the distress suffered by colleagues as a consequence of an accusation of malpractice or litigation itself. Thus, although the likelihood of facing malpractice litigation in Canada maybe less real than in the US, the fear of litigation may be just as real.

103 See: Canadian Institute for Health Information, Health Care in Canada 2004 (2005), online: <https://secure.cihi.ca/free_products/hcie2004_e.pdf> at 44.
105 The Canadian Medical Protective Association, 2012 Annual Report (2012), online: The Canadian Medical Protective Association <https://oplrfrpd5.cmpa-acpm.ca/annual-report> (“[i]n 2012, the number of newly opened legal cases was just below 900, well under the peak in 1995 in 1,415 cases. These declines are increasingly apparent when membership growth is taken into consideration. During the past decade, legal cases opened per 1,000 members have declined consistently from 17 in 2003, to 10 in 2012. This is well below the 1995 peak of 25 cases per 1,000 members”).
This fear is particularly taxing on a physician’s confidence. By way of example, Canadian ICU nurse Claudia Wong notes “law suits are really hard on the confidence of physicians to do their jobs effectively, they become skittish about their own opinions.” Wong recalls that even where a SDM has given consent to the withdrawal of life-support, physicians have been known to order more diagnostic tests, as well as further invasive and harmful treatments. Where a physician loses her confidence she may be inclined to over-prescribe medical care to avoid making an error. In turn, these defensive tactics encourage an attitude within the medical profession that it is acceptable to provide unbeneficial treatment to mitigate the fear of prosecution.

2.5 Alternate levels of care

In a 2010 report from Ontario’s Ministry of Finance dealing with reform of Ontario’s public services, it was noted “many hospital beds are occupied by patients who could get better quality care at a lower overall cost elsewhere in the system.” These occupancies are labeled ‘alternate level of care’ stays (ALC), “where patients remain in hospital for longer than may be medically necessary.” In this sense, ALC patients are receiving futile treatment – they are receiving a greater intensity of healthcare services than is warranted by their medical condition.

---


108 Interview of Claudia Wong by Catherine Deans

109 Ibid (Wong described an incident where the SDM of a patient in the ICU had consented to the withdrawal of life-support but the treating physician would not sign off the withdrawal until a further CT scan was done to confirm the diagnosis. As well the physician ordered the insertion of a catheter, which was particularly difficult because of the patient’s illness. The treating physician had been subject to a malpractice suit in the not too distant past).


ALC stays absorb a significant amount of healthcare resources. The CIHI reported that 5% of all hospitalizations and 13% of all hospitals days were ALC stays in 2008-2009\(^\text{112}\) and estimated that ALC patients occupied 7550 beds in acute hospital settings across Canada on any given day.\(^\text{113}\) Considering that acute hospital care can cost up to CAD$3000 a day, the cost of ALC stays may exceed CAD$22.5 million per day. It is little wonder that “there is a growing concern that over time there are more ALC [patients], and these are increasingly affecting the ability of hospitals to provide services to those requiring hospital based care.”\(^\text{114}\)

The most common reasons why ALC patients linger in hospital settings are because they are waiting for palliative care (34%), or waiting for discharge to long-term care facilities (72%),\(^\text{115}\) neither of which are widely available in Canada’s healthcare system.\(^\text{116}\) Indeed, it has been estimated that 95% of people in Canada would benefit from palliative care as they pass away, but 70% of people lack access to such treatment because it is unevenly distributed throughout Canada.\(^\text{117}\) Absent the ready availability of alternate medical care, ALC patients will continue to receive excessive levels of treatment which is unlikely to result in a health benefit beyond what the patient would have experienced if provided less intensive treatment elsewhere in the system. The persistent failure of the state to comprehensively fund palliative services or long-term care facilities will drive the provision of excessive, expensive and futile care in acute hospital settings.

### 2.6 Summary: futility-drivers

The discussion above leads to two observations. First, the provision of futile treatment is not exclusively driven by demand from patients or SDMs. The medical profession is responsible for the proliferation of futile treatment to the extent that physicians overuse medical technology, over-supply treatment for income, and practice defensively. This may seem odd

\(^{112}\) *Ibid* (in the same period, 62% of ALC patients remained in hospital more than a week, 24% remained more than a month and 5% of ALC patients were hospitalized for more than 100 days, at 50).

\(^{113}\) *Ibid*.

\(^{114}\) *Ibid*.

\(^{115}\) *Ontario Ministry of Finance, supra* note 110.

\(^{116}\) Canadian Hospice Palliative Care Association, *Fact Sheet: Hospice Palliative Care in Canada* (2012), online: <http://www.chpca.net/media/7622/fact_sheet_hpc_in_canada_may_2012_final.pdf> (it is estimated that only 16% to 30% of Canadians have access to or receive hospice palliative care at the end of life, at 2).

\(^{117}\) Schulklenkm, *supra* note 38 at 12.
given that physicians generally oppose the prescription of futile treatment in futility disputes. However, it appears that futility-drivers are cultivating an attitude amongst physicians that the provision of futile treatment is acceptable. Indeed, it may be only in extreme cases – for example, where futile treatment is especially harmful, or particularly expensive and resource intensive, or being provided for an indefinite period of time - that physicians raise concerns about its further provision.

Second, the futility-drivers are engrained aspects of the healthcare system. Failing a dramatic overhaul of the healthcare system, the fee-for-service model will remain in effect and ALC patients will remain in acute hospital settings. Likewise, medical technology will continue to advance, physicians will continue to fear litigation, and patients and SDMs will continue to hold out hope that any medical care will produce a cure.

Nevertheless, given the harms caused by futile treatment discussed above it is desirable to limit the provision of futile treatment and stymy the further influence of futility-drivers within the healthcare system. In my view, a legal standard of medical futility should be recognized against which the benefit of a treatment can be assessed. If an intervention fails to meet this standard it should be withheld or withdrawn.

The difficulty in establishing such a legal standard is the lack of consensus as to what constitutes ‘futile treatment’. Broadly, futile treatment may be defined as a therapy that is of no benefit to the patient. However, there is disagreement about what is non-beneficial treatment. The assessment of benefit is a value-laden judgment, and so a determination of medical futility is “a subjective judgment which rests largely on the beholder’s treatment philosophy.” Thus, the futility debate is frequently reduced to “what effects count as benefit and who decides which benefits are worth pursuing?”

---

118 Health Care in Canada, 2010, supra note 111 (the CIHI suggest that ineffective care could be reduced within the healthcare system if the provision of treatment is more closely aligned with evidence of its appropriateness, at 22-24).
119 Miles, supra note 56 at 310.
120 Palda, supra note 33 at 211.
The following section will discuss and critique four oft-cited definitions of futility. Drawing from this discussion, I will propose a definition I envisage can be transformed into a suitable legal standard of medical futility.

3 What is Futile Treatment?

3.1 Physiological futility

Physiological futility describes a treatment that offers no physical benefit to the patient and is often exampled by absurd scenarios, such as performing CPR on someone dying of exsanguination. The critical element in identifying physiological futility is that it is value-free assessment of whether the intervention will benefit the patient. In other words, it is determined against purely objective criteria agreed upon by the doctor and the patient or the patient’s SDM. In contrast to the other three types of futility, discussed below, there is little debate surrounding physiological futility, as it would be difficult to defend a system that obligated physicians to prescribe absurd forms of treatment simply because it was demanded by a patient. It follows that few would argue against physiologically futile treatments being withheld or withdrawn based on clinical judgment alone.

Nonetheless, Cranford and Gostin note that, aside from trivial or absurd examples, few medical interventions have absolutely no chance of succeeding and would be classified as physiologically futile. In most cases a judgment of futility is an intensely value-laden judgment, and I will discuss three value-laden meanings of ‘medical futility’ below.

---

122 Steven H Miles, "Medical Futility" (1992) 20 L Med & Health Care 310 at 310; Cranford & Gostin, supra note 1 at 307.
124 Cranford & Gostin, supra note 1 at 308. C.f. Schneiderman & De Ridder, supra note 79 (“far from being value-free, it in fact a value choice. It privileges physiology and body parts over the patient” at 171).
125 Miles, supra note 56 at 310.
126 Grant, supra note 59 at 331.
127 Cranford & Gostin, supra note 1 at 308.
128 Ibid.
3.2 Goal-driven futility
The first value-laden category of medical futility involves interventions where there are disagreements about the goals of the treatment and whether the intervention will satisfy those goals.\(^{129}\) For example, tube feeding provides nutrition for unconscious patients in order to sustain life in a comatose state. To the patient’s family, the extension of life may be the goal of the feeding tube, regardless of long-term prospects of recovery. The treating physician may disagree and argue that the goal of the feeding tube is to sustain the life of the patient for the purpose of enabling long-term recovery.\(^{130}\) There is no disagreement as to the physiological effectiveness of the treatment - tube feeding is providing the patient sustenance and keeping him alive - rather there is discord about the purpose of the treatment.\(^{131}\)

The critical question then becomes who makes the authoritative decision about the goals of treatment?\(^{132}\) Historically, physicians were tasked with defining the goals of treatment and informing the patient whether those goals were being achieved.\(^{133}\) However, as medical paternalism has given way to patient autonomy, patients are increasingly taking control of treatment decisions, and treatment is being prescribed to satisfy both medical goals and the patient’s personal goals.\(^{134}\) Nevertheless, an impasse will emerge if the patient, or the patient’s SDM, and the treating physician cannot reach a consensus as to the goals of treatment.

3.3 Quantitative futility
The second value-laden definition of futility refers to instances where there is agreement on the goals of treatment but disagreement on the probability of achieving those goals.\(^{135}\) Quantitative futility measures the likelihood that a treatment will benefit a patient.\(^{136}\)


\(^{130}\) Cranford & Gostin, *supra* note 1 (“[medical treatment] cannot restore or maintain health, for health is a meaningless concept for someone who is permanently and completely unconscious. It cannot minimize disability, because someone in PVS is no more or less “disabled” than someone who is dead and, finally, medical treatment cannot minimize suffering for one who experiences no consciousness and therefore no suffering” at 308)

\(^{131}\) Taylor & Lantos, *supra* note 121 at 4.

\(^{132}\) Bailey, *supra* note 45 at 174.

\(^{133}\) *Ibid.*

\(^{134}\) *Ibid.*

\(^{135}\) Baylis, *supra* note 129.

\(^{136}\) Schneiderman & De Ridder, *supra* note 179 at 171.
A physician must refer to medical data to assess the quantitative futility for a particular intervention. For example, in *London Health* the treating physician testified that “the literature indicates that no patient with the combination of test results that RK exhibited has survived.”\(^{137}\) A study examining ICU treatment for multi-organ failure provides an example of clinical data that can be used to assess the futility of ICU care.\(^{138}\) The authors reviewed 398 cases of patients who received intensive care treatment for multi-organ failure prior to death.\(^{139}\) Out of the 398 patients not one survived to be discharged from hospital, leading the authors to conclude:

\[\text{...in a world of unavoidable clinical uncertainty, finite resources and competing demands, allocation decisions must be made in health care. It is difficult to specify limits beyond which treatment should be withheld when there is any chance that a life can be saved. However, if we cannot agree that treating 400 patients with prolonged intensive care without producing a single survivor is beyond such a limit, then it is unlikely we can reach a consensus about limiting care in any clinical situation.}^{140}\]

Quantitative futility attracts criticism, however, because the likelihood of success can never be precisely determined for each individual patient. As Schneiderman and De Ridder observe:

\[\text{clinical circumstances are so complex that one can never be absolutely certain of the outcome... medical practice almost never achieves certainty; rather, it depends on empiric clinical experience. Physicians prescribe specific drugs and dosages because such treatments have been observed to achieve beneficial effects (over unwanted side-effects) sufficiently often in the past that they feel confident these practices will work in the future. But each patient represents a new challenge...uncertainty lurks in the shadow of every medical decision.}^{141}\]

Schneiderman and De Ridder suggest that the uncertainty of medicine has lead to a “kind of paralysis of action’. If the physician can never be absolutely certain, then isn’t the physician obligated to do anything and everything that might conceivably work?”\(^{142}\) Put another way, where the probability of success is uncertain, it is better to over-treat than under-treat. Nevertheless to avoid the over prescription of futile treatment Schneiderman and De Ridder argue that quantitative futility should be imbued with a reasonableness requirement, whereby


\(^{139}\) *Ibid.*

\(^{140}\) *Ibid* at 632.

\(^{141}\) Schneiderman & De Ridder, *supra* note 179 at 171.

\(^{142}\) *Ibid* at 172.
it is reasonable to conclude an intervention is medically futile if research shows that a treatment has not worked in the past 100 occasions.\textsuperscript{143}

A study by Gabbay and colleagues tested the validity of this quantitative definition of futility by examining the extent to which data concerning claims of futility varied.\textsuperscript{144} Statistically, the quantitative definition holds “clinicians can be 95\% confident that no more than three successes would occur in every 100 comparable trials.”\textsuperscript{145} The results showed that the degree of statistical confidence was highly variable, and many studies were considered to have low sensitivity, meaning that there were relatively few patients in the poor prognosis category on which the futility claim was based.\textsuperscript{146} Importantly, most articles supporting futility did not meet the 95\% confidence limit that an adverse outcome would result on 96\% or 97\% of occasions and so failed to meet the quantitative definition’s threshold. Gabbay and colleagues concluded:

that in most clinical scenarios, clinicians cannot base decisions to withhold or withdraw treatment based on data-proven futility, since empirical evidence that provides a high level of statistical confidence is lacking.\textsuperscript{147}

Therefore, before quantitative futility can be justifiably relied on in medical decision-making, there must be general consensus in medical literature regarding outcomes for a particular treatment. Gabbay and colleagues found that the studies which satisfied the quantitative threshold were almost exclusively related to CPR; yet studies relating to critically ill patients, who had not suffered a cardiac arrest, almost always failed to meet the standard.\textsuperscript{148} This finding would suggest that quantitative futility is not yet a definitive decision-making tool in the ICU setting.

Finally, quantitative futility is unappealing from the perspective that it describes the patient as a statistical probability. Withholding or withdrawing treatment based on numbers and figures likewise removes the possibility that the patient is the 1 in 100 that experiences a positive outcome. Clinical judgment may suggest that a 1 in 100 survival rate is poor, but an

\begin{itemize}
  \item \textsuperscript{143} \textit{Ibid} at 171
  \item \textsuperscript{144} Ezra Gabbay, Jose Calvo-Broce, Klemens Meyer, Thomas Trikalinos, Joshua Cohen and David Kent, "The Empirical Basis for Determinations of Medical Futility" (2010) 25 (10) J Gen intern Med 1083.
  \item \textsuperscript{145} \textit{Ibid} at 1083.
  \item \textsuperscript{146} \textit{Ibid} at 1086.
  \item \textsuperscript{147} \textit{Ibid} at 1087.
  \item \textsuperscript{148} \textit{Ibid} at 1087.
\end{itemize}
optimistic patient may interpret the statistic as suggesting some hope of survival and place immense value on that hope in the decision-making process. However, if a commitment is made to treat every optimistic patient and 99 out of 100 present as believing they are the 1 out of 100, then the healthcare system is forced to expend resources in a sub-optimal way.

In summary, while quantitative futility may be a valuable analytical tool for physicians to advise patients when making treating decisions, it is still a value-laden definition because of the weight that the patient or SDM will put on his or her statistical probability of survival. If physicians do not account for the values of the patient, this threatens to dehumanize the patient and deprive them of hope. As Bishop and colleagues aptly note, “just because almost all patients in a similar situation would die does not mean that this patient will die.”

### 3.4 Qualitative futility

The final category of medical futility, and arguably the most value-laden, is where the intervention will not improve, or may further diminish, the patient’s quality of life. Interestingly, qualitative futility can trace its roots in ancient Greek philosophy. In The Republic Plato wrote:

> For those whose lives were always in a state of inner sickness Asclepius did not attempt to prescribe a regimen…to make their life a prolonged misery… …a life of preoccupation with illness and neglect of work isn’t worth living.

But assessing whether ‘life is worth living’ is an exceptionally value-laden and moral judgment. For example, a physician may opine that continuing life-support for a patient in a PVS is futile because the patient is incapable of conscious thought or meaningful human interaction and is suffering from ailments caused by prolonged confinement to bed. In contrast, the patient’s SDM may argue that assessments of quality of life are irrelevant; all that matters is that the patient still lives. Qualitative futility is marked by philosophical debate regarding the value of human life and what constitutes a meaningful existence.

Schneiderman and De Ridder suggest that in order to properly assess the qualitative impact of a treatment “we must distinguish between an effect and a benefit.”

---

149 Jeffrey Bishop et al, "Reviving the Conversation around CPR/DNR" (2010) 10:1 AJOB 61 at 63.
150 Baylis, *supra* note 129.
151 As quoted by Schneiderman & De Ridder, *supra* note 79 at 173.
152 Cranford & Gostin, *supra* note 1 at 308.
153 Schneiderman & De Ridder, *supra* note 79 at 173.
may have the *effect* of providing artificial respiration to a PVS patient but the ventilator does not have the *benefit* of allowing the patient to pursue life goals.\textsuperscript{154} This distinction essentially seeks to address the problematic technologic imperative, whereby it is acknowledged that a medical technology, such as a mechanical ventilator, may be clinically effective on the patient’s body but will still be futile if it has no benefit. In dismay, Schneiderman and De Ridder state that recognition of the clinical effects of end-of-life treatments are taking precedence over the benefits of such treatment:

One might also argue that the goal of medicine is not to keep people alive in the ICU, where they are preoccupied (to use Plato’s word) with treatment and can do nothing else with their life…When they were developed in the 1960s, ICUs were intended to be only temporary havens for desperately ill patients who would be expected either to die or to recover. But today, ICUs have become a type of purgatory for many patients who remain for months and months on the brink of death before succumbing to their illness.\textsuperscript{155}

Nevertheless, the distinction between ‘benefit’ and ‘effect’ is supported in the most recent policy statement on life-sustaining treatment from the CMA, which states a patient will only “benefit” from life sustaining interventions if she makes a recovery from a reversible illness or regains “a state of meaningful interaction with one’s environment where the illness is not reversible and the person cannot survive without life-sustaining interventions.”\textsuperscript{156}

The controversy surrounding qualitative futility is also tied to the debate surrounding the “right to life”, which is protected through s 7 of the *Canadian Charter of Rights and Freedoms*.\textsuperscript{157} Traditionally, the right to life has meant that human life must be preserved and protected independent of any other qualities of the person, such as physical or mental impairment.\textsuperscript{158} The majority of the Supreme Court in *Rodriguez v British Columbia* endorsed this sentiment in its decision not to repeal Canada’s anti-euthanasia laws:

The long-standing blanket prohibition in s 241(b), which fulfills the government’s objective of protecting the vulnerable, is grounded in the state interest in protecting life and reflects the policy of the state that human life should not be depreciated by

\textsuperscript{154} Ibid.

\textsuperscript{155} Ibid.

\textsuperscript{156} CMA Statement on Life-saving and –sustaining Interventions, supra note 46.


allowing life to be taken. This state policy is part of our fundamental conception of
the sanctity of life.\textsuperscript{159}

The majority acknowledged, however, the possibility for exception to the principle of the
sanctity of life “where notions of personal autonomy and dignity must prevail.”\textsuperscript{160} This
suggests that the state’s interest in preserving human life is not absolute where there are
concerns about the patient’s quality of life.

Over a decade later, the Supreme Court reasoned that arguments founded on a patient’s
quality of life engage the right to security of the person; whereas, where there is an actual
threat of death the right to life is engaged.\textsuperscript{161} This finding is interesting given the Supreme
Court’s previous conclusion in \textit{Rodriguez} that the patient’s right to security of the person
could not trump the right to life.\textsuperscript{162} Seemingly, evidence that a patient has a diminished
quality of life does not provide a legal counterweight to the state’s interests in preserving the
sanctity of life at all costs, at least in the right-to-die context. It follows then that the
Canadian courts may be reluctant to consider musician’s arguments regarding qualitative
futility in end-of-life cases.

Nevertheless, if any standard of legal futility is to be recognized by law then it should
account for the patient’s views, if known, about whether further treatment is worth pursuing.
Many people would be offended by the idea of someone else putting a ‘value’ on their life.
To find a life worthless and therefore not deserving of treatment, may be a severe
infringement of human dignity. Yet, every day physicians and SDMs make judgments about
the quality of another’s life, and futility disputes only arise where there is disagreement about
whether further treatment will improve the patient’s wellbeing or merely prolong her
suffering. However, as will be discussed in the next chapter, it is questionable whether
anyone has the expertise, including an SDM, to value the benefit that an intervention will
have on an incapacitated patient’s quality of life.\textsuperscript{163}

\textsuperscript{159} \textit{Rodriguez v British Columbia (AG)}, [1993] 3 SCR 519 at 522, 107 DLR (4th) 342.
\textsuperscript{160} \textit{Ibid} at 523.
\textsuperscript{161} \textit{Ibid}.
\textsuperscript{162} \textit{Rodriguez, supra} note 160 at 585.
\textsuperscript{163} Alpers & Lo, \textit{supra} note 51 at 328.
3.5 An integrated definition

The above discussion illustrates that a finding of futility not only requires examination of the physiological effectiveness of treatment but also involves judgments about the value of life, what is the purpose of treatment and how much hope the patient has that treatment will be successful. In light of this, I propose a definition of futility that incorporates the clinical and personal components of medical futility: a treatment is futile where there is no reasonable probability an intervention will create an effect the patient is able to experience as a benefit.164

This definition demands that the decision-maker must consider what the physiological effect of the treatment will be, what is the probability that the physiological effect will occur, and whether that physiological effect is beneficial to the patient in light of the patient’s values, beliefs and wishes. I venture then that this definition could be transformed into a legal standard of medical futility because it accounts for the views of both the medical profession and the patient. It will relieve fears that legal recognition of futility will be used to ‘pull-the-plug’ against the wishes of the patient or SDM. Further, it gives physicians a legal platform to open discussions with the patient or SDM about whether further treatment is truly benefiting the patient in a manner she could appreciate. In Chapter Five, I will explore how this definition can be translated into a legal standard of medical futility within Ontario’s Health Care Consent Act 1996 (HCCA).165

4 Futility and the Physician

Who should have the authority to decide whether a treatment is futile? It is preferable that the decision-making parties reach a consensus following discussions about the patient’s diagnosis and prognosis, the nature of the proposed treatment, and the patient’s views regarding treatment. In most cases agreement will be reached on a course of action in this way.166 One study found that 57% of SDMs agreed immediately with a proposed plan of care,

---

164 This definition is adapted from Lawrence Schneiderman’s definition of medical futility, “the unacceptable likelihood of achieving an effect that the patient has the capacity to appreciate as a benefit”: Lawrence Schneiderman, "Defining Medical Futility and Improving Medical Care" (2011) 8 Bioethical Inquiry 123 at 123.
166 Pope, supra note 91 at 204.
and 90% agreed within five days of the plan being proposed.\textsuperscript{167} Nevertheless, cases like \textit{Rasouli SCC} evince that an impasse cannot always be overcome by ongoing deliberation between physicians and the SDM.\textsuperscript{168} Thus, some person or body must be responsible for making the ultimate assessment on medical futility (even if the concept is defined in the manner I have proposed), whether it is the physician, SDM, a specialized tribunal (i.e. Ontario’s Consent and Capacity Board (CCB)) or even the courts.

Physicians have customarily employed medical futility to support withdrawing or withholding treatment they deem to be clinically ineffective.\textsuperscript{169} Futility, in this sense, is part of medical jargon. The concept empowers physicians to articulate the ends of medicine, and it protects them from breaching their ethical and professional obligations by directing that they provide only clinically appropriate treatment.

Nevertheless, this customary use ignores the fact that futility is a value-laden concept. It frames futility solely through the lens of the medical profession, leaving no room for input from patients or SDMs about the value of treatment. The dangers of physician-driven futility will be discussed below.

\textbf{4.1 Physicians are not always right}

Physicians are not always right. It has been estimated that the incidence of adverse medical events\textsuperscript{170} in Canada is about 185,000 annually or 7.5\% of all hospital admissions.\textsuperscript{171} Physician error is responsible for roughly 58\% of all adverse events that occur in hospital settings,\textsuperscript{172} with misdiagnosis being the second most common non-operative type of error.\textsuperscript{173}

\begin{flushright}
\textsuperscript{168} Rasouli, supra note 94 (the Court acknowledged there were an undisclosed number of meetings between “Mr Rasouli’s family and the doctors from the Critical Care Unit, neurologists, a neurosurgeon, nurses, a social worker and an ethicist” at para 4).  \\
\textsuperscript{169} The following are examples of cases where physicians have argued in evidence that treatment is futile: Re TC 2011 CanLII 12485 (ON CCB) at 6; Scardoni, supra note 94; Re DD, 2013 CanLII 18799 (ON CCB) at 23; London Health, supra note 2 at para 9.  \\
\textsuperscript{170} Baker, supra note 104 (adverse medical events are “unintended injuries or complications that are caused by health care management, rather than by the patient’s underlying disease and that lead to death, disability at the time of discharge or prolonged hospital stays” at 1678).  \\
\textsuperscript{172} \textit{Ibid} at 379.
\end{flushright}
Indeed, physicians are estimated to make diagnostic errors in 10-15% of cases.\textsuperscript{174} Statistically, it is highly likely that at some point a physician will make an error about the futility of treatment.

But, physicians are humans and ‘to err is human’.\textsuperscript{175} Clinical reasoning by nature involves a degree of uncertainty despite the use of objective, well-established scientific knowledge of pathophysiological processes.\textsuperscript{176} As Bishop and colleagues astutely note “[the] uncertainty in any decision, including those about futility of treatment, cannot be reduced to zero, or anything that approximates zero.”\textsuperscript{177} Errors may occur even where the physician is complying with professional standards of care.\textsuperscript{178} In other cases an adverse event will occur as a direct result of a physician’s failure to meet professional standards.\textsuperscript{179}

The inevitability of clinical error and the high incidence of adverse events suggest it is unwise to provide a single physician with unilateral power to determine futility. This reservation against physician-driven futility is particularly warranted given the consequences of erroneously withholding or withdrawing treatment include: prolonged suffering, worsening of the patient’s disability or disease, or even the patient’s premature death.

\textsuperscript{173} Ibid (drug related incidences were the most common type of physician mistake, at 378).
\textsuperscript{175} To Err is Human was the title of an influential report released in 1999 by the US Institute of Medicine discussing adverse events in health care and how safety in health care can be improved. The report recommendation that attention be focused on creating better health systems to reduce medical error, rather than fixing blame on individual physicians: Linda Kohn, Janet Corrigan & Molla Donaldson, eds, To Err is Human: Building a Safer Health System, Institute of Medicine (Washington DC: National Academy Press, 1999) at 179.
\textsuperscript{177} Jeffrey Bishop, supra note 149 at 64.
\textsuperscript{178} Bernard Dickens, “Medical Negligence” in Jocelyn Downie, Timothy Caulfield & Coleen M Flood, eds, 4\textsuperscript{th} ed, Canadian Health Law and Policy, (Markham; LexisNexis Canada, 2011) at 127.
\textsuperscript{179} For example: Simice, supra note 74 (the physicians did not adequately satisfy professional standard of care and this contributed to the patient’s death).
4.2 Reviving medical paternalism

Physician-driven futility has been criticized as being a disguised form of medical paternalism.\textsuperscript{180} Beauchamp and Childress argue that the term ‘futility’ is an indicator of passive paternalism, being a “professional’s refusal, for reasons of patient-centered beneficence, to execute a patient’s positive preferences for an intervention.”\textsuperscript{181} Passive paternalism holds that doctors can invoke arguments based on acceptable standards of practice and conscientious objections to negate their ethical obligation to prescribe treatment.\textsuperscript{182} The benefit for a physician in acting in a passively paternalistic fashion is that it “obviates the need to discuss their own uncertainty about medical issues, and because it reiterates their self-conception of scientific rationality.”\textsuperscript{183}

Ann Alpers and Bernard Lo argue that any form of physician-driven futility invites physicians to impose their own idiosyncratic judgments about who will receive care.\textsuperscript{184} It encourages physicians to make decisions based on sterile clinical reasons, devoid of consideration for the goals and values of the patient. Alpers and Lo conclude that, “[i]t offends the idea of justice to have life and death decisions rest in the hands of individual doctors who, by invoking futility, can ration health care without explanation either to the patient or to the community.”\textsuperscript{185}

Indeed, as stated above, very few futility decisions will be devoid of some objective assessment of the patient’s quality life. To avoid the label ‘paternalism’ physicians will have to give considerable attention and weight to the patient’s subjective values, as well as ignore any idiosyncratic views she may have that will inappropriately influence a judgment of futility. Yet, even the most astute physician will be tempted to impose her own views when it comes to medical decision-making.\textsuperscript{186} The reality is that physician-driven futility is unavoidably paternalistic.

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{180} Miles, supra note 56 at 310.
\item \textsuperscript{181} Tom Beauchamp & James Childress, Principles of Biomedical Ethics, 6th ed (NY: Oxford University Press, 2009) at 219.
\item \textsuperscript{182} Ibid at 220.
\item \textsuperscript{183} Brennan, supra note 5 at 336.
\item \textsuperscript{184} Alpers & Lo, supra note 51 at 328.
\item \textsuperscript{185} Ibid.
\item \textsuperscript{186} Grant, supra note 59 at 333; Allen Verhey, "The Death of Infant Doe" (1982) 32:6 Reformed Journal 10
\end{itemize}
\end{footnotesize}
4.3 Masking discrimination

Some commentators warn that physician-driven futility could be used to discriminate against vulnerable populations, such as the elderly or profoundly disabled. An example of the discriminatory use of medical futility was the case of Infant Doe in 1982 in Indiana, US. Infant Doe was a baby boy born with Down’s Syndrome and esophageal atresia - a malformation of the esophagus that prevents food from entering the stomach. His parents did not consent to the procedure to remedy the esophageal atresia. His treating obstetrician supported the parents’ decision, arguing that the chance of successful surgery was 50/50, and the child would continue to suffer a life of ill-health and retardation. In other words, the obstetrician viewed the surgery to be futile.

In conflict, a consulting pediatrician argued that the chance of successful surgery was high (90%) and the quality of the infant’s life, as measured by the degree of retardation, was unknown. The decision of the parents and the obstetrician, which a court refused to overturn, was criticized on the basis that had the child not suffered from Down Syndrome the surgery would have been performed immediately (even if the surgical risk was 50/50). Infant Doe was discriminated against via the obstetrician’s finding of futility, which was predominantly based on the infant’s mental disability rather than whether the surgery would effectively cure his physical ailments.

---

187 See for example: Grant, *ibid*.
188 Verhey, *supra* note 186 at 10.
189 *Ibid* at 10-11.
190 *Ibid* at 11.
191 This case resulted in the enactment of the *Child Abuse Amendment Act of 1984*, Pub L No 98-457, 98 Stat 1749, which requires the provision of all medically indicated treatment unless 1) the baby is comatose 2) the treatment would not be effective in ameliorating the life threatening condition or otherwise be futile in terms of the infant or 3) the treatment would be futile or otherwise inhumane.
192 Verhey, *supra* note 186 at 11. It is arguable that it was not appropriate for the court in the case of Infant Doe to intervene given a consensus had been reached by the infant’s primary treating physician and parents. However, in other US cases the courts have been willing to overturn a treatment decision agreed upon by a SDM and the treating physicians, such as the infamous case of Karen Quinlin. Quinlin was in a PVS after suffering oxygen deprivation to the brain. Her parents and guardians sought an order from the court to remove her mechanical ventilator and her treating physicians and the hospital supported the application. The New Jersey Superior Court denied the application in the first instance. However, on appeal to the New Jersey Supreme Court, the order was granted: Robert McFadden, “Karen Ann Quinlan, 31 Dies; Focus of ’76 Right to Die Case” (1985) *The New York Times*, online:
The Infant Doe saga illustrates that physician-driven futility risks discriminatory medical practices where the physician’s assessment of the futility is divorced from a clinical evaluation about the burden and benefits of the proposed treatment, and instead, is reliant on consideration of other irrelevant qualities of the patient.\textsuperscript{193} Again even if a physician makes a conscious commitment not to let her personal values influence her assessment of futility, unconscious biases may still infiltrate her proposal to withhold or withdraw treatment. As the courts have acknowledged, “there is [always] a risk of unconscious bias about the quality of life of a person with a disability.”\textsuperscript{194} The threat of unconscious bias may explain the legal reluctance to recognize medical futility throughout Canada.

**Evaluation**

In this Chapter I have explored the controversy surrounding medical futility. I have argued that the provision of futile treatment is harmful to: the healthcare system, patients, the medical profession and society. The harms caused by futility will continue to proliferate because the influences driving futility are ingrained aspects of Canada’s public health system and are creating patient demand as well as encouraging physician supply of futile care. Therefore, law reform is desirable to eliminate, or at least limit, futile treatment within Canada’s healthcare system and to counter the strong and stubborn influence of futility-drivers within the healthcare system.

But medical futility is a value-laden concept; a finding of futility rests on the beliefs of the decision-maker. While most reasonable people will defer to a physician’s opinion about the physiological effects of treatment, they many not agree with the physician’s assessment of whether the treatment is worth pursuing. Indeed, any legal endorsement of physician-driven futility will prioritize the beliefs of a physician over the beliefs of the patient she is treating, which may lead a verdict on the futility of treatment that is wrong, overly paternalistic or discriminatory. Therefore, the definition of futility I have proposed above insists that both the views of the medical community and the patient are weighted when determining whether

---

\textsuperscript{193} Grant, supra note 59 at 334.

\textsuperscript{194} *Carter v Canada (Attorney General)*, 2012 BCSC 886 (CanLII) at para 853.
treatment is futile. In Chapter Five, I will use this definition to suggest amendments to Ontario’s HCCA.

Nonetheless, any conceptualization of medical futility will have to cohabitate the bioethics sphere alongside the principle of personal autonomy, which has “dominated the control of medical practice more than any other [principle] in the last half-century.”\(^{195}\) The rise of personal autonomy in medical decision-making, and the corresponding decline of medical paternalism, means that ultimately it is a patient’s right to determine what is done with his or her body, regardless of clinical advice offered by medical professionals.\(^ {196}\) Of course, if the patient or SDM and the physician agree further treatment is futile, then there is no conflict between the two concepts. However, in the event of a futility dispute, the recent dominance of personal autonomy suggests there is arguably no place for medical futility in medical decision-making - even in the balanced manner I have proposed - because it may diminish the high authority of personal autonomy. The nature of personal autonomy and the reasons why it holds such a dominant position in medical decision-making will be discussed in the following chapter.

\(^{195}\) J K Mason & G T Laurie, *Mason & McCall Smith’s: Law and Medical Ethics*, 7th ed (Oxford; Oxford University Press, 2006) at 6-7.

\(^{196}\) Bishop, *supra* note 149 at 63.
Chapter Two
Personal Autonomy

Introduction

The common law right to bodily integrity and personal autonomy is so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order of protection. This right forms an essential part of an individual’s security of the person and must be included in the liberty interests protected by s. 7. Indeed, in my view, the common law right to determine what shall be done with one’s own body, and the constitutional right to security of the person, both of which are founded on the belief in the dignity and autonomy of each individual, can be treated as co-extensive.¹

This statement from Ontario’s Court of Appeal in Fleming v Reid is often cited² to support the proposition that the principle of personal autonomy is a fundamental consideration in medical decision-making. In fact, over the last four decades, the principle of personal autonomy has become the dominant legal principle in medical decision-making.³ The importance of personal autonomy is reflected in Ontario’s Health Care Consent Act (HCCA) which is, in part, designed to “enhance the autonomy of persons for whom treatment is proposed.”⁴ Moreover, the Supreme Court has acknowledged personal autonomy trumps all other interests in the healthcare context, including medical futility.⁵

Personal autonomy reigns despite its enigmatic nature. Broadly, the principle of personal autonomy holds that it is the right of every individual to make reasoned decisions for herself based on personal values, beliefs and goals.⁶ The principle is championed as a safeguard to protect a patient’s right to decide what is done with his or her body against the threat of

---

¹ Fleming v Reid (1991), 4 OR (3d) 74, 82 DLR (4th) 298 (Ont CA) at 21 [Fleming].
² A search of this quote on www.CanLII.org reveals it has been cited 119 times in judicial decisions or in judgments from the CCB.
⁴ Health Care Consent Act, SO, 1996, c 2, s 1(c) [HCCA].
⁵ Rasouli SCC, ibid at 3.
⁶ J K Mason & G T Laurie, Mason & McCall Smith’s: Law and Medical Ethics, 7th ed (Oxford: Oxford University Press, 2006) at 5.
medical paternalism. However, controversy exists about the scope of personal autonomy. Increasingly, personal autonomy is being applied in a manner that suggests patients are entitled to receive all or any treatment they desire, regardless of other interests that may justifiably limit the extent to which individuals can make demands on the public healthcare system. Moreover, the law protects patient autonomy even where a substitute decision-maker (SDM) is charged to make treatment decisions on behalf of an incapacitated patient. Given the potential for SDM error in expressing a patient’s preferences, it is questionable whether personal autonomy deserves strong legal recognition and protection when a patient is incapacitated.

The purpose of this chapter is to explore the nature and scope of personal autonomy within the healthcare context, and explain why it has risen to be “one of, if not the, dominant concept in health law and theory.” This discussion is central to understanding why the law is reluctant to recognize medical futility. The chapter is divided into three parts. In Part One, I will show that personal autonomy is the human capacity for decision-making and its promotion in the healthcare setting empowers patients to become active and informed consumers of healthcare services. Further, I will argue that personal autonomy has become the paramount principle in medicine because of its strong roots in the common law and constitutional law.

In Part Two, I will explore the legal scope of personal autonomy. In particular, I will assess whether personal autonomy contains positive obligations such that it could be used to compel a physician to prescribe contra-indicated treatment. I will then introduce four interests that support a narrow, communitarian understanding of personal autonomy. The purpose of this part will be to show that personal autonomy should not be applied in a way that entitles a patient to receive all or any treatment desired, regardless of its medical implications.

In Part Three, I will examine the extent to which personal autonomy survives incapacity. I will focus on two scenarios: first, whether personal autonomy survives through a patient’s prior known wishes and second, whether personal autonomy survives through the substitute decision-making model. My aim is to show that in some instances, though not all, personal autonomy is extinguished at the time the patient becomes incapacitated, and therefore

---

personal autonomy should not necessarily be considered the dominant decision-making principle when a SDM is tasked with making treatment decisions.

1 What is Personal Autonomy?

1.1 The basics

Personal autonomy has attracted criticism for its ill-defined nature and heterogeneous application within the medico-legal context. The inarticulate characterization and use of personal autonomy endures despite the notion of ‘autonomy’ being the focus of academic debate for over two thousand years. The concepts of autos (“self”) and nomos (“rule”) were originally used by the ancient Greeks to describe city-states that enjoyed self-governance. Thus, understood literally, personal autonomy is the idea of self-governance or self-management.

In the 18th century, philosophers began reformulating autonomy as a human quality. Notable amongst these philosophers was Emmanuel Kant who argued that individuals should be free to act according to their own rational insights, as opposed to being strictly bound to the laws of the state or religion. Ideally, the individual should be guided by her own ‘rational will’ that is formed from her acknowledgement and acceptance of shared moral norms in society, but which, if she is to be truly autonomous, cannot be forced upon her by external powers. Hence, Kantian autonomy is heavily imbued with the question of whether a person is acting according to socially accepted moral norms.

Modern ideas of personal autonomy insist on “the atomistic rights of individuals to decide for themselves”, unrestrained and undeterred by the opinions and moral interests of other people or the broader community. Contemporary notions reflect the Western-liberal philosophy that, absent just cause, the state should not interfere with an individual’s values,

---

9 Beauchamp & Childress, supra note 3 at 99.
10 Stirrat & Gill, supra note 8 at 127.
11 Ibid.
12 Theda Rehbock, "Limits of autonomy in Biomedical Ethics? Conceptual Clarifications" (2011) 20 Cam Q Healthe Ethic 524 at 527.
13 Ibid.
14 Mason & Laurie, supra note 6 at 5.
beliefs and choices regardless of how unwise or irrational they are. The individual should be free to make choices and pursue personal projects without oppressive external influences.

Gerald Dworkin in his seminal work *The Theory and Practice of Autonomy* argues that contemporary personal autonomy is more complex than simply being free from oppressive external influences. Rather, autonomy incorporates the distinctive human capacity:

> to reflect upon one’s motivational structure and make changes in that structure. Thus, autonomy is not simply a reflective capacity but also includes some ability to alter one’s preferences and to make them effective in action. Indeed to make them effective partly because one has reflected upon them and adopted them as one’s own.\(^\text{15}\)

It follows that, on a Dworkinian analysis, personal autonomy includes both individual *freedom* of choice and individual *capacity* to make choices. In other words, personal autonomy represents the human capacity for decision-making. The association between personal autonomy and the human ability to make decisions is supported by the New Dictionary of Medical Ethics, which defines ‘autonomy’ as “the capacity to make deliberated or reasoned decisions and act on the basis of such decisions.”\(^\text{16}\) For the purposes of this paper, personal autonomy is defined as the capacity of an individual to make reasoned decisions for him- or herself based on personal values, beliefs and goals.

### 1.2 The value of personal autonomy

The principle of personal autonomy evolved in response to medical paternalism. Paternalism holds that a physician can usurp the decision-making capacity of the patient by making treatment decisions on behalf of a patient, justified on the basis that treatment or non-treatment is in the patient’s best interests.\(^\text{17}\) This model of decision-making was not ideal as patients were provided medical care in accordance with the idiosyncratic views of their treating physician, which in some circumstances led to the misuse of medicine. For example, the influence of paternalistic ideology allowed for the forced sterilization without consent of

---


\(^\text{17}\) Dworkin, *supra* note 15 at 123.
more than 60,000 people living in the US between 1907 and 1953, mostly women institutionalized in prisons or asylums.\footnote{18}

In response to such abuses, the principle of personal autonomy emerged within the healthcare system. The principle recognizes that healthcare should not be ‘one-size-fits-all’; rather, the patient is an individual with a unique set of values, beliefs and goals that will influence the form and extent of care required. The “triumph of personal autonomy”\footnote{19} is that it empowers patients to become active and informed consumers of healthcare services, so that medical care is delivered in a way that caters to their personal needs and values.

The normative significance of the principle of personal autonomy also warrants consideration i.e. why is recognizing personal autonomy a good thing? I propose the answer to this is threefold. First, autonomous agents are free to pursue projects and relationships of importance, and in turn, the individual will be a content and self-fulfilled member of society.\footnote{20} Dworkin claims “being able to shape one’s own choices and values makes it more likely that one’s life will be satisfying than if others, even benevolent others, do the shaping.”\footnote{21} It follows that the “good-life” is not possible for a non-autonomous agent.\footnote{22} In the healthcare context, if patients are to be happy and satisfied consumers of the healthcare system, they will necessarily have to operate as autonomous agents within it.

Second, by respecting others’ autonomous choices, we command respect for our own autonomous choices. The exercise of personal autonomy cannot be fully realized if others do not also respect it.\footnote{23} The intrinsic value of personal autonomy stems from “the desire to be recognized by others as the kind of creature capable of determining our own destiny.”\footnote{24} By

\begin{itemize}
\item \footnote{18} Hoangmai Pham & Barron Lerner, “In the patient’s best interest? Revisiting sexual autonomy and sterilization of the developmentally disabled” (2001) 175 West J Med 280 at 281.
\item \footnote{19} Stirrat & Gill, supra note 8 at 127.
\item \footnote{20} Mason & Laurie, supra note 6 at 7.
\item \footnote{21} Dworkin, supra note 15 at 111.
\item \footnote{22} Ibid at 112.
\item \footnote{23} Ibid.
\item \footnote{24} Ibid.
\end{itemize}
encouraging a culture of personal autonomy, individuals are ensuring peace and security for all members of society, including themselves, free from oppressive external influence.\textsuperscript{25}

Third, an autonomous agent assumes responsibility for the consequences of his autonomous choices. Personal autonomy exists when “the agent is able to identify with its own choices.”\textsuperscript{26} If the exercise of personal autonomy harms the individual or society then the autonomous agent must accept the burden of blame and punishment.\textsuperscript{27} Hence, in the healthcare context, if a patient has made an autonomous choice regarding treatment then she must accept the consequence of that decision, and, at least in theory, the physician is absolved from responsibility for any harm associated with a patient’s decision-making.

Nevertheless, patients rarely make healthcare decisions without some external influence or guidance, such as from the medical profession or loved ones. The treating physician has a duty to: substantively and clearly consult with the patient regarding her prognosis and diagnosis, advise the patient on available treatments, describe the benefits and burdens of those treatments, and recommend a course of treatment which the physician believes is in the patient’s best interests. Likewise, a patient’s family and friends will help support and guide the patient to make treatment decisions, taking account of medical advice as well as the patient’s personal and familial values and beliefs. The purpose of personal autonomy is not to eliminate the influence of external assistance in the decision-making process. Indeed, the decision-making process may be overwhelming even to a patient who is mildly unwell, let alone a patient with a severe disease or disability. Rather, personal autonomy ensures that any external assistance serves only to guide the patient in making treatment decisions; professional or familial input should not coerce the patient to make a particular choice or unduly oppress the patient’s values, beliefs or wishes.\textsuperscript{28}

\textsuperscript{26} Begum Bulak & Alain Zysset, ”'Personal autonomy' and 'Democratic Society' at the European Court of Human Rights: Friends or Foes?” (2013) 2 UCLJLJ 230 at 248.
\textsuperscript{27} Dworkin, \textit{supra} note 15 at 112.
1.3 The legal foundations of personal autonomy

The legal roots of personal autonomy are deeply engrained in both common law and constitutional law. Personal autonomy is not a legal right in and of itself, but is informed by human rights norms, including the concepts of human dignity, the right to self-determination and the doctrine of informed consent, and the rights to liberty and security of the person. My purpose, in this section, is to examine how personal autonomy has evolved from these human rights norms to become the dominant principle in medical ethics, and explain why this relationship enables the principle to triumph over other considerations, such as medical futility.

1.3.1 Human dignity

In *Law v Canada*, Iacobucci J asked the question “what is human dignity?” His answer was that, “human dignity means that an individual or group feels self-respect and self-worth.” Human dignity is marked by its absolute universality: every person has human dignity. In this way, human dignity forms the basis of equality between human beings – it unites us through the intrinsic quality of humanity, divorced from other qualities such as race, gender, intellect, wealth, religion, and age.

Due to its universality, human dignity underpins the theory of human rights. For example, the Preamble to the Charter of the United Nations affirms “faith in fundamental human rights, in the dignity and worth of the human person.” Similarly, the International Covenant on Civil and Political Rights and the International Covenant on Economic Social and Cultural Rights are both based on “the recognition of the inherent dignity and of the equal and

---

29 C.f. Fleming, supra note 1 (“[t]he common law right to bodily integrity and personal autonomy” at 21).
31 Ibid.
32 James Griffin, *On Human Rights*, (Oxford: Oxford University Press, 2008) (“no known species but Homo Sapiens has the capacity that carries autonomy…the uniqueness of human beings among known species is enough to justify the ground of human rights that the United Nations has adopted: the dignity of the human person” at 156).
34 Griffin, supra note 32 at 156.
inalienable right of all members of the human family.”36 In the domestic sphere, the Canadian Supreme Court has noted that human dignity is an underlying inspiration in the formation and interpretation of constitutional rights: “[t]he Charter and the rights it guarantees are inextricably bound to concepts of human dignity. Indeed notions of human dignity underlie almost every right guaranteed by the Charter.”37 Therefore, despite human dignity not enjoying status as a fundamental right itself,38 it is the quality that human rights serve to protect.

Human dignity is a formative part of the evolution of personal autonomy. This is because the inherent dignity of an individual is protected when she is the master of her own life.39 Viewed another way, overriding or rejecting the autonomous choices of an individual diminishes the worth of the individual as a thoughtful, self-managed and equal human being.40 Therefore, to preserve a patient’s dignity in the healthcare context, her values, expectations and autonomous choices must be considered and respected by healthcare practitioners.41 By promoting personal autonomy in the healthcare context, the law is preserving human dignity.

37 Blencoe v British Columbia (Human Rights Commission), 2000 SCC 44, [2000] 2 SCR 307 at para 76 [Blencoe]. See also R v Oakes, [1986] 1 SCR 103, 1986 CanLII 46 (SCC), Dickson CJ (“[t]he Court must be guided by the values and principles essential to a free and democratic society which I believe embody, to name but a few, respect for the inherent dignity of the human person” at para 64).
38 Blencoe, ibid (“[r]espect for the inherent dignity of persons is clearly an essential value in our free and democratic society which must guide the courts in interpreting the Charter. This does not mean, however, that dignity is elevated to a free-standing constitutional right protected by s 7 of the Charter. Dignity has never been recognized by this Court as an independent right but rather has been viewed as finding expression in rights, such as equality, privacy or protection from state compulsion” at para 77).
40 B R v Children’s Aid Society of Metropolitan Toronto, [1995] SCR 315, 21 OR (3d) 479 [Children’s Aid Society] (granting an individual “personal autonomy over important decisions intimately affecting his or her private life” preserves the “human dignity of individuals and enable[s] them to feel self-worth and exercise self-determination” at 335)
41 Delmur, supra note 39 at 976.
1.3.2 The right to self-determination and informed consent

An explicit right to self-determination is absent in the Canadian Charter of Rights and Freedoms, but the Supreme Court has confirmed its existence as a common law right on several occasions. This common law right holds that a person is entitled “to determine what shall be done with one’s own body.” The notion that it is wrong to intrude upon another’s physical space without permission stems from the understanding that “a dignified body is whole. It integrates the material and symbolic bodies; it provides a vessel for a whole self.”

To respect human dignity one must also respect the embodiment of dignity - the human body. It follows that a failure to respect a person’s wishes regarding their body is an “insulting denial of autonomy.”

The right to self-determination demands not only non-interference with the human body, but also non-interference with an individual’s mental integrity: the right protects the patient’s capacity to decide what is done with her body. The judiciary has on several occasions reasoned that unwarranted interference with an individual’s decisional capacity breaches the right to self-determination, regardless of whether the patient’s bodily integrity has also been infringed. For example, in Starson v Swayze the Supreme Court held that an incorrect finding of incapacity - which divests a patient of her authority to make medical decisions for herself - “severely infringe[s] upon a person’s right to self-determination.” In Malette v Shulman, Ontario’s Court of Appeal reasoned that “patients have the decisive role in the medical decision-making process. Their right of self-determination is recognized and

---

44 Fleming, ibid at 21.
46 Dworkin, supra note 15 at 113.
47 Mason & Laurie, supra note 6 at 546.
48 See for example: Starson, supra note 43 at para 75; Malette v Shulman, 72 OR (2d) 417, 67 DLR (4th) 321 (ONCA) [Malette] at 10; McInerney v MacDonald, [1992] 2 SCR 138 at para 36, [1992] SCJ 57 (denying patients access to medical records interferes with the right to self-determination). See also Re D, 2005 CanLII 57868 (ON CCB) (“[i]n reaching a conclusion with regards to competency, considerable weight must be given to the desirability of maintaining the patient’s dignity, autonomy and right to self-determination…Care must also be taken not to confuse incompetence with the right of an individual to make decisions, including financial decisions, that others might find unusual, eccentric or even unwise” at 6).
49 Starson, ibid at para 75.
protected by law.” Thus, any unwarranted interference or undue influence affecting a patient’s decisional capacity breaches that patient’s right to self-determination.

The right to self-determination is exercised when a patient gives or refuses consent to a treatment. In effect, consent places a legal barrier between the patient and the physician such that the physician is prevented from providing medical treatment until consent is given. It is this barrier that acts as the “cornerstone for the protection of the fundamental right to physical integrity and self-determination in every field of medical intervention.” If a physician fails to obtain consent before prescribing treatment, she may be liable for medical malpractice, assault, civil battery or negligence, and/or face disciplinary action for professional misconduct or incompetence.

But what is informed consent? Consent may be given through direct expression, in writing or orally, or by implication, where the behaviour of the patient indicates it has been given or withheld. Although informed consent owes its creation to common law, the doctrine has since been codified in Ontario’s HCCA. Under the HCCA, consent must satisfy four criteria to be valid: first, it must be given voluntarily and free from coercion or undue influence; second, consent must be informed, meaning that the patient has received information sufficient for a competent patient to make a decision in his or her situation; third, the

---

50 Malette, supra note 48 at 10.
51 Onora O’Neil, Autonomy and Trust in Bioethics (Cambridge: Cambridge University Press, 2002) at 37; Griffin, supra note 32 (“in medical practice nowadays, ‘patient autonomy’ often comes down to informed consent…” at 153); T(I) v L(L) (1999), OJ No 4237 (available on CanLII) (ONCA) (“the right to decide whether to accept or refuse invasive medical treatment is fundamental to an individual’s bodily integrity and personal autonomy” at para 28).
53 Brian Butler, “Physician and Hospital Liability” in Bloom & Bay, supra note 28, at 172.
55 In 1980’s the Canadian Supreme Court delivered two landmark cases relating to informed consent and the obligations it places on health practitioners: Hopp v Lepp, [1980] 2 SCR 192, 22 AR 361 and Reibl v Hughes, [1980] 2 SCR 880, 114 DLR (3d) 1.
57 Brian Hoffman, The Law of Consent to Treatment in Ontario, (Ontario: Butterworths, 1997) at 8. HCCA, supra note 4 (for consent to be valid the patient must receive information
consent must relate to the form of treatment and who will administer it; and fourth, consent must not be obtained through misrepresentation or fraud. Consent to treatment will be valid only if these criteria are satisfied.

The same criteria apply when measuring the validity of a refusal of consent. A refusal to consent to a treatment is sufficiently powerful in law to cover situations where non-treatment may not be in the patient’s best interests, such as where non-treatment will shorten the patient’s life. Similarly, public interest considerations do not trump a competent individual’s right to refuse consent to treatment. This idea was forcefully confirmed by Robins J in Fleming, where he found that the state’s interest in treating and preserving the life of patients does not - unless very compelling - trump an autonomous agent’s right to refuse treatment. For example, the cost to the community of having to provide social support to the children of a single mother who dies as a result of refusing treatment is not a compelling enough reason to override the woman’s refusal of consent.

Personal autonomy is sometimes perceived as being synonymous with both the right to self-determination and the doctrine of informed consent. In my view personal autonomy is broader in scope than either of these concepts, as it casts a wide protective legal net over a bundle of key values within the healthcare system, including self-dependence, self-worth, human dignity, informed consent and the opportunity to choose and take responsibility for one’s actions. Effectively, personal autonomy empowers patients with a voice to assert their rights and interests within the healthcare systems.

about the nature of the treatment, the expected benefits of the treatment, the material risks of the treatment, the material side effects of the treatment, alternative courses of action and the likely consequences of not having the treatment, at ss 11(2), 11(3)).

HCCA, ibid (the health practitioner is entitled to presume, unless it is not reasonable to do so, that consent covers any variations or adjustments in the treatment - so long as the nature of the changed treatment is not significantly different from the nature of the original treatment - and the continuation of the same treatment in a different setting, at s 12).

Ibid at s 11(1).

Fleming, supra note 1 at 18.

A compelling reason to override a patient’s right to informed consent is where a patient’s refusal to consent to treatment is a threat to others (i.e. a refusal to take anti-psychotic medication) or to public health: see Malette, supra note 48 at 2.

Fleming, supra note 1 at 18.

Mason & Laurie, supra note 6 at 348.

See for example Fleming, supra note 1 at 3; Starson, supra note 43 at 77.

Delmur, supra note 39 at 975.
Yet, personal autonomy has become the paramount ethical consideration in healthcare due to the strong legal protection enjoyed by informed consent and right to self-determination, and personal autonomy’s association with these concepts. Therefore, the argument that life-sustaining treatment, however futile, should not be withdrawn or withheld against a patient’s wishes is derived from a strong common law tradition that preserves the patient’s decision-making capacity. In contrast (and as will be discussed in the next chapter) medical futility has unsettled common law roots. This partially explains the law’s reluctance to acknowledge the concept of medical futility within the healthcare context, and certainly explains why it is given less primacy than personal autonomy in medical decision-making. Nevertheless, I will argue later in this chapter that although the common law roots of personal autonomy provide patients with a legal voice in the healthcare setting, this legal voice is not powerful enough to compel a physician to provide contra-indicated treatment.

1.3.3 The Canadian Charter of Rights and Freedoms

The Charter is an instrumental component of personal autonomy’s legal evolution in healthcare. The courts have even hailed personal autonomy as a “constitutional value.” Specifically, personal autonomy is affiliated with s 7 - the right to life, liberty and security of the person - which is sometimes argued before the courts to address restrictions on individual freedom to make medical decisions. The right to life has already been discussed in the previous chapter and so my discussion here will largely focus on the right to security and liberty of the person.

In the healthcare context, the right to security of the person protects individual freedom to make medical decisions of fundamental importance. In R v Morgentaler, the Supreme Court struck down strict abortion laws that forced women, by threat of criminal sanction, to carry fetuses to term unless they met certain legal criteria, which were unrelated to their own priorities and aspirations. The Court concluded that “[s]tate interference with bodily integrity and serious state-imposed psychological stress…constitutes a breach of security of

---

66 The Charter, supra note 42.
68 Nola M Reis, “Charter Challenges” in Downie, supra note 54 at 620.
69 Children’s Aid Society, supra note 40 at 368.
70 R v Morgentaler, [1988] 1 SCR 30 at 32, 63 OR (2d) 281.
the person.”⁷¹ Five years on, the Supreme Court in *Rodriguez v British Columbia* added an additional protection to the right by finding that not only must the state ensure non-interference with the physical and psychological integrity of the person, it must also ensure non-interference with the right to make choices concerning one’s body.⁷² In that case, the Supreme Court clearly established a relationship between s 7 and personal autonomy:

> Security of the person in s 7 encompasses notions of personal autonomy (at least with respect to the right to make choices concerning one’s own body), control over one’s physical and psychological integrity which is free from state interference, and basic human dignity.⁷³

Similarly, the right to liberty protects an individual’s entitlement to make fundamental decisions concerning one’s body. This proposition was evident in *Morgentaler* where Wilson J held that “[the right to liberty] guarantees to every individual a degree of personal autonomy over important decisions intimately affecting his or her personal life.”⁷⁴ This sentiment was later reiterated in *B(R) v Children’s Aid Society of Metropolitan Toronto*, where the Supreme Court reasoned:

> [L]iberty does not mean mere freedom from physical restrain. In a free and democratic society, the individual must be left room for personal autonomy to live his or her own life and to make decisions that are of fundamental personal importance.⁷⁵

The Supreme Court’s findings illustrate that both the principle of personal autonomy and s 7 protect the psychological and physical integrity of the patient and promote patient decision-making. Thus personal autonomy is transformed into a ‘constitutional value’ as it serves to protect and promote Charter principles within the healthcare context. As such, the principle is “deserving of the highest order of protection.”⁷⁶

But s 7 rights are not absolute. A breach of s 7 may be justified under s 1 of the Charter, which “guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.”⁷⁷ Insofar as s 7 protects individual liberty, the Supreme Court has reasoned that “liberty in [s 7]

---

⁷¹ Ibid.
⁷² *Rodriguez v British Columbia (AG)*, [1993] 3 SCR 519 at 587-588, 107 DLR (4th) 342
⁷³ Ibid at 521.
⁷⁴ *Morgentaler, supra* note 70 at 172.
⁷⁵ *Children’s Aid Society, supra* note 40 at 317.
⁷⁶ *Fleming, supra* note 1 at 21.
⁷⁷ *The Charter, supra* note 42 at s 1.
is not synonymous with unconstrained freedom." Hence, an individual’s liberty may be justifiably constrained where a person’s healthcare choices harm other people (i.e. a person refusing treatment for the Ebola virus may be compulsorily detained). In some cases, s 7 rights are internally conflicted, with one s 7 right justifiably limiting another. As discussed in Chapter One, the Canadian courts still recognize a strong state interest in preserving life, regardless of the quality of life. In Rodriguez, the majority judgment concluded that a patient’s right to choose what is done with her body is limited by the state’s interests in preserving the sanctity of life. Here, the right to life triumphed over the right to security of the person. Thus, it appears the Charter does not create an absolute right to decide what is done with one’s body.

Finally, it is important to note the duties and obligations created by the Charter fall upon the shoulders of governmental bodies, including federal, provincial or territorial health departments and local health authorities. To date, the courts have held that the actions and decisions of physicians are not subject to Charter scrutiny because physicians are not agents of the Government in the same way hospitals are; rather, physicians are independent contractors and owe duties exclusively to patients. A patient could therefore not bring a Charter challenge alleging her s 7 rights had been infringed by the actions of a physician.

That said, the Supreme Court has confirmed that “where the government puts in place a scheme to provide health care, that scheme must comply with the Charter.” Therefore, the Charter’s inherent values and principles must be respected within the public healthcare system. Following the Supreme Court’s sentiment, Ontario’s Court of Appeal in M(A) v

---

78 R v Edwards Books and Art Ltd, [1986] 2 SCR 713, 35 DLR (4th) 1 (“[l]iberty, whatever be its precise contours, does not extend to an unconstrained right to transact business whenever one wishes” at 717); see also Children’s Aid Society, supra note 40 ([a]lthough the scope of “liberty” as understood by s. 7 is expensive, it is certainly not all-encompassing” at 430).
79 See generally the Quarantine Act, SC, 2005, c 20 for information about the states’ powers to detain individuals where they pose a threat to public health.
80 Rodriguez, supra note 72.
81 Reis, supra note 68 at 615.
82 Rasouli v Sunnybrook Health Sciences Centre, 2011 ONSC 1500, 105 OR (3d) 761 at para 90.
Benes declared that the HCCA must be construed in a manner consistent with the Charter. Here the Court was asked to determine whether the phrase “in accordance with this Act” imposed a statutory obligation on health practitioners to ensure SDMs understand their obligations under the HCCA. With specific regard to s 7 of the Charter, the Court concluded:

When the words “in accordance with this Act” are constructed in a manner consistent with the Charter and afforded the fair, large and liberal interpretation they deserve to best attain the objects of the Act, we are satisfied that s 10(1)(b) does impose an obligation on health practitioners to ensure that SDMs understand the requirements of s 21 of the Act when deciding whether consent to a proposed treatment should be given or refused.

In sum, as a constitutional value personal autonomy enjoys strong, but not absolute, legal protection. It follows that other interests may constrain personal autonomy’s dominance in medical ethics. Later in this chapter I will discuss four interests that I believe justifiably limit the legal scope of personal autonomy.

2 The Right to Receive All or Any Treatment

I have demonstrated that personal autonomy has become the dominant principle in medical-decision making through its association with human rights norms found in the common law and the Charter. I turn now to consider the scope of personal autonomy. Specially, I will explore whether personal autonomy empowers the patient to demand all or any treatment she desires, including futile treatment.

Personal autonomy could be conceived of as containing both positive and negative obligations. The negative arm of personal autonomy holds that “autonomous actions should not be subjected to controlling constraints by others”, as long as those actions do not harm other people. The positive arm requires society to foster autonomous decision-making in a material way. If the law does recognize positive obligations within personal autonomy, the question becomes: to what extent does the healthcare system have to foster a patient’s autonomous choices? Put another way, can personal autonomy compel a physician to provide all or any treatment demanded by a patient?

---

84 M (A) v Benes, 1999 CanLII 3807 at para 36, 46 OR (3d) 271 (ONCA) [Benes].
85 Ibid at paras 22-23.
86 Beauchamp & Childress, supra note 3 at 104.
87 Ibid.
88 Ibid.
William Prip and Anna Moretti suggest that the principle of personal autonomy would be “hollow if it were confined only to the right to refuse care.”89 Conceived only as a right to refuse treatment, personal autonomy does little more than the doctrine of informed consent. If personal autonomy is to be fully realized in the healthcare setting a patient or SDM should have a right to refuse treatment and a right to receive treatment.

While acknowledging that this logic is compelling, Prip and Moretti note that:

the law underlying the right to refuse treatment does not easily transfer to the right to receive treatment. The difference between the demands ‘don’t touch me’ and ‘you must touch me’ is dramatic.90

In other words, there is no evident legal basis upon which a patient can claim an entitlement to receive treatment. On this point, Hilary Young makes a forceful case that “doctors have no legal obligation to treat…unless the law imposes such an obligation”, but such an obligation cannot be rooted in the law of consent.91 Young argues that the traditional purpose of the law of consent was to protect a patient from unwanted physical interference.92 A right to receive treatment, or a right to be touched, cannot evolve from a legal principle designed to protect against unwanted touching.93

Today, however, informed consent also imposes on physicians a duty to “ensure patients are able to make informed or autonomous decisions.”94 This contemporary view suggests that the purpose of consent is not confined only to protecting the patient from unwanted touching. Rather, this view supports the notion of the active and informed patient who has the right to make treatment decisions, including, possibly, treatment demands. Nevertheless, Young argues that this modern view of consent is part of a broader duty “to treat according to the standard of a reasonable physician”95 and as such, a right to receive treatment is limited to

90 Ibid.
92 Ibid at 62.
93 Ibid.
94 Ibid at 63.
95 Ibid at 63-64.
the provision of care a reasonable physician is willing to provide. Thus, the law of informed consent as it is understood today\textsuperscript{96} does not entitle a patient to demand treatment a physician is unwilling to provide.

Thus, there is little basis in law to recognize personal autonomy as creating an entitlement to receive all or any treatment. A patient’s autonomy should be balanced against a physician’s duty to provide treatment in keeping with her best clinical judgment. To suggest otherwise makes a mockery out of the medical profession by requiring a physician to ignore professional standards. In line with this conclusion, the courts have found it is inappropriate to compel a physician to begin treatment that is not in the best interests of the patient, despite the wishes of the patient or SDM.\textsuperscript{97}

The issue becomes more complicated, however, when treatment has already been proposed or commenced and the patient or SDM demands that treatment is continued contrary to medical opinion. The courts’ approach to addressing these issues will be discussed in the following two chapters. Suffice to say here, if the courts accept that patients are entitled to receive treatment contrary to the opinion of their physician, this creates a legal entitlement to demand all or any treatment indefinitely, regardless of the treatment’s medical implication. Moreover, as will be discussed in the chapter to follow, neither law nor logic supports a distinction between discontinuing treatment and not providing it in the first place i.e. the withhold v withdrawal anomaly. Hence, even if the judiciary endorses only an entitlement to the continuation, but not the commencement, of treatment, this creates a slippery slope that may eventually lead to legal sanctioning of a right to receive all or any treatment demanded by a patient, including futile treatment.

\textsuperscript{96} \textit{Ibid} (Young also explores the idea of expanding the law of informed consent so that patients will have the ability to make decisions about whether treatment will be provided or continued, regardless of its medical implications. This understanding of consent presumes an entitlement to treatment unless rebutted by a material and relevant countervailing consideration, including concerns about resource allocation. Young cautions against this expanded view, however, as it creates exceptions to the law of consent depending on the type of treatment being offered, at 69-71).

\textsuperscript{97} See for example: \textit{Rotaru v Vancouver General Hospital Intensive Care Unit}, 2008 BCSC 318 (CanLII) (where the court found that it was inappropriate to order the treating physician to administer an aggressive course of life-sustaining treatment); \textit{Re IHV}, 2008 ABQB 250 (CanLII), 449 AR 211 (where the court refused to order an injunction that life-sustaining treatment be provided to an elderly woman).
2.1 Limitations of personal autonomy

In the section above, I have cautioned against legal recognition of a broad principle of personal autonomy that includes positive obligations. In the following discussion, I will examine four factors that provide further support for a narrow understanding of personal autonomy in the healthcare context. Specifically, I will argue these interests justify a communitarian theory of personal autonomy, where an individual has a right to make reasoned decisions based on personal values, beliefs and wishes so long as those decisions do not harm the interests of others or the state.

2.1.1 Optimal resource allocation

In the United Kingdom case of *R v Cambridge Health Authority, ex B*, the parents of a minor suffering from acute myeloid leukemia petitioned the Court to compel the local health authority to fund a second round of chemotherapy and bone marrow transplant. Both procedures failed to cure the minor in the first instance, and the health authority refused to authorize a second attempt because of the high cost (£75,000) and low probability of complete remission (10-20%). In upholding the decision to refuse the treatment, Sir Thomas Bingham MR stated:

> I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much it cost, particularly when a life was potentially at stake. It would however, in my view, be shutting one's eyes to the real world if the court were to proceed on the basis that we do live in such a world... Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients.

Optimal resource allocation - i.e. providing the most medical benefit to the most people - is threatened by patient autonomy. This threat is heightened in the Canadian context where medical services are entirely publically funded; a patient cannot access treatment by paying for it privately. The problem with personal autonomy is that it ignores resource scarcity. An individual’s disproportionate and futile demand on the finite pool of healthcare resources prevents alternative use of those resources that may result in greater and more dispersed benefits.
health benefits.\textsuperscript{101} For example, where a terminal patient, or their SDM, demands life-support when this would directly prevent others from having cardiac surgery due to the unavailability an ICU bed required for post-op care.\textsuperscript{102}

Personal autonomy also ignores the burden of the taxpayer. Canadian tax dollars are funneled to provincial governments who, under the Canada Health Act 1985, are tasked with funding a comprehensive, universal, portable and accessible public healthcare system.\textsuperscript{103} The cost of expensive treatment demands from patients or SDMs will therefore be borne by the taxpayer. In addition, the taxpayer suffers the opportunity cost of futile treatment, i.e. the reduction in available healthcare resources. A broad legal recognition of personal autonomy therefore conflicts with the state’s goal of facilitating “reasonable access to health services” for all Canadians.\textsuperscript{104}

That said, any treatment decision must be made first and foremost in light of the best interests of the patient. A physician must recommend treatment if it is in the patient’s best interests, regardless of concerns about resource constraints.\textsuperscript{105} Optimal resource allocation is a secondary consideration that arises only after a treatment is deemed futile.\textsuperscript{106} This requirement is necessary to ensure the medical profession is not putting a dollars and cents value on a patient’s life. Provincial legislatures instead should be responsible for any rationing of healthcare resources that may deprive a patient of potentially beneficial treatment. However, before rationing potentially beneficial healthcare services, governments should “[find] ways of eliminating or at least reducing unnecessary utilization”\textsuperscript{107} of healthcare resources, including limiting the extent to which patients can demand treatment, regardless of its medical implications. Constraining the legal contours of personal autonomy will ensure patients can only make reasonable and proportionate demands for healthcare services, which will, in turn, ensure a robust and fair public healthcare system.

\textsuperscript{102} See: \textit{London Health Science Centre v RK} (1997), 152 DLR (4th) 724 (available on CanLII) (ONSC) at para 9 [\textit{London Health}].
\textsuperscript{103} \textit{Canada Health Act}, RSC, 1985, c C-6, s 7.
\textsuperscript{104} \textit{Ibid}, s 3.
\textsuperscript{105} \textit{Simice}, supra note 74 at 17-18.
\textsuperscript{106} \textit{London Health}, supra note 102 at para 9.
\textsuperscript{107} William Lahey, “Medicare and the Law: Contours of an Evolving Relationship” in Downie, \textit{supra} note 54 at 23.
2.1.2 Integrity of the medical profession

A social contract exists between the medical profession and the public. The profession “makes a commitment to promote the public good” and in return the public trusts the profession to enjoy a monopoly over the practice of medicine.\(^{108}\) The profession’s commitment requires physicians to meet a standard of excellence that, in part, requires physicians to always act according to clinical skills and knowledge.\(^{109}\) The physician who acquiesces to a demand for futile treatment jeopardizes the scientific and ethical principles on which the medical profession is founded and risks becoming a quack or fraud.\(^{110}\)

Indeed, what is the purpose of the medical profession and its rigorous training of physicians if a patient’s autonomous choices could force the provision of clinically inappropriate treatment? Thaddeus Pope muses “[t] hose in the health procession surely must have some role in defining the ends and goals of medicine.”\(^{111}\) Pope argues it is not only contrary to the purpose of medicine to use medicine to “maintain corporeal existence and perpetuat[e] biological function”, but it may also be “gruesome, distressing, and demoralizing to provide treatment that harms patients.”\(^{112}\) In short, providing clinically ineffective treatment is just bad medicine.\(^{113}\)

The integrity of the medical profession is central to fostering public trust in the healthcare system. Prescribing treatment on demand, without any clinical evidence, undercuts a physician’s commitment to uphold the scientific base of medicine. Where the scientific base of a physician’s practice is impaired, the public may lose faith in medicine and view physician’s advice with increasing skepticism and distrust. Thus, as Pope surmises, “[t]he ‘integrity of the medical profession’ is an important societal interest that must be balanced against patient autonomy.”\(^{114}\)

---


\(^{109}\) *Ibid* at 9.


\(^{112}\) *Ibid* at 197.

\(^{113}\) *Ibid* at 197.

\(^{114}\) *Ibid* at 196.
2.1.3 The doctor/patient relationship

The effect of personal autonomy on the doctor-patient relationship has been hotly debated. On one hand, some have argued that “exaggerating the desirability of autonomy can undermine justified deference to authority or trust in others.”\(^{115}\) Koche and colleagues contend that personal autonomy’s dominance in healthcare is not in the patient’s best interests because it is physicians who wield the expertise and knowledge – or Aesculapian power - to make medical decisions.\(^{116}\) Aesculapian power is diminished where patients or their SDMs are “empowered to make medical decisions for which they have no medical expertise.”\(^{117}\) Yet, Aesculapian power is critical to the doctor/patient relationship if the patient is to be treated according to a reasonable standard of care.\(^{118}\)

It follows that broad and absolute recognition of personal autonomy expressed by the patient or SDM may infringe a physician’s fiduciary duty to act in the patient’s best interests. Beauchamp and Childress argue that physicians have an ethical duty to respect a patient’s autonomy,\(^{119}\) but they do not consider personal autonomy as a necessary prerequisite for the doctor-patient relationship, which they argue relies on the existence of veracity, privacy, confidentiality and fidelity.\(^{120}\) In other words, the doctor-patient relationship depends on the

---

\(^{115}\) Griffin, supra note 32 at 153; World Medical Association, *WMA Declaration of Seoul on Professional Autonomy and Clinical Independence*, Seoul: WMA General Assembly, 2008 (“[r]estraints on the physicians to refuse demands by patients or their families for inappropriate medical services are not in the best interests of either patients or society” at Art 4).


\(^{117}\) Ibid.

\(^{118}\) Ibid ("[t]he power balance in such situations had shifted to the family. They now own more of the formal power that the physician. They possess in full measure the referent and moral power, and have gained control over procedural power in how decisions are made….Finally with the malpractice claims and generally poor financial health of many medical institutions, families possess nuisance power as well. Putting families in the middle of a clear medical situation and giving them a legal mandate to exercise sanction power is not wise or rational” at 323).

\(^{119}\) Beauchamp & Childress, supra note 3 at 99.

\(^{120}\) Ibid at 324. See also: CPSO Practice Guide, supra note 108 (the CPSO does not consider autonomy to a cornerstone of a healthy doctor-patient relationship, and instead identifies compassion, service, altruism and trustworthiness as being the vital components to the relationship, at 8).
exchange of mutual trust and confidence, rather than absolute deference to the wishes of the patient.

On the other hand, if patient autonomy is to be taken seriously, it is unacceptable for treatment decisions to rest solely with physicians. Patients must take primary responsibility for their healthcare, including directing when further treatment is needed. This is because patients are an inherently vulnerable group of people and granting physicians dominance in the doctor-patient relationship serves to increase, rather than remedy, this vulnerability. The fact that physicians have Aesculapian power and are unofficial stewards of healthcare resources means that physicians will, by default, enjoy the dominant position in the relationship. Personal autonomy acts as a counterweight to the physician’s natural dominance and ensures the idiosyncratic views of physicians do not prevent patients from accessing medicine.

Proponents of both side of the argument will agree, however, that the increasing influence of personal autonomy will shift the decision-making power in the doctor/patient relationship away from physicians. The difference in opinion relates to whether this shift in power is beneficial or harmful to the wellbeing of the patient and the healthcare system more generally. Nevertheless, it is a compelling argument that personal autonomy should not be able to diminish the credibility of the physician by forcing her to act contrary to accepted standards of clinical practice.

2.1.4 A physician’s right to freedom of conscience

In Golubchuk v Salvation Army Grace General Hospital, the family of Mr Golubchuk - an 84-year-old man in a PVS - sought an interim injunction requiring his medical team to provide him with comprehensive and aggressive life-sustaining treatment. The family argued that Mr Golubchuk, an Orthodox Jew, believed it was immoral to hasten death and so he would have wanted to be sustained on mechanical ventilation despite his dire prognosis.

---

121 Beauchamp & Childress, supra note 3 at 356.
122 Peppin, supra note 54 at 192.
123 Koche, supra note 116 at 323.
124 Golubchuk, supra note 83.
125 Canadian Broadcasting Company, “Doctors offer to treat dying Winnipeg man after colleagues refuse”, CBC (18 June 2008), online:
Mr Golubchuk’s original treating physician, Dr Kumar, threatened to resign if he were forced to provide such treatment. He considered further life-sustaining treatment to be “grotesque”, in large part, because Mr Golubchuk’s medical team had to routinely carve flesh from his body to prevent an infection spreading. Dr Kumar argued “to inflict this kind of assault on him without a reasonable hope of benefit is an abomination…I can’t do it.”

Here, Dr Kumar’s conscience conflicted with Mr Golubchuk’s desire, expressed through his family, to have life-sustaining treatment continued.

Physicians have a right to freedom of conscience guaranteed under s 2(a) of the Charter. For example, some physicians invoke this right to refuse to carry out abortions or provide contraception. As a general rule, once the doctor-patient relationship is established, if a physician refuses to comply with the request of the patient or SDM on conscientious grounds, the physician must refer the patient to another health practitioner. If there is no other health institution or health practitioner willing to accept the patient, the physician cannot break the relationship and simply abandon the patient. Therefore, the physician’s right to freedom of conscience may be weakened by an ongoing duty to provide medical care. It follows that the Charter may insulate a physician from having to administer futile treatment, but it will be harder to invoke the right to argue that treatment should be discontinued, as withdrawing treatment may be conceived as an action of abandonment or neglect of the patient.

A physician’s right to freedom of conscience is not synonymous with her ethical and professional obligations. Ethical and professional duties are fluid obligations externally imposed on the physician; in contrast, the physician is the master of her own conscience. Therefore, although a physician may be legally excused for a breach of the duty ‘to do no

---

126 Ibid.
127 Ibid.
128 Ibid.
129 The Charter, supra note 42, s 2.
130 Bernard Dickens, “Medical Negligence” in Downie, supra note 54 at 118-119
131 Ibid. Theresa Boyle, “Hassan Rasouli to move out of Sunnybrook after long end-of-life court battle” Toronto Star (31 December 2013), online: <http://www.thestar.com/life/health_wellness/2013/12/31/hassan_rasouli_to_move_out_of_sunnybrook_after_long_endoflife_ court_battle.html> (the Toronto Star reports that Mr Rasouli is on a waiting list to be moved to Toronto’s West Park Healthcare Centre that has 40 chronic assisted ventilator care).
harm’ where, for example, the physician is being compelled to continue to provide invasive life-support, the physician’s conscience in continuing life-support may not be clear.

The negative implications of compelling individuals to act contrary to their conscience should not be understated. Individual conscience is “based on strongly held moral ideas of right and wrong” and the right to freedom of conscience ensures “society does not interfere with profoundly personal beliefs that govern one’s perception of oneself, humankind, [and] nature.” To force someone to act against their conscience is to force someone to act in a way they believe to be immoral, which may cause the individual psychological trauma or depreciate their self-confidence and human dignity.

The state has an interest in protecting the mental well being of medical professionals to maintain a strong and reliable public healthcare system served by content and committed health practitioners. Moreover, the state must encourage health practitioners to specialize in medical fields that are high-pressure and emotionally taxing, such as in ICUs, without having to compromise their morals. Health practitioners like Dr Kumar should not have to choose between their values and their profession.

Nevertheless, a physician’s conscience is confined by the duty to act in the best interests of the patient. A physician who wishes to argue her right to freedom of conscience must show that further treatment is both torturous and not in the patient’s best interests. A physician must also avoid invoking the right for paternalistic purposes. For example, a physician cannot carry out an abortion on a woman who already has ten children because she conscientiously believes it is in the best interests of the woman and of society that she stop reproducing. The right to freedom of conscience can only be legitimately invoked to preserve one’s own human dignity and not to depreciate the human dignity of another by disrespecting their values, beliefs and choices.

132 Rasouli SCC, supra note 3 (“[i]legally, a physician cannot be faulted for following the direction of the [CCB], any more than he could be faulted for abiding by a judge’s direction at common law not to withdraw life support” at para 72).

133 Roach v Canada (Minister of State for Multiculturalism and Citizenship), [1994] 2 FC 406, 113 DLR (4th) 67.

134 R v Big M Drug Mart Ltd, [1985] 1 SCR 295, 18 DLR (4th) 321(“[i]t is easy to see the relationship between respect for individual conscience and the valuation of human dignity that motivates such unremitting protection” per Dickson J, at para 121).
The question of how far a physician’s right to freedom of conscience extends is another Charter issue that remains to be considered by the courts in futility disputes. In my view, there is strength in a physician’s argument that she should not be forced to provide medical care where she believes it is torturing the patient without having any compensating benefit. Indeed, forcing a physician to ‘torture’ another person will infringe that physician’s moral compass to a far greater extent than forcing her to provide contraception at a patient’s bequest and so it seems anomalous that the Charter protects the latter but not the former. It is always open to the court, however, to find the right to freedom of conscience is justifiably limited by the state’s strong interest in preserving the sanctity of life and promoting personal autonomy. Nonetheless, if the state wants to ensure a motivated and resilient workforce in acute hospital settings, it should not foster patient autonomy in a manner that causes mental anguish to health practitioners.

2.2 Summary: a communitarian approach to personal autonomy

Taken together, the four interests discussed above suggest that personal autonomy should not be conceived in “particularly-individualistic sense”135 without regard for the interests of others. Rather, contemporary personal autonomy should re-adopt some of the Kantian ideals out of which the concept was born. Kant’s version of autonomy emphasized that autonomy is derived from shared moral norms, such as the moral duty to respect others and their rights.136 This characterization of autonomy requires a patient to consider her own self-preferences against the wider interests of society, including economic constraints and the legitimate entitlements of others.137

Judicial sentiment from Canadian ‘right to die’ cases support this communitarian approach to autonomy. Recently, the Supreme Court of British Columbia in Carter v British Columbia concluded:

Canadian values are not limited to those of autonomy and freedom from state interference. They also include recognition of the value of social connectedness and community. Indeed, the equality value itself has both an individual and group dimension.138

Similarly, Lamer CJ in Rodriguez found:

135 Mason & Laurie, supra note 6 at 7.
136 See: O’Neil, supra note 51 at 83-85.
137 Mason & Laurie, supra note 6 at 7.
138 Carter, supra note 6 at para 1153.
the common law recognized the fundamental importance of individual autonomy and self-determination in our legal system. That does not mean that these values are absolute. However, in my opinion s 15(1) requires that limitations on fundamental values should be distributed with a measure of equality. 139

These quotes endorse a view of autonomy that incorporates Kant’s idea that personal choice should only be realized “within the framework provided by society.” 140

In my view, the scope of personal autonomy in the healthcare context is properly conceived in this narrow, communitarian sense. Canada’s healthcare system exists for the benefit of the wider public good. The public nature of the healthcare system does not mean individuals are at liberty to make disproportionate and inappropriate demands on healthcare resources. Instead it requires that individual demands are balanced against demands from others and competing state interests, such as the state’s interest in preserving the integrity and well-being of the healthcare system and those who work within it.

Where public funds are in issue it is not unprecedented for the courts to interpret individual interests and rights narrowly. For example, in Adler v Ontario the Supreme Court found that the state is not obliged to expend public resources to fund the religious rights of a small group of individuals. 141 Hence, whilst the state must not unreasonably infringe individual rights, the state has no duty to foster individual rights through financial avenues. The same reasoning holds with patient autonomy: the state should not interfere with patient autonomy, but the state has no duty to fund a patient’s unreasonable demands within the healthcare system. Indeed, provincial governments are only obligated, under the Canada Health Act 1984 to fund “core” medical services. 142 “Many medically necessary or required services…fall outside this core” 143 and so it is difficult to see how the state could be legally bound to fund services deemed to be medically unnecessary, such as futile life-sustaining treatment.

Moreover, in Adler, McLachlin CJ, in a partially dissenting opinion, considered that the state’s objective in funding secular public schools and not independent religious schools “is to foster a strong public secular school system attended by students of all cultural and

139 Rodriguez, supra note 43 at 554.
140 Mason & Laurie. supra note 6 at 7.
142 Auton (Guardian ad litem of) v British Columbia (AG), 2004 SCC 78, [2004] 3 SCR 657 at para 32.
143 Ibid.
religious groups.”144 The state’s objective to “[foster] a more tolerant society” for the public good outweighed the state’s interest in satisfying individual religious demands.145 Again, similar reasoning could be applied in the healthcare context. The state’s interest in promoting fair and efficient distribution of healthcare resources for the public benefit outweighs the state’s interest in satisfying unreasonable individual healthcare demands.

Of course, it should not be overlooked that denying a patient access to healthcare is, in some cases, a matter of life and death. Given such high stakes, it is arguable that the patient or SDM, not the state or physicians, should have sole authority to say enough is enough. Yet, as discussed above, the pool of public healthcare resources is finite and providing treatment to one patient will reduce the level of resources available to others. A communitarian approach to personal autonomy measures a patient’s healthcare choices against the healthcare choices of other patients. Where these choices conflict (i.e. two patients desire access to an ICU where only one bed is available) the state’s interest in optimal resource allocation may deprive a patient access to core healthcare services (i.e. life-sustaining treatment will be withdrawn from a patient in a PVS who shows no sign of improvement to make room for a patient who will benefit from it). Thus, the communitarian approach to personal autonomy creates space for other interests to be considered in the medical decision-making process, beyond the views of the patient. The overarching public concern in maintaining a robust and fair public healthcare system should not deprive a patient of beneficial treatment, but a patient should not be able to make continued demands for futile healthcare services.

3 Does Personal Autonomy Survive Incapacity?

Autonomy is a very personal capacity – the individual alone is truly capable of making reasoned decisions for herself based on personal values, beliefs and goals. Yet, the issue of personal autonomy is raised in many futility disputes where the patient is incapacitated and thus unable to exercise personal autonomy.146 This raises the question: does personal autonomy survive incapacity?

144 Adler, supra note 141 at para 212.
145 Ibid at para 224.
146 See for example: Rasouli SCC. supra note 3; Sweiss v Alberta Health Services, 2009 ABQB 691 (available on CanLII) [Sweiss]; Golubchuk, supra note 83.
3.1 Prior known wishes

Section 5 of the HCCA states “a person may, while capable, express wishes with respect to treatment.” These prior known wishes may be expressed formally in a power of attorney (i.e. an advance directive or living will), or informally “in any other written form, orally or in any other manner.” Section 21 dictates that if a SDM knows of an incapacitated patient’s valid prior known wish regarding a particular treatment, consent must be given or refused in accordance with that wish. A prior known wish is essentially an extension of the patient’s autonomy to a time where the patient is incapacitated.

A physician must adhere to a patient’s valid prior known wish, even in an emergency situation, and, as with the giving or refusing of consent, the wisdom of the wish is generally irrelevant. Legal recognition of a patient’s prior known wish serves to foster public trust in physicians and healthcare providers by ensuring treatment is provided in a manner consistent with the patient’s autonomy. Prior known wishes are also valuable to the extent that they: reduce pain, indecision and argument between relatives of an incapacitated patient; reduce patient anxiety about the future; increase a physician’s confidence in making end-of-life decisions; and decrease a physician’s concerns about potential liability arising from treatment decisions.

A prior known wish must satisfy certain criteria to be valid. The Supreme Court has held an advance directive that is “unclear, vague or lacks precision” will be inoperative.

---

147 HCCA, supra note 4, s 5.
148 Ontario’s Substitute Decisions Act 1992, SO, 1992, c 30 (the Substitute Decisions Act describes the process of entrenching a prior known wish in a power of attorney for personal care. The power of attorney will identify a person or persons who the individual nominates as his or her SDM in the event the individual becomes incapacitated. The power of attorney may also provide instructions that the nominated person must follow relating to treatment decisions, such as a request against resuscitation in the event of severe brain damage).
149 HCCA, supra note 4, s 5.
150 Ibid, s 21(1).
152 Fleming, supra note 1, at 18.
153 Harmon, supra note 151 at para 12.
154 Hoffman, supra note 57 at 86.
155 Rasouli SCC, supra note 3 at para 83.
Additionally, s 21(1) of the HCCA directs that a prior known wish must be “applicable to the circumstances.” In Conway v Jacques, Ontario’s Court of Appeal held this phrase to mean that prior known wishes should not be applied mechanically or literally, but rather with regard to the relevant circumstances. Thus, the patient must have turned her mind to the nature and extent of the effects of the disease or disability the patient is suffering from while incapable. By way of example, in Scardoni v Hawryluck, the Court concluded that a general statement expressed in a power of attorney that the patient wished to be kept alive at all costs was neither specific enough, nor was it applicable to the circumstances, being that the patient had advanced Alzheimer’s, she was un-communicative and had already suffered severe complications from life-sustaining treatment.

Furthermore, under the HCCA an advance directive does not need to be followed if it is “impossible to comply with”, for example a particular drug requested by a patient may be unavailable or the patient is demanding an illegal procedure, such as voluntary euthanasia. However, Joaquin Zuckerberg warns that impossibility should not be equated with what is ‘medically inappropriate’: “thus, the wish for treatment that is not likely to improve the patient’s clinical condition (e.g. life support in a case of end stage metastatic cancer) cannot be said to be ‘impossible to comply with’.

The courts have deliberated whether a prior known wish that meets all the criteria for validity would nonetheless be invalid if it directed that life-support should be provided to a patient

157 HCCA, supra note 4, s 21(1).
158 Conway v Jacques (2002), 59 OR (3d) 737, 214 DLR (4th) 67 (ONCA) at para 31. See also: Scardoni v Hawryluck, 2004 CanLII 32326, 69 OR (3d) 700 (ONSC) (“[i]n determining whether a patient’s express wishes are applicable to the circumstances, they must be considered in their context” at para 73) [Scardoni]; Rasouli SCC, supra note 3 (“the question is whether, when the wish was expressed, the patient intended its application in the circumstances that the patient now faces” at para 82).
159 Scardoni, ibid at para 74-75.
160 Ibid at para 7. See also: Re Grover, 2009 CanLII 16577 (ONSC).
161 HCCA, supra note 4, s 21(2).
162 Zuckerberg, supra note 153 (Zuckerberg distinguishes the example of a drug not being available with instances of “a refusal of life-saving treatment in favour of another treatment that is not as effective,” which would not fall within the exception “impossible to comply with” at 148).
163 Hoffman, supra note 57 at 24.
164 Zuckerberg, supra note 153 at 148-149.
indefinitely. In Sweiss v Alberta Health Services, Ouellette J found that under Alberta’s Personal Directives Act 1985, a valid advance directive must be followed even if it runs contrary to the clinical judgment of the physician. Ouellette J’s findings were obiter, as the advance directive in the case was found invalid for other reasons. Nevertheless, if Ouellette J’s reasoning were adopted in subsequent cases, this would mean physicians could be legally compelled to satisfy a patient’s demand to receive all or any treatment, regardless of its medical implications. It follows logically that if a patient is entitled to receive all or any treatment desired under an advance directive, then a competent patient should likewise be entitled to demand all or any treatment. To suggest otherwise creates an anomaly where an incapacitated patient’s personal autonomy has greater legal weight than a competent patient’s personal autonomy.

3.2 Substitute decision-making

3.2.1 The role of a SDM

Common law jurisdictions have traditionally favoured either a ‘substituted judgment’ test or a ‘best interests’ test for making treatment decisions about an incapacitated person. The substituted judgment test requires the decision-maker to determine what the patient would have chosen if capable. The best interests test directs the decision-maker to make a decision based on the patient’s condition and the benefits and burdens of providing the proposed treatment. Canadian common law has favoured the ‘best interests’ test.

Ontario’s legislature, however, has combined the ‘substituted judgment’ test with a ‘best interests’ test within the HCCA. Section 21(1) establishes a two-stage test. At the first

---

165 Sweiss, supra note 146 at para 48.
166 Personal Directives Act, RSA, 2000, c P-6.
167 Sweiss, supra note 146 at para 48.
168 Zuckerberg, supra note 153 at 142.
169 Ibid.
170 Ibid.
171 E (Mrs) v Eve, [1986] 2 SCR 388, 61 Nfld & PEIR 273 (“[t]he court undoubtedly has the right and duty to protect those who are unable to take care of themselves, and in doing so it has a wide discretion to what it considers to be in their best interests” at para 99) [Eve]. See also: Benes, supra note 84 at para 40.
172 HCCA, supra note 4, s 21(1):

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.
stage, the SDM must follow any valid prior known wish expressed by the incapable person (s 21(1)(a)). At the second stage, if there is no prior known wish, the SDM must decide what is in the best interests of the incapable person (s 21(1)(b)). In assessing what is in patient’s best interests, the SDM must consider the values, beliefs and wishes of the patient (that do not fall within s 21(1)(a)), together with clinical evidence of the patient’s diagnosis, prognosis and the likely burdens and benefits of treatment or non-treatment.

Section 20 of the HCCA provides a hierarchical list of people who may give or refuse consent to treatment on behalf of an incapacitated patient. The hierarchy descends in line with the familial closeness between the potential SDM and the patient. The Public Guardian and Trustee may act as the SDM if there is disagreement between two or more persons who qualify equally as an SDM, or if there is no available person who meets the criteria. This hierarchy reflects the legislature’s intention to respect an individual’s right to choose who will represent them in the event of incompetency, and the legislative purpose in ensuring there is a “significant role for supportive family members when a person lacks capacity to make a decision about a treatment.”

---

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.

173 Benes, supra note 84 at para 32; Scardoni, supra note 158 (“[s]ections (2)(a) and (b) were enacted after the decision in Fleming and, in my opinion, represent a legislative acceptance of the value to be attributed to a patient’s individual autonomy and right to medical self-determination and, also, a response to the court’s comments on the level of clarity in the earlier provisions that referred to a patient’s wishes” at para 157).

174 HCCA, supra note 4, s 21(2).

175 Ibid (“a person described in a paragraph of subsection (1) may give or refuse consent only if no person in an earlier paragraph meets the requirements of subsection (2)” at s 20(3)).

176 Ibid, s 20.

177 Ibid (the hierarchy of potential SDMs is as follows: the patient’s guardian, the patient’s attorney for personal care, the patient’s representative appointed by the CCB under s 33, the patient’s spouse or partner, the child or parent of the patient or a children’s aid society or other person who is lawfully entitled to give or refuse consent, the parent of a patient who only has right of access, the sibling of a patient, or any other relative of the patient, at s 20)

178 Ibid, s 20(5).

179 Michael Bay et al, “Capacity and Substitute Decision Making for Personal Care” in Bloom & Bay, supra note 28 at 35.

180 HCCA, supra note 4, s 1(e). The SDM must also be: competent, available and willing to assume responsibility, at least 16 year’s old, and not prohibited by the court from having access to the patient (s 20 (2)).
A health practitioner cannot administer treatment for an incapable patient until consent is forthcoming from the highest-ranking SDM.\(^{181}\) Crucially, the SDM must suppress his or her personal choices when deciding what is in the best interests of the patient.\(^{182}\) Substitute decision-making “is not simply the authority to make decisions, but rather the ability to make appropriate substituted judgment in the presence of the patient’s prior expressed values and preferences, or a best interests decision in the absence of such information.”\(^{183}\)

In summary, the role of the SDM is to determine what is in the patient’s best interests by taking into consideration the patient’s diagnosis and prognosis, as well as any known values, beliefs and wishes of the patient. This role arises from a legislative presumption that the familial closeness of the SDM and the incapacitated patient means the SDM knows and will faithfully express the incapacitated patient’s values, beliefs and wishes when determining what is in the patient’s best interests.\(^{184}\) In this sense, the patient’s autonomy is given expression through the SDM.

### 3.2.2 Limits of a SDM

There exists a measure of judicial skepticism concerning a SDM’s ability to accurately articulate an incapacitated patient’s values, beliefs and wishes. In the UK case *Airedale Hospital Trustees v Bland*, Lord Goff mused “where the question is whether life support should be withheld from a PVS patient, it is difficult to see how the personality of the patient can be relevant, though it may be of comfort to his relatives if they believe [so].”\(^{185}\) In other words, the patient’s autonomy is redundant at the time she becomes incapacitated.

Ontario’s Court of Appeal in *M(A) v Benes* likewise discussed the limits of a SDM’s ability to express an incapacitated patient’s autonomy under the s 21 test.\(^{186}\) First, the Court noted that the SDM “does not stand in the shoes of an incapable person at least on questions of consent to treatment.”\(^{187}\) Second, the SDM is not a person chosen by the incapable person,

---

\(^{181}\) Hoffman, *supra* note 57 at 30.

\(^{182}\) Pope, *supra* note 111 at 208-209.

\(^{183}\) Katrina Bramstedt, “Questioning the decision-making capacity of surrogates” (2003) 33 Internal Med 257 at 259.

\(^{184}\) Dworkin, *supra* note 15 at 91.


\(^{186}\) *Benes*, *supra* note 84.

with the exception of an attorney for personal care nominated by the patient when
competent. Third, “although sometimes an SDM will know better than the [Consent and
Capacity Board (CCB)] about an incapable person’s beliefs, values and previous non-
binding wishes that will not always be so.” In reality, the highest-ranking relative may not be
close to the incapable person, or they may be poorly informed as to the patient’s wishes
regarding medical treatment. Benes supports the view that personal autonomy is
extinguished at the point the patient becomes incapacitated and does not survive via the
SDM.

Empirical evidence also illustrates the limits of substitute decision-making. A 2006 meta-
review of sixteen studies examining the accuracy of SDMs discovered that SDMs predict
patient treatment choices 68% of the time. A study conducted the following year found
“the overall ability of the proxies in this study to predict the patients’ preferences
was…62.68%.” Arguably these percentages support the substitute decision-making model
because roughly two-thirds of the time SDMs choose in the way the incapacitated patient
would have chosen. In the remaining one-third of cases, however, there is a significant
chance patients are being prescribed aggressive and invasive treatment contrary to their
wishes and at the expense of their dignity and bodily integrity. This is because in laboratory
studies, SDMs tend to make overtreatment errors – that is, the SDM opts for more treatment
than what the patient would have actually wanted. If an overtreatment error occurs in
reality, the patient will be subjected to a greater intensity of treatment than she would have
allowed if competent. Therefore, given that medical ethics holds dear to the maxim that ‘a
patient should not be treated against her will’, it is questionable whether a two-thirds success
rate justifies a legal regime which exposes one-third of incapacitated patients to intrusive
treatment against their wishes.

188 Benes, ibid at para 43.
189 Ibid at para 44.
190 Ibid.
191 David Shalowitz et al, “The Accuracy of Surrogate Decision Makers: A Systematic
192 Ines Maria Barrio-Cantalejo et al, “Advance Directives and Proxies Prediction About
Patients’ Treatment Preferences” (2009) 16 Nursing Ethics 93 at 105.
193 Sara Moorman & Deborah Carr, “Spouses Effectiveness as End-of-Life Health Care
Surrogates: Accuracy, Uncertainty, and Errors of Overtreatment or Undertreatment” (2008)
194 Pope, supra note 111 at 217.
Furthermore, reviews of CCB decisions were conducted on two separate occasions - 2010 and 2013 - which revealed disturbing trends in how SDMs are applying the best interests test.\textsuperscript{195} The reviews found SDMs frequently asserted their own beliefs and wishes with regard to treatment, rather than those of the patient.\textsuperscript{196} Moreover, SDMs almost exclusively focus on what they believe to be the values, beliefs and wishes of the patient, and in doing so, ignore clinical evidence.\textsuperscript{197} In a separate analysis of CCB decisions in the end-of-life context, Sarah Jones exposed the same trend that evidence tendered by families and SDMs focused almost exclusively on the patient’s values, wishes and beliefs.\textsuperscript{198} These findings suggest SDMs are engaging in a pure substituted judgment test by giving or refusing consent based entirely on their opinion of what the patient would have chosen; rather than applying the test as stated under the HCCA. Ontario’s Superior Court of Justice recently found the same in \textit{Ackie et al v Manocha}, where it held the CCB “reasonably concluded that the substitute did not consider the statutory test for making a decision for an incapable person, but, rather considered what she deemed was in the best interests of the patient.”\textsuperscript{199} The Court’s finding is alarming for two reasons. First, as highlighted above, there is a significant chance the SDM is mistaken about what the patient would have chosen. Second, by ignoring medical information, the SDM shows a failure to understand the consequences of consenting to or refusing treatment, which may (depending on whether consent is given or refused) include the death of the patient or a significant increase in pain or discomfort to the patient.

In line with the above, Louise Harmon opines that substitute decision-making is a “legal fiction”, meaning that a treatment decision made by a SDM will never truly be that of the

\begin{flushright}
\begin{itemize}
\item Sibbald & Chidwick, \textit{ibid} at 171e4 (a follow up review of CCB end-of-life cases until 2013 revealed three key themes regarding SDMs’ assessments of what is in a patient’s best interests: (1) SDM’s reported that incapable patients value suffering as a “price” for the extension of life (2) the patient’s retained an unrealistic hope for recovery and communication with patient (3) SDMs were not being properly informed of their duties and the decision-making process under the HCCA).
\item Chidwick, Sibbald & Hawryluck, \textit{supra} note 195 at 25.
\item Sarah Jones, "Determining Best Interests in End-of-life Decisions" (2011) 69:1 UT Fac L Rev 8 (by contrast, physicians tended not to give evidence about the patient’s wishes, values and beliefs and focused only on the medical evidence, at para 16).
\item \textit{Ackie et al v Manocha}, 2014 ONSC 669 (available on CanLII) at para 38 [emphasis in original].
\end{itemize}
\end{flushright}
incapacitated person. It is a fallacy to suggest that the personal autonomy of the patient truly survives beyond incapacity and can be accurately expressed by the SDM. Harmon argues that the legal fiction only allows healthcare practitioners to “invade the bodily integrity of the incompetent without having to justify the invasion. By using [the] legal fiction, the judges do not have to … say things about the incompetent that no one wants to say: things reflecting an attitude that the incompetent is something less than a person – or something less than alive.”

In sum, the law should tread cautiously in suggesting SDMs can voice the autonomous choices of incapacitated patients. In accepting a SDM’s decision, the law is acknowledging only that the SDM has correctly applied the best interests test set out in the HCCA. Legal recognition that patient autonomy is truly and definitively reflected in the SDM’s decision will undermine the value of personal autonomy, as there is a significant chance that, rather than expressing the values, beliefs and wishes of the patient, the SDM is simply expressing his or her own personal choices.

**Evaluation**

Over the last four decades the paternalistic model of treatment decision-making has given way to a patient-centered approach, which demands full respect for personal autonomy. The value of personal autonomy is that it promotes the full participation of the patient in medical decision-making and the patient’s beliefs, wishes and values are the central component in any treatment decision.

In this chapter, I have argued that personal autonomy is the dominant principle in healthcare because it has evolved from legal principles found in the common law and the *Charter* that protect an individual’s right to make decisions of fundamental importance. Specifically, personal autonomy is embedded in human rights norms, including human dignity, the right to self-determination and doctrine of informed consent, and the right to liberty and security of the person. Personal autonomy enjoys the highest level of legal protection because of its association with these common law and constitutional traditions.

---


201 *Ibid* at 61.
But the law should be cautious to over-promote patient autonomy if in doing so a patient could demand the provision of treatment that a physician is unwilling to administer. To suggest otherwise would unreasonably expand the common law of consent to recognize a patient’s entitlement to demand all or any treatment desired. This legal entitlement may undermine the integrity of the medical profession, lead to sub-optimal resource allocation, interfere with a physician’s freedom of conscience and even harm the doctor-patient relationship. Therefore, I have proposed a communitarian view of personal autonomy whereby the patient’s personal choices are weighed against the interests of the state and of other individuals. This communitarian approach prohibits a patient or SDM from making demands on the public healthcare system that are futile, disproportionate and not in the patient’s best interests.

Moreover, I have cautioned against legal recognition of personal autonomy as an omnipotent principle when decisions are made on behalf of an incapacitated patient. Section 21 of the HCCA directs that a SDM must consider the values, beliefs and wishes of the patient together with clinical evidence about the burdens and benefits of treatment in light of the patient’s prognosis. The emerging trend whereby SDMs are ignoring the latter criteria in favour of the former is concerning given the significant chance a SDM will consider her own views when making a decision, instead of those of the patient. Therefore, to protect vulnerable incapacitated patients from the potential harms of over-treatment (including physical pain and loss of dignity) the law should not over-promote the “cult of personal autonomy” in the end-of-life context. Instead, the law should emphasize that treatment decisions must be made in light of the patient’s best interests, which instructs the decision-maker to consider the medical implications of treatment as well as the patient’s values, beliefs and wishes.

Yet, as will be discussed in the chapter to follow, the courts are increasingly recognizing personal autonomy in a positive manner as the dominant principle in the end-of-life context. As such, the ever-expanding scope of personal autonomy leaves little room for concerns about medical futility. Personal autonomy, in fact, fuels concern that medical futility will encourage the unacceptable abuse of physicians’ power and position at the expense of the patients.

---

202 HCCA, supra note 4, s 21.
203 Mason & Laurie, supra note 6 at 22.
patient’s rights. It is feared that by recognizing futility the value judgments of the physician, disguised as factual or scientific expertise, will take precedence over the values of the patient. In sum, it is clear that the principle of personal autonomy is a barrier to legal recognition of medical futility, and this barrier will only strengthen if the principle continues to be endorsed in the medico-legal arena in a broad and positive way.

204 Brody, supra note 110 at 9.
205 Ibid at 2.
Chapter Three
Medical Futility and the Common Law

Introduction

Canada’s common law suffers a “dearth of authority” \(^1\) \textit{vis-à-vis} futility disputes. Nevertheless, a small number of cases exist where the judiciary has been tasked with determining whether it is in an incapacitated patient’s best interests to receive life-sustaining treatment. Generally in these cases, the treating physicians have argued life-sustaining treatment is futile, and the patient’s family have advocated for continued life-support, believing there is hope for the patient.

The common law futility debate essentially asks two questions: first, to what extent does a finding of futility justify withholding or withdrawing treatment; and second, do physicians have unilateral powers to withhold or withdraw futile treatment? To date, the Canadian judiciary has struggled to convincingly answer either of these questions.

In contrast, the United Kingdom’s judiciary has made a commendable effort to resolve the futility debate. More than 20 years ago, the House of Lords decisively concluded that “it is the futility of the treatment which justifies its termination” \(^2\) and physicians have unilateral authority to withhold or withdraw treatment deemed to be futile, even if to do so will result in the patient’s death. Since then, the UK legislature has intervened to reduce physicians’ exclusive authority to withhold or withdraw treatment in the end-of-life context without prior

---

\(^1\) \textit{Re LIC (Dependent Adult)}, 2006 ABQB 130 (available on CanLII) \[Re LIC\] at para 17. See also \textit{Children’s Aid Society of Ottawa-Carleton v MC} (2008), 301 DLR (4th) 194 (CanLII) (ONSC) \[MC\] (“there is very little case law in Canada on the meaning of the word treatment, and there is particularly little discussion of whether treatment can include a decision to cease treatment where a patient is terminally ill or has very little chance of survival” at para 11).

\(^2\) \textit{Airedale NHS Trust v Bland}, [1992] UKHL 5, [1993] AC 789 at 870, per Lord Goff \[Bland\].
approval from the courts. Nevertheless, medical futility remains a paramount consideration in medical decision-making in the UK.

In this chapter, I will explore the Canadian common law and UK law surrounding medical futility. An examination of the common law is central to understand the hurdles preventing the recognition of a legal standard of medical futility in Canada. Moreover, my exploration of the UK law will provide an insight into how medical futility could be recognized as an important consideration in medical decision-making.

This chapter is divided into four parts. I begin this chapter by describing the unsettled nature of the Canadian common law relating to medical futility, and I suggest several reasons why this is so. In Part Two, I explore the first branch of the futility debate: have the Canadian courts recognized a legal standard of medical futility which justifies withholding or withdrawing futile treatment? The purpose of this exploration is to show that the common law does not recognize such a standard, in no small part due to the influence of personal autonomy.

In Part Three, I turn to discuss the second arm of the futility debate: whether physicians have unilateral power to withdraw or withhold futile treatment. I will show that there exists limited common law authority supporting the position that physicians have unilateral authority to withhold or withdraw treatment if to do so does not involve touching the patient. Generally, however, the courts find it is their role to oversee contentious treatment decisions in the end-of-life context.

Finally, in Part Four, I will detail a handful of prominent UK cases regarding medical futility which are often cited, although rarely decisively, by the Canadian courts. Additionally, I will explore how the UK legislature has intervened to provide guidance in the resolution of futility debates. My examination of the UK law will reveal a markedly different approach in the way the UK resolves futility disputes compared with Canada, and I suggest that certain aspects of the UK approach could be applied in the Canadian context to improve the Canadian law surrounding medical futility.

---

1 The Unsettled Common Law

The Canadian courts have time and again failed to decisively resolve the futility debate. Manitoba’s Court of Appeal in *Child and Family Services of Central Manitoba v Lavallee* was the first appellant court in Canada to consider a futility dispute.⁴ Here, the parents of an infant in an irreversible permanent vegetative state (PVS)⁵ sought an appeal from a previous court order granting Child and Family Services the authority to direct the infant’s medical team to issue a Do-Not-Resuscitate (DNR) order for the infant.⁶ Twaddle J, speaking for the Court, set the order aside on the basis:

Neither 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 decision 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. The wishes of the patient’s family or guardian should be taken to account, but neither their consent nor the approval of the court is required.⁷

On its face, *Lavallee* stands for the proposition that physicians have sole authority to withhold or withdraw treatment deemed to be medically futile.

*The courts have subsequently distinguished* *Lavallee.* For example, in *Re LIC (Dependent Adult),* Alberta’s Queen Bench was asked to determine whether the Public Guardian had legal authority to consent to the withdrawal of life-sustaining treatment for a severely disabled adult patient.⁸ *Lavallee* was cited for the following proposition:

---

⁴ *Child and Family Services of Central Manitoba v Lavallee et al* (1997), 123 Man R (2d) 135, 154 DLR (4th) 409 (Man CA) [*Lavallee*].
⁵ Barney Sneiderman, "A Do Not Resuscitate Order for an Infant Against Parental Wishes a Comment on the Case of Child and Family Services of Central Manitoba v RL and SLH" (1999) 7 Health L J 205 (the child was PVS because of a ‘savage attack’ from an ‘unknown assailant’, following which the Child and Family Services immediately removed the infant from its home. At paragraph 3 the Court made the telling comment that it is in no-one’s best interests to artificially prolong the life of a child unless they were trying to avoid criminal responsibly. This statement was directed towards the parents of the child who were likely responsible for the attack but who could not be charged with homicide if the child remained on life-support and survived past a year and a day pursuant to s 227 of the Criminal Code (now repealed), at para 5).
⁶ *Lavallee*, supra note 4 at 3.
⁷ Ibid at 8.
⁸ *Re LIC*, supra note 1.
it appears that the decision of whether or not to withhold or withdraw life sustaining medical care is inherently a medical decision, within the sole purview of a patient’s treatment doctor.\footnote{Ibid at para 36.}

Despite this nod to Lavallee, the Court held that the Public Guardian did indeed have authority to consent to the withdrawal of life-support.\footnote{Ibid at para 34.} This finding shows that the decision to discontinue life-sustaining treatment is not within the sole purview of the treating physician.

Similarly, in Children’s Aid Society of Ottawa-Carleton v MC, Metivier J, delivering the judgment for Ontario’s Superior Court of Justice, acknowledged Lavallee as “one of the only Canadian judicial commentaries on the need for consent when withdrawing treatment,” but noted that the “decision is not binding on the Superior Court of Justice in Ontario.”\footnote{MC, supra note 1 at para 12.} Given the ambiguity in the common law, Metivier J directed that a court order should be sought where a proposal is made to withdraw treatment from an incapacitated patient “until further clarification of this issue.”\footnote{Ibid at para 34.} Like Re LIC, MC supports the view that the withdrawal of futile treatment is not a decision to be singularly made by a treating physician.

Nevertheless, the courts were more sympathetic to the argument that clinical evidence of futility is a relevant consideration in deciding whether it is in the patient’s best interests to withhold or withdraw treatment. For example, in London Health Science Centre v RK McDermid J found:

There is no treatment that can be given [to] RK that will ameliorate his condition and there is no hope that it may improve. He is as close as a person can be to being clinically dead. Therefore, it is futile to maintain him on the life-support systems. He will simply continue to deteriorate until the inevitable eventually occurs.\footnote{London Health Science Centre v RK (1997), 152 DLR (4th) 724 (CanLII) (ONSC) [London Health] at para 10.}

Likewise, in Sweiss v Alberta Health Services, Ouellette J concluded that cardiopulmonary resuscitation (CPR) would provide no benefit to the patient and may even cause him further harm, and therefore a DNR order was appropriate.\footnote{Sweiss v Alberta Health Services, 2009 ABQB 691 (available on CanLII) [Sweiss] at para 69.} However, in no case was medical futility the decisive consideration, and as will be discussed below, evidence about the medical implications of treatment was frequently overshadowed by the patient’s values, beliefs and
wishes. Even in Lavallee, where Twaddle J found “it is in no one’s interest to artificially maintain the life of a terminally-ill patient who is in an irreversible vegetative state”, the order was made to withdrawal life-support on the basis that “there is no need for a consent from anyone for a doctor to refrain from intervening.”

The judiciary has been reluctant to recognize medical futility as a fundamental consideration in the healthcare context or the unilateral authority of physicians to withdraw or withhold futile treatment. But this does not mean the judiciary has rejected both propositions outright. The courts have simply refused to articulate clear findings on either issue.

The unsettled nature of the law is perhaps best expressed in a string of cases involving interim injunction applications being sought either to: remove a DNR order that had been placed on a patient’s chart, prevent the withdrawal of life-sustaining treatment, or compel the provision of life-sustaining treatment. Broadly, in each instance the physicians argued that an interim injunction was inappropriate given the finding in Lavallee that physicians have unilateral authority to withhold or withdraw treatment. Only in the cases where an injunction was being sought to compel physicians to begin life-sustaining treatment did the physicians’ arguments find favour, as it was held to be “inappropriate” for the judiciary to force the hand of physicians. Where an injunction was sought to remove a DNR order or prevent the withdrawal of life-sustaining treatment the courts rejected the physicians’ argument and interim injunctions were ordered accordingly.

The interim injunction proceedings signify that Lavallee did not create a binding precedent that physicians can withdraw or withhold treatment they deem futile without consent or court

---

15 Lavallee, supra note 4 at 4.
16 Ibid at 6.
18 Golubchuk v Salvation Army Grace General Hospital et al, 2008 MBQB 49, 227 Man R (2d) 290 [Golubchuk].
19 Re IHV, 2008 ABQB 250 (available on CanLII), 449 AR 211 [Re IHV]; Rotaru v Vancouver General Hospital Intensive Care Unit, 2008 BCSC 318 (available on CanLII) [Rotaru].
20 Re IHV, ibid (“I have concluded in this particular cases that it is inappropriate for the courts to injunctively prescribe a course of treatment for a patient that may be contrary to the unanimous view of the healthcare authorities” at para 27); Rotaru, ibid (“I am satisfied that such an intervention would be inappropriate in this case” at para 18).
approval. Cases of interim relief, however, cannot support the argument that physicians do not have unilateral power to withdrawal or withhold treatment either, as the proceedings are not designed to rule decisively on points of law. Rather, these cases simply illuminate the ambiguous nature of the law surrounding medical futility.

There are three main reasons why the common law remains so unsettled. First, the judiciary is inclined to distinguish a futility dispute on its fact. For example, Lavallée concerned a physician’s legal authority to refrain from actively treating a patient (i.e. resuscitating the patient); whereas in Golubchuck v Salvation Army Grace General Hospital, the issue was whether a physician has capacity to discontinue treatment already in place (i.e. withdrawal a mechanical ventilator).\(^2\) One case involved discontinuing treatment and the other refraining from providing treatment in the first place, and as such they were distinguishable from each other. The ratio from Golubchuck was similarly distinguished in Rotaru v Vancouver General Hospital Intensive Care Unit on the basis Golubchuk involved the withdrawal of treatment, whereas Rotaru concerned the restoration of treatment after it had already been withdrawn.\(^2\)

Likewise, the condition of the patient in question may limit the precedential value of the case. In Sawatzky v Riverview Health Centre Inc, the treating physician conceded that at times Mr Sawatzky appeared ‘alert’.\(^2\) This concession led the Court to find Mr Sawatzky’s condition was significantly different from patients in other futility cases who were mostly described as being in a PVS and this raised issues not considered in other cases.\(^2\) For example, Mr Sawatzky had some capacity for interaction with his environment, and so, ongoing life-support was not simply maintaining his biological functions, but sustaining his mental capacity as well. In other words, life-sustaining treatment was arguably less ‘futile’ for Mr Sawatzky than patients in a PVS.

The second reason why the law of futility is so unsettled is because of the urgent nature in which such cases are decided. Futility disputes raise complex questions of law, ethics and

\(^{21}\) Golubchuk, supra note 18.
\(^{22}\) Rotaru, supra note 19.
\(^{23}\) Sawatzky, supra note 17 at para 33.
\(^{24}\) Ibid.
medicine and, as such, are ill-suited to be heard on a time-constrained basis without an “opportunity for leisurely reflection.” As much was admitted by McDermid J in *London Health*:

Because the parties have agreed that October 8, 1997, is the date upon which life-support shall be withdrawn, I have expedited the release of my reasons. Therefore, I have not dealt with this matter as extensively as I might otherwise have done.

Indeed, Barney Sneiderman criticizes *Lavallee* on the basis it took up “a scant two pages in the law reports” and “the question warrants more than the cursory treatment afforded by the Manitoba court, whose rush to judgment stands in marked contrast to rulings by courts in the United States, Great Britain, and elsewhere which have given attention that is deserved to life and death matters.”

The third reason why the common law remains so uncertain is that the judiciary does not recognize itself as the appropriate body to determine questions of “such complex moral, ethical, religious and legal issues.” McDermid J vehemently stated in *London Health* that it was inappropriate for the judiciary to make a declaration that a physician has a legal right to withdraw life-support without consent. Instead this question is “best dealt with in a multicultural society by Parliament rather than the courts.” The courts do not have faith that the common law alone is the appropriate tool for resolving futility disputes.

In summary, the Canadian futility cases do not establish a clear precedent for resolving futility disputes. The judiciary was neither able to articulate how concerns about futility were to be balanced when treatment decisions are made on behalf of incapacitated patients at the end-of-life, nor identify who was ultimately responsible for making decisions to withhold or withdraw treatment. Consequently, futility cases have been repeatedly brought before the courts to be decided on a case-by-case basis. This piecemeal line of authorities provides little guidance for health practitioners or SDMs on how to make treatment decisions on behalf of incapacitated patients.

---

25 *Bland, supra* note 2 (Lord Browne-Wilkinson famously stated, “behind the questions of law lie moral, ethical, medical and practical issues of fundamental importance to society” at 878).
31 *Ibid* at para 17.
2  Is Medical Futility Considered in the ‘Best Interests’ Test?

In the preceding discussion I noted that the Canadian judiciary is reluctant to recognize medical futility as a fundamental consideration in the healthcare context. In the discussion to follow, I will expand on this statement by exploring the extent to which medical futility is considered when the courts are asked to resolve futility disputes.

The best interests test is central to medical decision-making in the common law. The test requires the decision-maker - whether it is the SDM, the physician, or the court - to place “the best interests of the patient at the forefront of the analysis”\(^\text{32}\) regarding whether treatment should be prescribed. Even in the injunction proceedings involving futility disputes, the courts have discarded the traditional test for allowing injunctive relief,\(^\text{33}\) in favour of a best interests test.\(^\text{34}\) The value of the best interests test is that it ensures that healthcare services are provided for the benefit of the patient.

Generally, the Canadian common law supports the view that personal autonomy is the paramount principle in healthcare, with clinical evidence of futility having little impact on the courts’ assessment of whether it is in the patient’s best interests to receive further life-support. The dominance of personal autonomy is best illustrated in Sweiss. In this case, the patient, Mr Schweiss, suffered severe brain damage and cardio-pulmonary problems, and he lived at the mercy of a mechanical ventilator.\(^\text{35}\) Mr Schweiss’ treating physicians opined that mechanical ventilation should be withdrawn and a DNR order placed on Mr Schweiss’ chart should remain. Prior to his incapacitated state, Mr Schweiss signed a declaration stating any treatment decision must comply with the rules of Sharia law,\(^\text{36}\) which hold that mechanical

\(^{32}\) Sweiss, supra note 14 at para 61.

\(^{33}\) The Supreme Court in RJR-MacDonald Inc v Canada (Attorney General), [1995] 3 SCR 199, 127 DLR (4th) 1 established the following three part test to determine whether an injunction is appropriate: first, is there a serious issue to be tried; second, will irreparable harm result if an injunction is not ordered; and third, does the balance of convenience favour granting an injunction?

\(^{34}\) Sweiss, supra note 14 at paras 49-65 (in the context of cases involving medical crises Ouellette J found the traditional test developed in RJR-MacDonald, above, to be “inappropriate” and “nonsensical”. He found the second part of the test to be particularly impertinent in the end-of-life futility disputes given “[t]here will never be an application made in this context where irreparable harm would not flow should the injunction be refused” at 53. See also Re IHV, supra note 19 at 31.

\(^{35}\) Sweiss, ibid at para 4.

\(^{36}\) Ibid at para 43.
ventilation cannot be withdrawn unless the patient’s heart stops completely and cannot be revived, or the patient’s brain starts to disintegrate.\(^{37}\) Thus, in the opinion of his family, withdrawing the ventilator and issuing a DNR order was contrary to Mr Sweiss’ wishes. Speaking for the Court, Ouellette J concluded that the DNR order should remain on Mr Sweiss’ chart but mechanical ventilation should not be withdrawn.\(^{38}\)

One of the critical issues in Sweiss was “what, if any, consideration should be given to a patient’s wishes, beliefs and values when they are contrary to the course of treatment recommended by the health care providers?”\(^{39}\) In answer, Ouellette J held that assessing a patient’s best interests involves consideration of the patient’s values, beliefs and wishes, as well as clinical evidence about the appropriate course of treatment.\(^{40}\) While noting that “no one factor should be treated as paramount,”\(^{41}\) Ouellette J appeared to give more weight to Mr Sweiss’ autonomy than to clinical evidence about his condition. Ouellette J accepted the futility of further life-sustaining treatment, agreeing with the treating physician that further medical treatment would not benefit Mr Sweiss and may cause him harm.\(^{42}\) Nonetheless, he ordered continued use of the ventilator because this “respects the wishes and beliefs of Mr Sweiss and is consistent with the Sharia law.”\(^{43}\) Ouellette J also allowed the DNR order to remain because CPR is an “extraordinary measure” under Sharia law\(^{44}\) and so the order is also “a reflection of [Mr Sweiss’] wishes or beliefs.”\(^{45}\) Here, personal autonomy was the trump card in determining whether treatment was in Mr Sweiss’ best interests.\(^{46}\)

\(^{37}\) Ibid at para 10.
\(^{38}\) Ibid (the declaration did not meet the requirements for an advance directive under Albertan law but nonetheless Ouellette J found it “provided a clear indication of his wishes to have Islamic Sharia law apply to these issues concerning his health” at para 67-69).
\(^{39}\) Ibid at paras 43-48.
\(^{40}\) Ibid at para 64.
\(^{41}\) Ibid at para 63.
\(^{42}\) Ibid at para 69 (“I accept the evidence of Dr Williams that active intervention would create substantial harm to Mr Sweiss and that any such procedure would be of no benefit to him”).
\(^{43}\) Ibid at para 68.
\(^{44}\) Ibid at para 68
\(^{45}\) Ibid at para 70.
\(^{46}\) Ibid at para 48 (recall also Ouellette J’s finding - discussed in Chapter Two – that under Albertan law a patient’s valid prior known wishes “must be followed”, even where the wish is for indefinite provision of life-support. This obiter finding suggests that a patient’s autonomy can compel a physician to provide contra-indicated treatment).
Swiss also demonstrates that the judiciary is transforming the best interests test into a substituted judgment test. By elevating personal autonomy above other considerations when applying the best interests tests, the court in Swiss is tacitly affirming that a patient’s views, even when expressed by a SDM, can force a physician’s hand. This covert recognition of the positive nature of autonomy is worrying because it is disguised within a supposedly balanced best interests test.

The Canadian jurisprudence also illustrates how the constitutional dimensions of personal autonomy support its preeminence in healthcare. In Sawatzky, Beard J refused to follow Lavallee on the basis there were untested Charter issues to be considered.\(^{47}\) The question put to the court was whether a DNR order:

\[\text{deprive[d] [the patient] of the right to equal protection and benefit of the law contrary to s 15 in that, by deciding that such treatment would be futile, it has discriminated against him on the basis of his mental and physical disability, thereby depriving him of the right to autonomy over his own body and the opportunity to make an informed decision regarding his own health care.}\(^{48}\)

In other words, will a finding of medical futility unreasonably interfere with a patient’s personal autonomy? This untested issue was one of the reasons why Beard J granted an interim injunction pending a full hearing of the case.\(^{49}\) Similarly, Shulman J in Golubchuck noted that even “if the Charter does not apply, common law principles must develop in keeping with Charter values, which include respect for religious freedom (s 2(a)) and respect for life and personal autonomy (s 7).”\(^{50}\) Golubchuck and Sawatzky show that where there is a conflict between personal autonomy and medical futility, the constitutional protection afforded to the former concept supports its triumph over concerns about the latter. Moreover, these cases both involved incapacitated patients and so indicate that patient autonomy survives incapacity when expressed through a SDM.

The courts may not be ignoring the value of medical futility \textit{per se}; rather, they are refusing to recognize a purely clinical understanding of futility, which does not consider the views of the patient or patient’s SDM on whether treatment has any benefit. The case of Re IHV supports this reasoning.\(^{51}\) Here, the court was faced with an application from the daughter of

\(^{47}\) Sawatzky, supra note 17 at para 26.  
\(^{48}\) Ibid at para 27.  
\(^{49}\) Sawatzky never proceeded to a full hearing to decisively decide the Charter issue.  
\(^{50}\) Golubchuk, supra note 18 at para 25.  
\(^{51}\) Re IHV, supra note 19.
a terminally ill patient that her mother should receive aggressive life-sustaining treatment. The treating physician and the patient’s other daughter opposed the application on the grounds that further treatment was “hopeless and unnecessarily cruel.” Germain J, speaking for Alberta’s Queen’s Bench, refused to order further life-support. In reaching this conclusion, Germain J placed considerable weight on an affidavit from the patient’s other daughter that attached a letter from an independent consultant stating “further treatment offers no hope of recovery.” It can be supposed that because one of the patient’s daughters agreed with the physician that treatment was futile, arguments about the futility of treatment were afforded greater weight in this case than in instances where only the treating physician has argued treatment is futile, as in Golubchuck, Sweiss and Sawatzky.

With the exception of Re IHV, however, the common law does not equally weigh the principles of medical futility and personal autonomy. In the majority of cases, the physician’s concerns about the futility of treatment garner little, if any, weight. The courts are unwilling to find futility to be the decisive consideration if doing so would diminish the values, beliefs and wishes of the patient, even where the patient is incapacitated and unable to express herself. This hesitation to acknowledge a standard of medical futility is a product of the dominance of personal autonomy in healthcare.

3 Do Physicians have Unilateral Authority to Withhold or Withdraw Treatment?

I now turn to consider the second arm of the futility debate: whether physicians have unilateral authority to withhold or withdraw treatment. Given my finding above that the courts are reluctant to recognize medical futility for fear it will encroach on the dominance of personal autonomy, it arguably follows that physicians have no blanket authority to withhold or withdraw treatment that is deemed to be futile. However, the case law on this issue is confused, in no small part due to an odd distinction developed in Lavallee whereby the requirement for consent depends entirely on the invasiveness of the intervention. Moreover, I will show that, in general, the courts believe they should retain some oversight of controversial treatment decisions, while at the same time paying little attention to physicians’ concerns that they will breach ethical and professional obligations unless they are granted authority to decide when enough is enough.

---

52 Ibid at para 8.
3.1 Touching vs. non-touching dichotomy

One of the most contentious statements from Twaddle J in *Lavallee* was that “consent is needed only where the medical treatment without it would amount to an assault.”\(^54\) The effect of this statement is that ‘treatment’\(^55\) requires a positive act on the patient’s physical body (i.e. touching of the patient) and so “there is no need for a consent from anyone for a doctor to refrain from intervening.”\(^56\) Thus, consent is not required to withhold or withdraw treatment if there is no interference with the patient’s physical body.

This distinction between touching and non-touching has been much criticized for confusing the law of consent.\(^57\) Jocelyn Downie argues that the underlying reasoning for creating the touching vs. non-touching dichotomy is flawed because the “avoidance of assault is not the only basis for requiring consent.”\(^58\) There are many instances where consent is required for medical interventions that do not involve touching, such as with psychotherapy.\(^59\) The purpose of consent has expanded beyond simply protecting the individual from physical assault and preserving bodily integrity, to protecting the individual’s dignity and right to make a fully informed decision.\(^60\) Ultimately, Downie laments that Manitoba’s Court of Appeal misconceived the nature and purpose of consent by focusing on the invasiveness and physicality of a particular procedure.

Downie further argues that the touching vs. non-touching dichotomy creates an anomaly where “consent would not be required for the withholding of treatment but would be for the

\(^{54}\) *Lavallee*, supra note 4 at 5.
\(^{55}\) *The Child and Family Services Act* CCSM, 1980, c C80, (the term “treatment” is defined as: “An agency may apply to court for an order…authorizing medical…treatment for an apprehended child…” at s 25(3)).
\(^{56}\) *Lavallee*, supra note 4 at 6.
\(^{57}\) See Jocelyn Downie, "Unilateral Withholding and Withdrawal of Potentially Life-sustaining Treatment: A Violation of Dignity Under the law in Canada" (2004) 20 Journal Palliative Care 143; Sneiderman, *supra* note 5; Hilary Young, “Why Withdrawing Life-Sustaining Treatment should not Require ‘Rasouli Consent” (2012) 6:2 MJLH 54. See also: *Golubchuk*, *supra* note 18 (the distinction requires courts to perform “mental gymnastics to fit whatever is being proposed into one category or the other” and that “virtually all treatment given to a patient consists of both… commissions and omissions”, at paras 24-26).
\(^{58}\) Downie, *ibid* at 145.
\(^{59}\) *Ibid*.
\(^{60}\) *Ibid* at 147.
withdrawal of the very same treatment.”  61 This anomaly is problematic because any distinction between withdrawing treatment and withholding treatment is largely based on emotive concerns, as opposed to ethical or clinical reasoning.  62 Health practitioners and family members may be more comfortable withholding treatment from the outset, rather than withdrawing it once it has been prescribed.  63 Withholding treatment ensures non-interference with the natural dying process – the decision-maker does not assume responsibility for when or how the patient will pass away.  64 In contrast, withdrawing treatment may seem like a more momentous action and render the decision-maker causally responsible for a patient’s death.  65 Withdrawing mechanical ventilation may have particular symbolic significance for families, as it is generally the action that most proximally precedes death,  66 and the withdrawal can cause visible distress and discomfort.  67

Beauchamp and Childress argue from a moral perspective that there is no distinction between withdrawing treatment and withholding treatment: “both can be instances of allowing to die, and both can be instances of killing.”  68 A decision to withhold life-sustaining treatment will have the same result as a decision to withdraw life-sustaining treatment – the patient will die. As Lord Goff surmised in Airedale Hospital Trustees v Bland, “in each case, the doctor is simply allowing his patient to die in the sense that he is desisting from taking a step which might, in certain circumstances, prevent his patient from dying as a result of his pre-existing condition.”  69 Therefore, the distinction is “morally irrelevant.”  70

There is also no clinical basis upon which to distinguish between withdrawing treatment and withholding treatment. Any proposal from a physician to withhold or withdraw treatment

61 Ibid at 145. See also Sneiderman, supra note 5 at para 31.
62 Tom Beauchamp & James Childress, Principles of Biomedical Ethics, 6th ed (New York: Oxford University Press, 2009) at 155. Vardit Ravitsky, “Times on ventilators” (2005) 330:7488 BMJ 415 (Ravitsky argues the distinction between withholding and withdrawing treatment “stems at least in part from the religious approach that humans should not have an active role in the dying process, which should remain in the hands of God” at 415).
63 Beauchamp & Childress, ibid at 155.
64 Ravitsky, supra note 62 at 415.
65 Beauchamp & Childress, supra note 62 at 155.
67 Ibid.
68 Beauchamp & Childress, supra note 62 at 157.
69 Bland, supra note 2 at 866.
70 Beauchamp & Childress, supra note 62 at 156.
must be made in the patient’s best interests. If life-sustaining treatment is not in the patient’s best interests it should not be administered, and if already administered, it should be withdrawn. Gordon Rubenfeld\(^{71}\) argues that there exists a high level of hypocrisy and irrationality in situations where a decision is made to withhold life-sustaining treatment, such as dialysis, yet mechanical ventilation is continued.\(^{72}\) Such decisions imply that the patient’s death is inevitable, yet the dying process is prolonged with assistance of mechanical ventilation while the patient suffers the effects of renal failure. Hence, Rubenfeld urges decision-makers to “strongly consider whether continuing…mechanical ventilation while withholding dialysis makes clinical sense.”\(^{73}\) The illusory and emotive distinction between withholding and withdrawing treatment should not detract from considering first and foremost what is in the patient’s best interests.

Finally, the line between withholding or withdrawing treatment is indistinct. A physician’s proposal not to prescribe treatment could be characterized as either withholding or withdrawing treatment. For example, issuing a DNR order is usually conceived as withholding resuscitative treatment. Yet, on admission to hospital a patient will be automatically classified “full code”, meaning that the treatment team will take all measures to resuscitate the patient in the event of cardiac arrest.\(^{74}\) Thus, in issuing a DNR order the physician is actually withdrawing treatment that would otherwise have been available.\(^{75}\) Identifying when a treatment is being withheld as opposed to being withdrawn is a difficult exercise, if not a pointless one.

In my opinion, withdrawing treatment and withholding treatment should be subject to the same legal principles as regards whether consent is required from the SDM. The requirement for consent should not depend on the physicality of the proposed course of action, or whether the proposal involves an act or omission. To hold otherwise would lead to inconsistent decision-making and ground the law of consent in the emotive concerns of physicians or

---

\(^{71}\) Dr Rubenfeld is one of Mr Rasouli’s treating physicians.  
\(^{72}\) Rubenfeld, \textit{supra} note 66 at 436  
\(^{73}\) \textit{Ibid.}  
\(^{74}\) Mark Handelman, “Consent to Withdrawal of Life-support: What the Supreme Court Said in \textit{Cuthbertson and Rubenfeld v Rasouli}” online: Whaley Estate Litigation <http://whaleyestatelitigation.com/resources/WEL_What_the_Supreme_Court_Said_In_Cuthbertson_and_Rubenfeld_v_Rasouli.pdf> at 23.  
\(^{75}\) \textit{Cuthbertson v Rasouli}, 2013 SCC 53, [2013] 3 SCR 341 (Factum of the Appellant at para 80) [FOA].
SDMs, which may be divorced from what is in the patient’s best interests. Nevertheless, if the reasoning in *Lavallee* garners further support from the courts, then physicians will have authority to withhold treatment, and in some cases even withdraw treatment, without consent if it can be done without touching the patient.

### 3.2 The role of physicians

As discussed in Chapter One, physicians frequently argue that the provision of futile care conflicts with both their professional and ethical obligations, specifically their obligations to treat patients according to best clinical judgment and ‘do no harm’. The Canadian courts have not been persuaded by such arguments. In *Sawatzky*, Beard J noted that life-sustaining treatment had been provided to Mr Sawatzky for five months prior to the hearing and so the prescription of such treatment was an “ethical dilemma” that Mr Sawatzky’s treating physician was evidently “able to live with for some time.” Beard J further held that maintaining a patient on life-support does not raise the same sort of ethical problems associated with procedures such as abortion, however she did not elaborate on the reasons for this conclusion.

Beard J’s sentiment was reflected a decade later in *Golubchuck*. Here, Schulman J reasoned that although the treating physician argued she was originally “talked into” administering Intensive Care Unit (ICU) treatment for Mr Golubchuk, prescription of the treatment at that time presumably “squared with [her] ethical obligations.” Moreover, since the treatment began there was unlikely to have been such a significant disruption to the physician’s ethics to justify disturbing the status quo by withdrawing ICU treatment. Schulman J also cited with approval Beard J’s statement that maintaining life-support was not so much of an ethical dilemma as abortion.

---

76 *Sawatzky*, *supra* note 17 at para 31.
77 *Ibid* (it could be argued that ending the life of an already live human being is more unethical than terminating a human fetus. Alternatively, both procedures are equally wrong as they are both akin to playing God).
78 The treating physician cited as the defendant in *Golubchuk* was not Dr Kumar who, as discussed in the previous chapter, refused to work at the hospital treating Mr Golubchuck on the basis he conscientiously objected to further treatment.
79 *Golubchuk*, *supra* note 18 at para 28.
80 *Ibid*.
81 *Ibid*.
In my opinion, the judicial logic in Golubchuk and Sawatzky neither appreciates the purpose of life-sustaining treatment nor accounts for the complexity of clinical decision-making. Following a severe adverse medical event such as a stroke or cardiac arrest, it may not be immediately obvious whether the patient will recover, even to an experienced physician. Life-sustaining treatment is therefore administered to stabilize the patient’s condition and allow the medical team time to conduct tests to determine the patient’s prognosis. It may take weeks or months for the medical team to conclude that continued life-support will not benefit the patient, and it may only be at that point the physician faces an ethical dilemma if life-support is continued.82

Life-support has the further purpose of extending time for the patient’s loved ones to come to terms with the patient’s condition and say their good-byes. In Jin v Calgary Health Region, Martin J concluded that the balance of convenience favoured granting an interim injunction to allow Mr Jin’s family “more time to understand and assess the medical information, and perhaps to absorb the reality of their loved one’s condition.” Administering life-support for this purpose could be conceived as a waste of scarce medical resources. However, physicians have a professional and ethical obligation to show care and compassion for the patient and their loved ones, and the grant of life-support, at least temporarily, aligns with those obligations. Indeed, Martin J conceded that the extension of life-sustaining treatment would utilize further medical resources, but that the injunction is effective only for a brief period.84 On balance, the temporary sacrifice of medical resources is worth promoting a healthy relationship between the patient’s family and the patient’s medical team, and reassures the public that medical services are provided in a caring and compassionate environment.

82 Bland, supra note 2 (“[w]here (for example) a patient is brought into hospital in such a condition that, without the benefit of a life-support system, he will not continue to live, the decision has to be made whether or not to give him that benefit, if available. That decision can only be made in the best interests of the patient. No doubt, his best interests will ordinarily require that he should be placed on a life-support system as soon as necessary, if only to make an accurate assessment of his condition and a prognosis for the future. But if he neither recovers sufficiently to be taken off it nor dies, the question will ultimately arise whether he should be kept on it indefinitely. As I see it, that question (assuming the continued availability of the system) can only be answered by reference to the best interests of the patient himself, having regard to established medical practice,” Lord Goff, at 867).
83 Jin, supra note 17 at para 40.
84 Ibid.
Finally, physicians frequently raise the argument in futility disputes that providing contraindicated treatment conflicts with their ethical duty of non-maleficence and professional duty to practice according to a reasonable standard of care.\(^{85}\) This indicates a general consensus in the medical community that prescribing futile life-support is a significant infringement on the medical profession, contrary to the findings in Sawatzky and Golubchuk. Physicians are better placed to assess whether the prescription of a particular treatment is excessively harmful or falls below a reasonable standard of practice, compared to judges who lack both medical expertise about the effects of treatment and exposure to front-line medical practice. Therefore, in my view, the court should accept reasonable evidence tendered by physicians concerning the degree to which their professional and ethical obligations are impinged by the administration of futile treatment. This approach attributes added value and importance to a physician’s professional and ethical obligations, which serve to ensure that physicians always act in the patient’s best interests and that the patient is protected from immoral or inept medical practices.

Nevertheless, a physician’s obligations to do no harm and to always practice according to a reasonable standard of care must be balanced against competing considerations, including the ethical obligation to respect the patient’s autonomy.\(^{86}\) Indeed, physicians frequently and justifiably breach their ethical and professional obligations in the course of practice. For example, a physician’s duty to treat is conflicted when a patient refuses consent to treatment. As the Supreme Court remarked in Rasouli SCC “[s]uch tensions are inherent to medical practice.”\(^{87}\) It follows that a physician’s commitments to the medical profession do not provide a solid ground for the law to recognize futility in a purely clinical sense.

### 3.3 The role of the Court

If physicians do not have unilateral powers to withhold or withdraw treatment, should it be left for the courts to resolve futility disputes? On the one hand, the traditional argument against judicial intervention presupposes that judges do not have sufficient expertise to adjudicate matters pertaining to medicine and that decisions involving the diagnosis,

\(^{85}\) See: Sweiss, supra note 14 at para 12; Golubchuk, supra note 18 at para 28; Sawatzky, supra note 17 at para 2; Re IHV, supra note 19 at para 25; Rotaru, supra note 19 at paras 4, 10; Cuthbertson v Rasouli, 2013 SCC 53, [2013] 3 SCR 341 at para 33 [Rasouli SCC].

\(^{86}\) See generally: Beauchamp & Childress, supra note 62 at 99-140.

\(^{87}\) Rasouli SCC, supra note 85 at para 75.
prognosis and treatment of the patient are best left to health practitioners.\(^88\) Twaddle J in *Lavallee*, for example, found that the decision to issue a DNR order was a “judgment call for the doctor to make.”\(^89\) Germain J found similarly in *Re IHV* that “I am not satisfied that we as judges should be replacing our opinion with that of the medical community.”\(^90\)

On the other hand, Beard J in *Sawatzky* mused that the courts “have expertise in resolving factual disputes and legal decisions” and “advising of the legality or illegality of disputed decisions before the patient is dead.”\(^91\) Similarly, in *Re LIC*, Acton J acknowledged that the court’s role in medical decision-making is unsettled, given that physicians may unilaterally withdraw treatment without consent, but it is still “prudent to seek Court approval before proceeding [to withdraw or withhold treatment].”\(^92\) The benefit of judicial approval is that it allows all interested parties an opportunity to be heard, protects doctors from liability, protects patients from adverse medical practice, and helps to reassure the patient’s family and the general public that the healthcare system is not harming patients’ rights.\(^93\)

Leaving aside the question of whether judges have sufficient expertise to resolve futility disputes, there are four other reasons why judicial intervention is undesirable. First, the court system is expensive, with parties having to incur costs such as filing fees and lawyer’s fees. Second, the judicial system is inherently adversarial, which promotes further conflict between the parties. As Lord Mustill stated in *Bland*: “I believe that adversarial proceedings, even with the help of an amicus curiae, are not the right vehicle for the discussion of this broad and highly contentious moral issue, nor do I believe that the judges are best fitted to carry it out.”\(^94\) Third, although most cases are heard under urgency, an expeditious result is not guaranteed. The Rasouli saga, for example, it took more than two and a half years for the

\(^{88}\) *Jin, supra* note 17 (Martin J favoured an approach to the wording of the injunction that “does not involve the court unduly in the specifics of Mr Jin’s medical treatment.” On that basis she refused to authorize an interim injunction that ordered the specific administration of blood pressure medication that was contraindicated by Mr Jin’s condition: “this court is not in a position to order the delivery of specific drugs and this form of order provides that Mr Jin should be treated as all patients under this classification” at para 42).

\(^{89}\) *Lavallee, supra* note 4.

\(^{90}\) *Re IHV, supra* note 19 at para 31.

\(^{91}\) *Sawatzky, supra* note 17 at para 5.

\(^{92}\) *Re LIC, supra* note 1 at para 35.

\(^{93}\) *Ibid*.

\(^{94}\) *Bland, supra* note 2 at 890.
Supreme Court of Canada\textsuperscript{95} to make its decision following the decision of Ontario’s Superior Court of Justice.\textsuperscript{96} Further, as discussed above, even if a judicial decision is heard urgently this may result in inadequate and/or incomplete judicial reasoning. Inadequate judicial reasoning may be compounded by judges’ lack of expertise in medical decision-making. Finally, litigation absorbs the time of the patient’s medical team, which could be better applied treating patients. The court process requires health practitioners - including physicians, nurses, physiotherapists and residential carers - to spend time preparing witness statements and appearing as witnesses, and it also forces them to endure the stress of having their professional judgment and reputation scrutinized.

Hence, although court hearings are designed to satisfy parties that “justice must not only be done but be seen to be done,”\textsuperscript{97} in reality a court hearing may not be in the patient’s best interests. In my opinion, the court’s role should be limited to interpreting the applicable legislation and stipulating the legal considerations a decision-maker must take into account when making a treatment decision on behalf of another person. Courts should not be \textit{prima facie} responsible for assessing the merits of medical disputes as judges do not have the knowledge to understand complex medical information, especially on a time-constrained basis. Therefore, in Chapter Five, I will suggest the inception of an alternate quasi-judicial forum to hear futility disputes in the place of courts.

3.4 Summary: Physicians’ Unilateral Authority to Withhold or Withdraw Treatment

The Canadian common law has failed to pinpoint who is responsible for deciding when to withhold or withdraw treatment from an incapacitated patient. \textit{Lavallee} has an enduring presence in the case law but it has never been cited decisively to support physician-driven futility. The absence of any clear judicial directive on this issue has lead to the continuing interference of the courts in futility disputes. Nevertheless, judges are often reluctant to decide medical matters, and the costly, adversarial and time-consuming nature of the judicial system indicates that the courtroom is not the ideal forum to hear these matters.

\textsuperscript{95} \textit{Rasouli SCC}, supra note 85.
\textsuperscript{96} \textit{Rasouli v Sunnybrook Health Sciences Centre}, 2011 ONSC 1500, 105 OR (3d) 761.
\textsuperscript{97} \textit{Sawatzky}, supra note 17 at para 9.
In my view, the futility debate cries out for legislative attention. The legislature, as a proxy for society, has authority to direct how futility disputes should be resolved in keeping with shared moral interests, including the state’s interest in reducing the provision of futile treatment and preserving patient autonomy. Statutory guidance will also provide greater clarity and encourage greater consistency in the resolution of futility disputes.

The current state of the Canadian common law provides little guidance for legislatures on the legal principles upon which a statutory scheme for resolving futility disputes should be based. It is therefore prudent to look to other jurisdictions for guidance. The UK in particular has the benefit of strong common law authorities relating to medical futility as well as legislation designed, in part, to streamline the judicial process for resolving futility disputes. Moreover, UK futility cases are already frequently cited in Canadian jurisprudence, albeit rarely decisively. In the discussion below, I propose to examine why the Canadian courts and legislature have been reluctant to follow UK law, and whether adoption of UK legal principles would remedy the confused state of the Canadian law surrounding medical futility.

4 Medical Futility in the UK

4.1 UK Common Law

In Bland, the House of Lords famously recognized physician-driven futility as a legal justification to withdrawal or withhold treatment. Anthony Bland was in a PVS following an accident that caused oxygen deprivation to his brain. His medical team and family agreed that life-support should be withdrawn. At the time Bland was decided, there was no legal authority for the courts or any other person to consent to treatment on behalf of another person, even in the event of incapacity. Therefore, the question before the House of Lords

\footnote{Downie, supra note 57 at 147}
\footnote{Bland, supra note 2.}
\footnote{Ibid at 795.}
\footnote{Ibid at 796.}
\footnote{Ibid (Lord Lowry heavily lamented the loss of the parens patriae jurisdiction: “I have never heard a rational, or indeed any, explanation for this step, which has placed under a further disadvantage a class of adults who are already handicapped…but I sincerely hope that the parens patriae jurisdiction over adults will soon be restored” at 875.)}
was whether Mr Bland’s treating physicians could discontinue life-sustaining treatment without facing charges of manslaughter or murder.  

The five law lords unanimously concluded that any treatment decision must be made in accordance with the patient’s best interests.  Generally, it is not in a patient’s best interests to receive futile treatment and physicians have exclusive authority to make a finding of futility where “a large body of informed and responsible medical opinion is to the effect that no benefit at all would be conferred by continuance.” Physicians must respect the views of the patient’s loved ones, but such views are not determinative of the ultimate treatment decision. It follows that where a physician has deemed a particular intervention to be futile, the physician is justified in refusing to prescribe such treatment: “the futility of the treatment…justifies its termination.” With specific regard to patients in a PVS, the law lords concurred that “existence in a vegetative state with no prospect of recovery is [medically] regarded as not being a benefit, and that, if not unarguably correct, at least forms a proper basis for the decision to discontinue treatment and care.” Bland therefore stands for the proposition that it is not unlawful for a physician to withdraw life-support from a patient where the physician believes the patient has no prospect of any recovery or improvement, even when it is known that the discontinuance of treatment would result in the patient’s death.

In addition to Bland, Canadian judgments frequently cite three other UK decisions: Re R (a minor) (wardship: medical treatment), Re J (a minor) (wardship: medical treatment) and

103 Ibid at 795.
104 Ibid (“[t]here comes a stage where the responsible doctor comes to the reasonable conclusion (which accords with the views of a responsible body of medical opinion) that further continuance of an intrusive life-support system is not in the best interests of the patient, he can no longer lawfully continue that life-support system: to do so would constitute the crime of battery and the tort of trespass to the person, Lord Brown-Wilkinson, at 883).
105 Ibid, Lord Keith, at 858.
106 Ibid at 871.
107 Ibid, Lord Goff, at 869.
108 Ibid, Lord Keith, at 859.
The question in Re R was whether the court has authority to override a minor’s decision to refuse anti-psychotic medication, and as such is not directly relevant to the futility debate. However, two obiter statements made by Lord Donaldson in the course of the judgment are relevant:

It is trite law that in general a doctor is not entitled to treat a patient without the consent of someone who is authorized to give that consent…However consent by itself creates no obligation to treat. It is merely a key which unlocks the door….in the case of an adult of full capacity there will usually only be one keyholder, namely the patient.  

And later:

No doctor can be required to treat a child, whether by the court in the exercise of its wardship jurisdiction, by the parents, by the child or anyone else. The decision whether to treat is dependent upon an exercise of his own professional judgment, subject only to the threshold requirement that, save in exceptional cases usually of emergency, he has the consent of someone who has authority to give that consent. In forming that judgment the views of the wishes of the child are a factor whose importance increases with the increase in the child’s intelligence and understanding.  

Put simply, Lord Donaldson found that the power of consent is limited: consent permits a physician to administer a proposed treatment, but consent cannot be used to compel the physician to administer treatment against her clinical judgment.  

The court in Re J considered whether resuscitative treatment should be administered to a severely brain damaged minor (J). J’s treating physician argued that resuscitative treatment was inappropriate if J suffered a life-threatening event. J’s mother and a local social work agency disagreed, and sought an injunction requiring all available treatment to be provided to J, including CPR. Lord Donaldson, delivering the lead judgment, refused injunctive relief for the following reason:

I have to say that I cannot at present conceive of any circumstances in which this would be other than an abuse of power as directly or indirectly requiring the practitioner to act contrary to the fundamental duty which he owes to his patient…to treat the patient in accordance with his own best clinical judgment.  

---

111 R (Burke) v General Medical Council, [2005] EWCA Civ 1003, [2005] All ER (D) 445 [Burke].  
112 Re R, supra note 109 at 184.  
113 Ibid at 187.  
114 Re R, supra note 109 at 619.  
115 Re J, supra note 110 at 619-620.  
116 Ibid at 622.
Finally, *Burke* illustrates that the principle of personal autonomy cannot be employed to compel physicians to act contrary to clinical judgment. Here, Mr Burke sought review of guidelines issued by the General Medical Council in the wake of *Bland*, which granted physicians unilateral authority to withhold or withdraw treatment deemed to be futile and contrary to the patient’s best interest. On the issue of personal autonomy, Lord Phillips, speaking on behalf of the Court of Appeal of England and Wales, stated:

> The proposition that the patient has a paramount right to refuse treatment is amply demonstrated by the authorities…The corollary does not, however, follow, at least as a general proposition. Autonomy and the right of self-determination do not entitle the patient to insist on receiving a particular medical treatment regardless of the nature of the treatment. Insofar as a doctor has a legal obligation to provide treatment this cannot be founded simply upon the fact that the patient demands it. The source of the duty lies elsewhere.\(^\text{117}\)

Together these cases demonstrate that physicians in the UK have authority to withhold or withdraw life-sustaining treatment if sound clinical judgment shows it is in the patient’s best interests to do so. Put another way, a physician cannot be compelled to provide treatment by a patient, a patient’s loved ones or even a court where the physician believes treatment to be contra-indicated. A physician’s discretion in this respect is fettered only by the physician’s professional and ethical obligations, including, importantly, the physician’s duty to practice to a reasonable standard of care and respect the patient’s autonomy.\(^\text{118}\)

### 4.2 Mental Capacity Act 2005

In 2005, the UK legislature enacted the Mental Capacity Act (MCA),\(^\text{119}\) which codifies the law of consent regarding incapacitated individuals.\(^\text{120}\) Section 5 of the MCA states that a physician will not be liable for doing any act in connection with the care or treatment of an incapable patient that the physician believes is in the patient’s best interests.\(^\text{121}\) This provision reinforces the common law position that a physician has legal authority to withhold or withdraw futile treatment if she believes it is in the patient’s best interests.

---

\(^{117}\) *Burke*, *supra* note 111 at para 31.

\(^{118}\) See: *Bland*, *supra* note 2 at 871.

\(^{119}\) *Mental Capacity Act 2005* (UK), c 9 [MCA].

\(^{120}\) *Mental Capacity Act 2005* (UK), c 9, Explanatory Notes: Summary and Background, online: The National Archives <http://www.legislation.gov.uk/ukpga/2005/9/notes/division/2>.

\(^{121}\) *MCA*, *supra* note 119, s 5.
Oddly, the MCA is not clear which factors should be considered in applying the best interests test, except that the “person making the determination must consider all the relevant circumstances.” The statute does, however, provide detailed guidance about the process the decision-maker should follow when applying the best interests test, including a requirement to consider any values, beliefs, feelings or wishes held by the patient. Whether or how medical evidence should be weighed against the patient’s views is not expressly apparent.

The MCA is, however, accompanied by a Code of Practice designed to provide “guidance and information about how the [MCA] works in practice.” The Code anticipates that “there will be a limited number of cases where treatment is futile, overly burdensome to the patient or where there is no prospect of recovery”, and in such circumstances it may “be in the best interests of the patient to withdraw or withhold life-sustaining treatment, even if this may result in the patient’s death.” Hence, medical futility is a fundamental consideration in the MCA’s best interests test. The Code also urges decision-makers to “consider any statement that the [patient] has previously made about their wishes and feelings about life-sustaining treatment.” In sum, the Code “recognizes that ‘best interests is not limited to an objective assessment about what is clinically most appropriate for the patient, but rather it also encompasses much more subjective considerations about what treatment would best fit with the patient’s values and preferences.”

If there is a dispute as to whether withholding or withdrawing life-sustaining treatment is in a patient’s best interests, the Code directs that an application should be made to the Court of Protection for determination. The Court of Protection enjoys specialized jurisdiction over the financial affairs and personal welfare of incapacitated individuals, and it may appoint a ‘deputy’ to make treatment decisions on behalf of an incapacitated person. An application

---

122 Ibid, s 4(2).
123 Ibid, s 4(6).
124 MCA Code of Practice, supra note 3 at 1.
125 Ibid at 5.31.
126 Ibid at 5.32.
128 MCA Code of Practice, supra note 3 at paras 5.33-5.36.
130 MCA, supra note 119, s 16.
must be made to the Court in the advent of a proposal to withdraw or withhold treatment from a patient in a PVS, regardless of whether there is a dispute.  

_Aintree University Hospital NHS Foundation Trust v James_ was the first case to come before the UK Supreme Court under the MCA. The issue in _Aintree_ was whether it was in the best interests of a patient, Mr James, to prescribe life-sustaining treatments, including the administration of drugs for circulatory support, renal replacement therapy and CPR. At the time of the hearing, Mr James was “gravely ill” and in a minimally conscious state. Counsel on both sides acknowledged that life-sustaining treatments would possibly be futile, would be extremely burdensome to endure and it would not be in Mr James’ best interests to face a “prolonged, excruciating and undignified death.” Both sides also acknowledged that Mr James still received some benefit from visiting friends and family, and would want to maintain treatment up until the point where it became hopeless. Against this later finding, Mr James’ family disputed the proposed withdrawal of life-sustaining treatment. 

Lady Hale, delivering the judgment on behalf of the Supreme Court, declared that under the MCA, “the court has no greater powers than the patient would have if he were of full capacity.” Hence, the courts - like a patient or patient’s loved ones - have no authority to compel a physician to provide treatment she believes is not in the patient’s best interests. When considering the patient’s best interests, the physician cannot rely exclusively on clinical evidence of the patient’s prognosis and the nature of the proposed treatment, but she must also turn her mind to the views of the patient and the patient’s friends and family. Moreover, assessing the patient’s wishes and feelings is not an objective test (i.e. what the reasonable patient would think) but rather the decision-maker must “consider matters from the patient’s point of view.” The patient’s views are important because “they are a

---

131 _MCA Code of Practice, supra_ note 3 at paras 6,18, 8.19.  
132 _Aintree University Hospitals NHS Foundation Trust v James_ [2013] UKSC 67, [2014] 1 All ER 573 [James].  
133 _Ibid_ at para 8.  
134 _Ibid_ at para 3-6.  
135 _Ibid_ at para 11.  
136 _Ibid_.  
137 _Ibid_ at para 10 -11.  
138 _Ibid_ at para 18.  
139 _Ibid_ at para 39.  
140 _Ibid_ at para 45.
component in making the choice which is right for him as an individual human being.”

However, Lady Hale stressed that such views are not determinative of the final decision, and must be balanced against the realities of the patient’s clinical condition.

The issue of futility was found to be relevant in considering the nature of the proposed treatment. To overcome the controversy surrounding the meaning of ‘futility’, Lady Hale defined the concept as being where treatment was “ineffective or …of no benefit to the patient.” This standard of futility was distinguished from the definition given by the Court of Appeal in an earlier judgment where treatment must have “a real prospect of curing or at least palliating the life-threatening diseases or illness from which the patient is suffering.”

In Lady Hale’s opinion, the Court of Appeal set the threshold of futility too high. Treatment does not have to cure the underlying disease; rather, it is beneficial if it provides a quality of life that the patient could regard as worthwhile.

Lady Hale’s review of the proposed treatment revealed that further treatment was not only futile – in the sense that it did not improve Mr James’ quality of life – but also harmful. Against these findings, the physicians’ decision to withhold further treatment from Mr James was upheld. Ultimately, Mr James’ wishes gave way to what is in his best medical interests. James has been authoritatively cited in subsequent UK cases for the proposition “that neither a patient nor her family can require a doctor to administer treatment that doctor does not consider to be clinically indicated.”

Nevertheless, the recent case of Tracey v Cambridge Hospitals NHS Foundation Trust imposes a stringent duty upon physicians to consult and provide an explanation of any decision to withhold or withdraw treatment. This obligation endures even in relation to

---

141 Ibid at para 45.
142 Ibid (“[t]hat is not to say that his wishes must prevail, any more than those of an fully capable patient must prevail” at para 45).
143 Ibid at para 40.
144 Ibid at para 43.
145 Ibid.
146 Ibid at para 40.
147 Ibid at para 46.
148 Ibid at para 46.
150 Ibid at para 16-22 (here the Court of Appeal was only tasked with determining whether an order should be overturned from the lower court which refused a judicial review application
treatment that the doctor believes to be clinically contra-indicated.\textsuperscript{151} The purpose of this obligation is to allow the patient or the patient’s family to request a second opinion on whether treatment should be provided.\textsuperscript{152}

Therefore, although physicians in the UK cannot be compelled to provide contra-indicated treatment, they have a wide duty to consult patients and their loved ones about why further treatment will not be prescribed. If there is disagreement with the physician’s opinion, the MCA Code of Practice directs that an application should be made to the Court of Protection. Thus, a physician’s power to unilaterally withdraw or withhold futile treatment in the UK is limited by both a robust duty to consult and the possibility the Court of Protection will overturn the physician’s findings.

\textbf{4.3 Contrast between UK and Canadian common law}

There are four striking differences between the UK and Canadian common law regarding futility disputes. First, the UK courts, in contrast with the Canadian courts, recognize medical futility as an important consideration, if not the paramount consideration, in assessing whether treatment is in the patient’s best interests. The patient’s values, beliefs and wishes are also a factor in the UK’s best interests test, but not the dominant consideration, unlike in Canada.

Second, the UK Supreme Court has concretely defined medical futility to be where treatment is “ineffective or…of no benefit to the patient.”\textsuperscript{153} The benefit and effectiveness of treatment is measured predominantly against a competent body of medical opinion, while the patient’s values, belief and wishes are regarded only as secondary considerations.\textsuperscript{154} A clinical finding that treatment is futile \textit{prima facie} suggests that it is not in a patient’s best interests to receive treatment.\textsuperscript{155} A patient or patient’s family can only rebut this presumption by showing that

\textsuperscript{151}{\textit{Ibid.}}
\textsuperscript{152}{\textit{Ibid}} (“[t]he points on consultation and a second opinion are, moreover, matters of some general importance” at para 17).
\textsuperscript{153}{\textit{Ibid}} at para 40.
\textsuperscript{154}{\textit{Bland, supra}} note 2, Lord Keith, at 858.
\textsuperscript{155}{\textit{Ibid}} at 859.
the patient’s desire to be kept alive is reasonable despite her dire circumstances.\textsuperscript{156} In contrast, in Canada, physicians cannot be compelled to provide treatment contrary to a patient’s best interests,\textsuperscript{157} but in applying the best interests test, the physician’s views on the clinical benefits of treatment hold little sway against evidence that the patient desires such treatment.

Third, the UK case of \textit{Bland} created a prevailing assumption that life-prolonging treatment is not in the best interests of a patient in a PVS.\textsuperscript{158} As the High Court of England and Wales remarked in \textit{Primary Care Trust v CW}:

> Whether or not the withdrawal of life-sustaining treatment measures is in CW’s best interests will depend upon whether or not his diagnosis of PVS is correct. If it is correct, in other words if he has no awareness of self or environment and no prospect of recovery then the provision of any treatment is futile and cannot be in his best interests.\textsuperscript{159}

It follows that the need for approval from the Court of Protection to withdraw treatment from a PVS patient is largely a formality.\textsuperscript{160} By contrast, the Canadian courts have held that further treatment for patients in a PVS may sometimes be in their best interests, particularly so where the prescription of treatment accords with the patient’s values, beliefs and wishes expressed while competent.

Fourth, the UK government has created a specific judicial body - the Court of Protection - to resolve issues related to incapacitated persons, including futility disputes. The Court acts as a check on physician’s authority to decide whether treatment should be withdrawn or withheld. Generally, the Consent and Capacity Board (CCB) consider futility disputes in Ontario in the first instance. However, as will be discussed in Chapter Five, the CCB does not have a specific mandate or the relevant expertise to resolve such disputes. Indeed, none of the Canadian provinces or territories has established a forum - judicial or quasi-judicial - specifically purposed to resolve futility disputes.

\textsuperscript{156} James, \textit{supra} note 132 at para 47.
\textsuperscript{157} See: Sweiss, \textit{supra} note 14 at para 64.
\textsuperscript{158} Jackson, \textit{supra} note 127 at 559.
\textsuperscript{159} \textit{Primary Care Trust v CW}, [2010] EWHC 3448 (Fam) at para 70.
\textsuperscript{160} Jackson, \textit{supra} note 127 at 559.
4.4 Why the difference?

There are four major factors fueling the disparity between the two jurisdictions’ approach to medical futility disputes. First, although the Charter was only mentioned in two Canadian cases, its background influence in the Canadian common law should not be understated. The Charter creates a presumption in favour of arguments directed to protect human rights absolutely, unless an infringement of individual rights “can be demonstrably justified in a free and democratic society.” The protective arm of the Charter covers specific Charter rights (i.e. the right to life, liberty and security of the person) and broad Charter values (i.e. personal autonomy). The constitutional protection given to personal autonomy means that the principle is afforded a significant degree of legal weight in comparison to competing interests, such as resource concerns or the professional views of physicians. Hence, the broad influence of the Charter indicates that, in principle, a patient’s views should always direct what treatment should, or should not, be given.

Of course, human rights are also protected in the UK through the Human Rights Act 1998 (HRA), which incorporates the European Convention on Human Rights (ECHR). The ECHR protects patient autonomy via the right to respect for private and family life (Article 8). Specifically, the protection for an individual’s private life under Article 8 encompasses a patient’s physical and mental integrity.

---

161 Golubchuk, supra note 18 at para 25; Sawatzky, supra note 17 at para 27.
162 Canadian Charter of Rights and Freedoms, Part 1 of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11 (“The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society” s 1)
163 See: Golubchuk, supra note 18 at para 25.
164 Human Rights Act 1998 (UK), c 42.
166 See Pretty v United Kingdom, (App 2346/02) (2002) 35 EHRR 1, [2002] 2 All ER (D) 286 [Pretty] (the court ruled: “[a]lthough no previous case had established as such any right to self-determination as being contained in art 8 of the Convention, the notion of personal autonomy was an important principle underlying the interpretation of its guarantees” at 286); Burke, supra note 111 (“Article 8 would be engaged because Mr Burke’s dignity and autonomy would have been flouted” at para 35).
167 YF v Turkey, No 24209/94, [2003] IV ECHR 3607, [2003] 14 HRCD 439 (“Article 9 is clearly applicable to these complaints, which concern a matter of “private life”, a concept with covers the physician and psychological integrity of a person” at para 33).
Article 8 is qualified by Article 8(2), which reads:

There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.\(^{169}\)

For example, the European Court of Human Rights has applied this exception to find that the prohibition on assisted suicide protects vulnerable patients and is therefore a justified interference with an individual’s autonomy.\(^{170}\) In the context of medical futility, the Court in \textit{Burke} concluded that a patient cannot effectively employ Article 8 if treatment is withheld or withdrawn in accordance with common law requirements.\(^{171}\) Indeed, the same court in the recent decision \textit{R (on the application of Nicklinson and Anor) v Ministry of Justice} confirmed that autonomy “may have to yield to other rights and interests” and whether autonomy is given priority or not will depend on the circumstances and the strength of the other interests.\(^{172}\) In other words, the protection afforded to patient autonomy under Article 8 is qualified by competing rights and interests which are given legal weight through common law principles already governing futility disputes, including concerns about resource allocation and the integrity of the medical profession. Thus, patient autonomy is more circumscribed in the UK than in Canada.

Following closely from the first reason, the second reason why Canada and the UK differ in their approach to futility disputes is that the UK courts are more willing to explicitly recognize a wide range of other interests as justifiable fetters on patient autonomy. The UK courts have recognized the following considerations restrict the ability of a patient’s family to demand further life-sustaining treatments: the ineffectiveness of treatment,\(^{173}\) the patient’s predicted quality of life with and without the treatment,\(^{174}\) the patient’s predicted quality of

\(^{168}\) \textit{Bensaid v United Kingdom}, No 44599/98, [2001] III ECHR 1667 (“[t]he preservation of mental stability is…an indispensable precondition to effective enjoyment of the right to respect for private life” at para 47).

\(^{169}\) \textit{ECHR}, supra note 165 Art 8(2).

\(^{170}\) \textit{Pretty}, supra note 166.

\(^{171}\) \textit{Burke}, supra note 111 at paras 38-39.

\(^{172}\) \textit{R (on the application of Nicklinson and Anor) v Ministry of Justice}, [2013] EWCA Civ 961, [2014] 2 All ER 32 at para 54

\(^{173}\) \textit{R v Cambridge Health Authority, ex B}, [1995] EWCA Civ J0310-6, [1995] 2 All ER 129 at 137 [\textit{Cambridge Health Authority}].

\(^{174}\) \textit{Pretty}, supra note 166 at para 65.
death,\textsuperscript{175} the scarcity of healthcare resources,\textsuperscript{176} and physicians’ conscientious objections to providing treatment.\textsuperscript{177} Of course, these considerations are tempered by physicians’ duty to first act in the patient’s best interests.\textsuperscript{178} Nevertheless, this list of considerations reveals that the UK courts have a protective attitude to preserving the wellbeing of the public healthcare system and those who work within it. This attitude is not apparent in the Canadian jurisprudence where the patient’s autonomy overshadows other considerations.

The third reason for the disparity is that the House of Lords in deciding \textit{Bland} enjoyed the benefits of a full hearing and time to deliberate fully on the issues involved in futility disputes. Consequently, the \textit{Bland} decision was well-reasoned, thorough and applicable to factual situations beyond the confined facts of Mr Bland’s situation.\textsuperscript{179} In comparison, the Canadian futility cases are hurried and confined to the facts.

Finally, the healthcare system in the UK is a mixed private/public model. As such, the UK public healthcare system is not a means of first and last resort. If a patient is denied care under the public system in the UK on the basis treatment is futile, it remains open to the patient to access further treatment privately, assuming of course that a private physician is willing to provide futile treatment and that the patient has the means to pay for it. By contrast, in Canada the public health system is a patient’s first and last resort. If there is no physician in the public healthcare system willing to provide treatment, the patient is bereft of further options. The notion of wholly depriving an individual access to medicine is unsettling and encourages a cautious approach to judicial recognition of medical futility.

\textsuperscript{175} \textit{Burke, supra} note 111 at paras 62-65
\textsuperscript{176} \textit{Re J, supra} note 110 at 623; \textit{Cambridge Health Authority, supra} note 173 at 137.
\textsuperscript{177} \textit{Ibid} at 625.
\textsuperscript{178} \textit{Bland, supra} note 2 (“it is not legitimate for a judge in reaching a view as to what is for the benefit of the on individual whose life is in issue to take into account the wider practical issues as to allocation limited financial resources or the impact on third parties of altering the time at which death occurs”, Lord Browne-Wilkinson, at 879)
\textsuperscript{179} \textit{Ibid} (\textit{Bland} is a much cited decision despite Lord Browne Wilkinson’s remark: “I am very conscious that I have reached my conclusion on narrow, legalistic grounds which provide no satisfactory basis for the decision of cases which will arise in the future where the facts are not identical” at 884)
4.5 Is the UK approach preferable?

End-of-life futility disputes in the UK are resolved using against clear legal processes that can be applied across different situations. In contrast, the Canadian manner of resolving futility disputes is fragmented and decision-makers suffer having no robust legal principles to frame treatment decisions.

Together, the UK judiciary and legislature have established principles against which treatment decisions must be made, including a clear requirement to consider the patient’s overall best interests, which accounts for the patient’s best medical interests and her values, beliefs and wishes. Crucially, the UK law also imposes a strict duty on physicians to consult with patient’s loved ones about any proposal to withdraw or withhold treatment. This duty demands a high degree of communication between health practitioners and families in the healthcare system, which will ultimately promotes an open and amicable decision-making process. The UK law is also clear about how fundamental considerations are to be balanced in applying the best interests test – a patient’s views must be considered and respected, but they will not trump a physician’s reasonable opinion that treatment is contra-indicated. Finally, the UK legislature has appeased any judicial reluctance to adjudicate medical matters by creating the specialized Court of Protection to resolve disputes and issues involving incapacitated patients.

By comparison, the Canadian courts cling to the position that personal autonomy is the dominant consideration – even when expressed through a SDM - for fear that any lesser recognition of this principle will harm patients’ rights or undermine the Charter. The Canadian courts purport to be applying the best interests test, yet on many occasions the judicial reasoning better resembles a substituted judgments test. As such there is little room for medical evidence pertaining to the futility of treatment in the face of evidence about a patient’s beliefs, wishes and values. By ignoring physicians’ concerns about futility, the courts further encourage patients or SDM to make unnecessary and disproportionate demands on the public healthcare system. Moreover, provincial and territorial governments have not provided any guidance to the judiciary regarding how competing interests should be balanced in the end-of-life context.
However, the UK approach is by no means perfect. I venture that the judiciaries’ involvement is still troublesome, even with a specialized court adjudicating the disputes. Critically, there is no assurance that judges sitting on the Court of Protection will have sufficient expertise to resolve futility disputes. This is because judges are appointed to the Court by virtue of them holding a judgeship already (i.e. district judge or circuit judge),\(^\text{180}\) rather than on account of having any particular expertise in the medico-legal field. Moreover, the Court of Protection’s current policy is to enable a hearing to take place within six weeks from the time a judge directs that a hearing is required.\(^\text{181}\) In my view, six weeks is an unacceptably long time to wait to resolve questions of life or death. Finally, given that a physician \textit{prima facie} has authority to decide to withhold or withdraw futile treatment, the burden falls on a patient’s family to apply to the Court of Protection to refute a physician’s assessment of the best interests test. This burden is heightened by the fact that the applicant will likely instruct expensive legal counsel and have to pay filing fees.\(^\text{182}\)

Nevertheless, Canada can learn from the legal principles in the UK governing the law of medical futility. A statutory standard of medical futility - similar to the standard articulated by Lady Hale in \textit{James} - will provide guidance to decision-makers about when it is not in a patient’s best interests to receive treatment. Explicit recognition of medical futility will also achieve the following: ensure clinical expertise is not devalued in treatment decision-making; protect patients from over-treatment caused by a SDM demands for treatment; and promote optimal resource allocation by reducing the excessive use of healthcare resources where there is no compensating medical benefit. Canada has for too long ignored the problem of medical futility, but ignoring the problem will not stymy the harms it causes. The wholly public nature of Canada’s healthcare system and the influence of the \textit{Charter} must not deter legislatures from finding ways to balance the state’s interest in reducing futile treatment against individual rights to access public healthcare services.

\(^{180}\) \textit{MCA, supra} note 119 at 46(2)


Moreover, given the Canadian judiciaries’ reluctance to determine medical matters, I suggest that provincial and territorial legislatures should establish quasi-judicial forums to resolve futility disputes in an expedient and expert manner. It is beyond the scope of this paper to consider how every province and territory in Canada could establish such a forum. However, in Chapter Five I will explore how these features could be incorporated into Ontario’s Health Care Consent Act 1996 (HCCA) to improve the way futility disputes are resolved in that jurisdiction.

Evaluation

My review of the Canadian cases concerning medical futility reveals a turbulent and piecemeal line of authorities. It is clear that the judiciary does not yet recognize a legal standard of medical futility. When assessing what is in the patient’s best interests, the courts give only cursory consideration to physicians’ concerns about the futility of treatment. The Canadian courts have also refused to accept that physicians have unilateral powers to withhold or withdraw futile treatment, due to the dominance of personal autonomy. As a consequence, the judiciary has left open the question of who decides whether treatment should be withheld or withdrawn and, in some instances, has expressed reluctance at having to decide the fate of patients without legislative guidance.

The UK approach is not perfect; nevertheless, it is superior to the current Canadian approach. Together, the UK courts and legislature have provided clear guidance to physicians and SDMs about the process for making treatment decisions on behalf of another person and what considerations should be taken to account in that process. Although the UK law gives considerable weight to a physician’s opinion as to whether treatment is contra-indicated, the Court of Protection provides an independent forum where the patient’s family can refute the finding of futility.

In the next chapter, I will discuss the Supreme Court’s judgment in Rasouli SCC and examine whether it provides any clarity on the Canadian common law surrounding futility disputes. My discussion will reveal that the Supreme Court’s decision provided no such clarity and that Ontario’s HCCA is an inadequate piece of legislation for resolving futility disputes. My findings support the argument already made in this chapter that legislative intervention is imperative if the law is to satisfactorily resolve medical futility disputes.
Chapter Four
The Rasouli Impasse

Introduction

When the Supreme Court of Canada released its judgment in the case of Hassan Rasouli, it was immediately labeled a ‘landmark’ decision.¹ *Cuthbertson v Rasouli*² was the first time the Supreme Court addressed the question of whether physicians have unilateral authority to withdraw futile life-sustaining treatment from an incapacitated patient. The majority decision concluded that physicians have no such authority in Ontario; rather, under the Health Care Consent Act (*HCCA*),³ physicians must obtain the consent of a patient’s substitute decision-maker (*SDM*) to withdraw life-sustaining treatment. The purpose of this chapter is to evaluate the effect of *Rasouli SCC* on the law surrounding medical futility.

In **Part One**, I will set the stage for *Rasouli SCC* by describing the relevant provisions of the HCCA. In **Part Two**, I will describe the facts of the *Rasouli* saga. In **Part Three**, I will discuss the majority judgment of *Rasouli SCC*, penned by McLachlin CJ with Lebel, Fish, Rothstein and Cromwell JJ concurring, and in **Part Four**, I will detail the minority decision, delivered by Karakatsanis J with Abella J concurring. In **Part Five**, I will critique *Rasouli SCC* in light of my conclusions in the preceding three chapters. The central thrust of my critique will reveal that *Rasouli SCC* is a very narrow decision and does little to clarify the law of medical futility in Ontario. Finally, in **Part Six**, I will discuss a recent decision from Ontario’s Superior Court of Justice which further illuminates that the HCCA does not adequately govern futility disputes, despite McLachlin CJ’s finding in *Rasouli SCC* that the

---

¹ See for example: Michelle Mandel, “Doctors do not have ultimate say on life-support: Supreme Court” *The Toronto Sun* (18 October 2013), online: <http://www.torontosun.com/2013/10/18/supreme-court-to-rule-on-life-support-case> (“[i]n a landmark decision, the nation’s highest court rules that doctors cannot play God and unilaterally withdraw life support”); Sean Fine “Physicians denied unilateral power to remove life-support” *The Globe and Mail* (18 October 2013), online: <http://www.theglobeandmail.com/news/national/toronto-right-to-life/article14924931/> (“[t]he family of Hassan Rasouli, a father of two hospitalized and on life support for the past three years, won a landmark victory at the Supreme Court of Canada denying doctors the power to unilaterally remove the breathing machine and feeding tubes keeping him alive”).

² *Cuthbertson v Rasouli*, 2013 SCC 53 at para 115, [2013] 3 SCR 341 [*Rasouli SCC*].

³ *Health Care Consent Act*, SO, 1996, c 2 [*HCCA*].
HCCA provides an “established regime” that has competently “resolved end-of-life disputes in Ontario for 17 years.”

1 The HCCA

1.1 The meaning of treatment

Section 10(1)(a) of the HCCA states that no health practitioner shall administer a ‘treatment’ unless consent has been given by a competent patient.\(^5\) Section 2 defines ‘treatment’ as follows:

“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.\(^6\)

Neither the terms therapeutic, preventative, palliative, diagnostic, cosmetic, nor the phrase ‘other health-related purpose’ are defined in the HCCA. A ‘course of treatment’ is defined as “a series or sequence of similar treatments administered to a person over a period of time for a particular health problem.”\(^7\) A ‘plan of treatment’ is 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.\(^8\)

The definition at (c) above is notable because it refers to “the withholding or withdrawal of treatment in light of the person’s current health condition.”\(^9\) On its face, this subsection suggests that withdrawing or withholding treatment requires consent from the patient or the patient’s SDM.\(^10\) However, this conclusion is uncertain because of the repetition of the word ‘treatment’ in (c). ‘Treatment’ is defined as ‘plan of treatment’ which is then defined as including the ‘withdrawal or withholding of treatment’ - but this does not provide clarity as

---

\(^4\) Rasouli SCC, supra note 2 at para 115.
\(^5\) HCCA, supra note 3, s 10(1)(a).
\(^6\) Ibid, s 2.
\(^7\) Ibid.
\(^8\) Ibid.
\(^9\) Ibid.
\(^10\) Rasouli v Sunnybrook Health Sciences Centre, 2011 ONSC 1500 at para 28, 105 OR (3d) 761 [Rasouli ONSC].
to which interventions actually constitute ‘treatment’. The definition of treatment is circular and enigmatic.\(^\text{11}\)

Finally, the HCCA expressly excludes a number of procedures from the definition of ‘treatment’.\(^\text{12}\) Section 85(1)(f) also grants authority to Ontario’s Lieutenant Governor in Council to issue a regulation excluding a particular intervention from the definition of ‘treatment’.\(^\text{13}\) The Lieutenant Governor has no equivalent power, however, to assert that an intervention is ‘treatment’.

1.2 Incapacitated patients

Under s 10(1)(b) of the HCCA, a SDM has the right to consent to treatment on behalf of an incapacitated patient.\(^\text{14}\) As discussed in Chapter Two, s 20 provides a hierarchical list of people\(^\text{15}\) who may act as SDMs.\(^\text{16}\) For Mr Rasouli, the highest-ranking SDM was his wife, Ms Salasel.

Applying step one of the two-stage test set out under s 21(1) of the HCCA, if the SDM knows of a valid prior known wish then the SDM must give or refuse consent in accordance with that wish.\(^\text{17}\) Mr Rasouli did not express any wish regarding life-sustaining treatment prior to falling into an incapacitated state.\(^\text{18}\) The second step requires that if the SDM does not know of a valid prior known wish, then the SDM shall give or refuse consent in accordance with the patient’s best interests.\(^\text{19}\) In deciding what is in the patient’s best interests, s 21(2) mandates that the SDM shall consider the following factors: (a) the values and beliefs of the

---

\(^{11}\) *Ibid* at para 29. *Cuthbertson v Rasouli*, 2013 SCC 53, [2013] 3 SCR 341 (Factum of the Respondent) [*FOR*] (Mr Rasouli’s treating physicians argued that the circular nature of the definition allowed for treatment to be defined broadly, at para 96).

\(^{12}\) *HCCA, supra* note 3 (the list of excluded procedures are: an examination done to assess competency, an assessment to determine the general nature of a condition, taking a person’s health history, communication of a diagnosis or assessment, admission to a hospital or other facility, a personal assistance services, treatment that poses little or no risk of harm to the person, or anything prescribed in regulations as not constituting treatment, at s 2(1)).

\(^{13}\) *Ibid*, s 85(1)(f).

\(^{14}\) *Ibid*, s 10(1)(b).

\(^{15}\) *Ibid* (“a person described in a paragraph of subsection (1) may give or refuse consent only if no person in an earlier paragraph meets the requirements of subsection (2)”’ s 20(3))

\(^{16}\) *Ibid*, s 20.

\(^{17}\) *Ibid*, s 21(1).1.

\(^{18}\) *Rasouli ONSC, supra* note 10 at para 7.

\(^{19}\) *HCCA, supra* note 3, s 21(1)2.
patient; (b) any wishes expressed by the patient (that do not fall under s 21(1)); and (c) the
effect of the treatment on the patient’s wellbeing or condition, whether the harms of the
treatment outweigh the benefits, and whether a less restrictive treatment could be
administered.\textsuperscript{20} The SDM must take each criterion into consideration but is not required to
give any criterion any specific weighting in the final decision.\textsuperscript{21}

1.3 Challenging the SDM

Under s 37 of the HCCA, a physician may apply to the Consent and Capacity Board (CCB) if
she believes the SDM did not comply with the s 21 requirements.\textsuperscript{22} In order to determine
whether the SDM complied with s 21, the CCB will apply a standard of correctness.\textsuperscript{23} If the
CCB concludes that the SDM did not comply, the CCB may substitute its own opinion for
that of the SDM or give other directions to the SDM, and in doing so shall itself apply the s 21 criteria.\textsuperscript{24}

If a party disagrees with the CCB’s findings, it can appeal the decision to Ontario’s Superior
Court of Justice on a question of law or fact, or both, within seven days of the decision being
released.\textsuperscript{25} In reviewing the CCB’s judgment, the Court will apply a standard of
reasonableness and will defer to the Board’s finding of fact and any finding of mixed law and
fact.\textsuperscript{26} Over one-third of all CCB decisions regarding end-of-life decisions are appealed (11
of 30 cases).\textsuperscript{27} The Court has only once overturned a decision of the CCB.\textsuperscript{28}

\textsuperscript{20} HCCA, supra note 3, s 21(2).
\textsuperscript{21} Joaquin Zuckerberg, "End-of-Life Decisions: A View from Ontario and Beyond" (2009) 16
Eur J Health L 139 at 149.
\textsuperscript{22} HCCA, supra note 3, s 37(1).
\textsuperscript{23} Scardoni v Hawryluck, 2004 CanLII 32326, 69 OR (3d) 700 (ONSC) [Scardoni] ("the
question for the Board is not whether the substitute decision-makers turned their minds to the
right question and weighed the considerations referred to in paras (a) and (b) - or even
whether the decision was reasonable - but whether they arrived at the correct conclusion with
respect to the patient’s best interests" at para 36); See also M (A) v Benes, 1999 CanLII 3807
at para 36, 46 OR (3d) 271 (ONCA) [Benes].
\textsuperscript{24} HCCA, supra note 3, s 37(3)-(4).
\textsuperscript{25} HCCA, supra note 3, s 80. See for example: Scardoni, supra note 23.
\textsuperscript{26} Scardoni, \textit{ibid}, at para 34; Starson v Swayze, 2003 SCC 32 at paras 81-86, [2003] 1 SCR
722.
\textsuperscript{27} Robert Sibbald, Paula Chidwick & Laura Hawryluck, “Standard of care and resource
implications of the Cuthbertson v Rasouli ruling” (2014) 185:5 CMAJ 328 at 329.
\textsuperscript{28} Scardoni, supra note 23 (the decision was overturned because the Board misunderstood the
medical information and improperly ignored evidence suggesting that the patient would want
to prolong life); Sibbald, \textit{ibid}, at 329.
2 Rasouli - The Facts

Mr Hassan Rasouli’s circumstances are tragic. In April 2010, Mr Rasouli, a retired mechanical engineer, emigrated from Iran to Canada together with his wife and two adult children.\(^{29}\) Five months later he experienced dizziness and a numb sensation in his right ear. Following a medical examination he was found to have a benign tumour in his head and non-emergency surgery was recommended.\(^{30}\) On 7 October 2010, Mr Rasouli went into surgery to remove the tumour at Sunnybrook Health Sciences Centre, Toronto.\(^{31}\) Post-surgery, Mr Rasouli developed bacterial meningitis and ventriculitis, which caused intensive brain damage and injury to his brainstem and spinal chord.\(^{32}\) Mr Rasouli has been in an unconscious state since 16 October 2010,\(^{33}\) kept alive by virtue of a mechanical ventilator and an intropic feeding tube.\(^{34}\)

Mr Rasouli’s treating physicians, Dr Brian Cuthbertson and Dr Gordon Rubenfield, have diagnosed Mr Rasouli as being in a permanent vegetative state (PVS) and prognosticate there is no realistic chance of his condition improving.\(^{35}\) In their opinion, further medical intervention is futile and will actually cause Mr Rasouli physical harm and suffering because of complications arising from confinement to a hospital bed, such as bed sores and infections.\(^{36}\) Two neurologists not involved in Mr Rasouli’s ongoing treatment have provided secondary medical opinions in agreement with the diagnosis and prognosis given by Mr Rasouli’s treating physicians.\(^{37}\)

Mr Rasouli’s wife and SDM, Ms Salasel, is vastly more confident about Mr Rasouli’s condition. She believes that Mr Rasouli is conscious of his environment, even though his responsiveness and ability to communicate is severely limited by his disability.\(^{38}\) She claims

\(^{29}\) FOR, supra note 11 at para 9.
\(^{30}\) Ibid at para 10.
\(^{31}\) Rasouli ONSC, supra note at para 2.
\(^{32}\) Ibid.
\(^{33}\) Ibid.
\(^{34}\) Ibid at para 3.
\(^{35}\) Ibid.
\(^{36}\) Ibid.
\(^{37}\) Ibid.
\(^{38}\) Richard Lautens, “Life-support ruling: Family remains hopeful for Hassan Rasouli’s continued recovery” Toronto Star (7 July 2011), online:
that Mr Rasouli communicates in small ways such as responding to commands to open his mouth, grasping a hand or a ball, and even giving the “thumbs-up”.

In her opinion, “where there is life, there is hope” and her husband just needs more time to recover. This view is strongly coloured by Ms Salasel’s deep Islamic belief that life is sacred and must be maintained at all costs.

The opinion of neurologist Dr Adrian Owen has provided some support for Ms Salasel’s hopeful outlook. His assessment of Mr Rasouli showed some signs of brain activity when Mr Rasouli was asked to imagine engaging in physical activities, such as a game of tennis, during an MRI scan. The findings of these examinations resulted in an upgrade in January 2012 of Mr Rasouli’s diagnosis from PVS to minimally conscious state.

Nevertheless, Mr Rasouli’s medical team cannot reconcile Ms Salasel’s hopeful attitude with their clinical judgment that ongoing treatment is futile. They assert that Mr Rasouli’s physical movements are reflexive and should not be interpreted as voluntary or a product of his awareness. The change in diagnosis from PVS to minimally conscious state is of little consequence because, in their medical judgment, his mental and physical state will never improve to a degree where he no longer requires life-support.

By the time the dispute
reached the Supreme Court, it remained the opinion of the treating physicians that Mr Rasouli was in a PVS.\(^{47}\)

Given the conflicting views on Mr Rasouli’s future prospects, it is little wonder a legal firestorm arose when Dr Cuthbertson and Dr Rubenfield indicated their intention to withdraw Mr Rasouli’s life-support. At the time of writing, Ms Salasel has refused to consent to the removal of life-support; nor have the treating physicians shifted their opinion that continued life-support is not medically appropriate.\(^{48}\)

### 3 Decision of the Majority

The majority judgment began by stating “[t]his case presents us with a tragic yet increasingly common conflict.”\(^{49}\) McLachlin CJ also made it clear from the outset that the provisions of the HCCA, which provide “a statutory scheme for resolving such disputes,” will frame her judgment,\(^{50}\) as the common law is too unsettled to adequately resolve futility disputes.\(^{51}\)

After setting out the key provisions of the HCCA, McLachlin CJ narrowed down the issue in the case to the interpretation of ‘treatment’ and ‘health-related purpose’ within the s 2(1) definition of ‘treatment’\(^{52}\) and whether the withdrawal of life-support fell within those interpretations.\(^{53}\) In her view, ‘treatment’ “is broadly defined as care given for a health-related purpose”\(^{54}\) and as such is wider than the “physician-made criterion for treatment (medical benefit).”\(^{55}\) ‘Medical benefit’ indicates whether a particular treatment should be offered to a patient and has legal implications regarding a physician’s standard of care.\(^{56}\) By contrast, the term ‘health-related purpose’ “is a legal term used in the HCCA to set limits on when actions taken by health practitioners will require consent under the statute.”\(^{57}\) Thus,

\(^{47}\) *Cuthbertson v Rasouli*, 2013 SCC 53, [2013] 3 SCR 341 (Factum of the Appellant at paras 9-10) [FOA].


\(^{49}\) *Rasouli SCC*, ibid at para 1.

\(^{50}\) *Ibid* at para 2.

\(^{51}\) *Ibid* at para 53.

\(^{52}\) *Ibid* at para 31.

\(^{53}\) *Ibid* at para 33.

\(^{54}\) *Ibid* at para 30.

\(^{55}\) *Ibid* at para 35.

\(^{56}\) *Ibid* at para 36.

\(^{57}\) *Ibid*. 
McLachlin J reasoned that if the legislature intended to limit the meaning of ‘treatment’ to medically beneficial treatment then it could have used such language but instead it used the wider language of health-related purpose.\(^{58}\)

Turning to the question of whether ‘treatment’ includes the withdrawal of treatment, McLachlin CJ contended that the phrase “anything that is done”, which appears in the definition of ‘treatment’, is broad enough to include ‘withdrawals of treatment’.\(^{59}\) Other provisions of the HCCA also supported this conclusion. First, had the legislature intended to exclude withdrawals of treatment, it could have specifically included it in the list of procedures that are omitted from constituting ‘treatment’ under the HCCA.\(^{60}\) Second, one of the purposes of the HCCA is to protect patient autonomy and encourage a meaningful role for family in treatment decisions, which suggests a legislative intention that consent is required for withdrawals of treatment.\(^{61}\) Third, the Lieutenant Governor in Council has regulatory authority to constrict, but not widen, the meaning of treatment, and so the “legislature intended the overall concept of treatment to be broadly construed.”\(^{62}\) Fourth, the fact that withdrawal of treatment falls under the definition of ‘plan of treatment’ implies “the legislature contemplated the withdrawal of treatment requires consent in some cases.”\(^{63}\) Fifth and finally, s 29(3) of the HCCA, which states a physician is not liable if she withholds or withdraws treatment believing reasonably and in good faith that it was consented to, would serve little purpose if withdrawing treatment is not included under the definition of treatment.\(^{64}\)

McLachlin CJ then considered whether withdrawing life-sustaining treatment serves a health-related purpose. Broadly, she found that the “words of the HCCA on their face cover provision of life-support that is effective in keeping the patient alive and forestalling death.”\(^{65}\) As regards the withdrawal of life-support, she concluded that discontinuing life-sustaining treatment involves a series of distinct but interrelated acts, all of which serve a ‘health related purpose’ to “effect the process of dying or [minimize] distress and discomfort as the dying

\(^{58}\) Ibid at para 39.

\(^{59}\) Ibid at para 46.

\(^{60}\) Ibid at para 47.

\(^{61}\) Ibid at para 51.

\(^{62}\) Ibid at para 48.

\(^{63}\) Ibid at para 50.

\(^{64}\) Ibid.

\(^{65}\) Ibid at para 40.
process occurs.” Thus, the Chief Justice concluded that the withdrawal of life-support fits within the definition of ‘treatment’ under the HCCA.

McLachlin CJ gave three further reasons to support this conclusion. First, drawing from reasoning developed in the Court of Appeal’s judgment, she recognized the close association between the provision of palliative care and the withdrawal of life-support, inferring that if the provision of palliative care requires consent then so should the withdrawal of life-support. Second, the withdrawal of life-sustaining treatment “often entails physician interference with the patient’s body” and, therefore, to preserve the patient’s bodily integrity at the end-of-life, physicians must obtain consent from the SDM to withdraw treatment. Third, adopting a purposive approach, McLachlin CJ reasoned that the inclusion of the withdrawal of life-support in the definition of ‘treatment’ “provides consistency with respect to consent, protects autonomy through the requirement of consent, and provides a meaningful role in the consent process for family members.”

McLachlin CJ then addressed two counter-arguments from the treating physicians in relation to her conclusion that the withdrawal of life-support is ‘treatment’ for the purposes of the HCCA. The first counter-argument was that Ontario’s legislature intended withdrawals of treatment to require consent only where it fell within a “plan of treatment”. However, McLachlin CJ found it difficult to extract any legislative inference from the inclusion of withdrawal of treatment in ‘plan of treatment’. In any event, McLachlin CJ cautioned that if consent was only required to withdraw treatments under a ‘plan of treatment’, this would give

66 Ibid at para 61.
67 See Rasouli v Sunnybrook Health Sciences Centre, 2011 ONCA 482, 107 OR (3d) 9 [Rasouli ONCA] (“removal of the ventilator is a necessary precondition to the administration of end-of-life palliative care and end-of-life palliative care is a necessary response to removal of the ventilator. The two go hand in hand. One is integrally linked to the other. And they foretell a single certain result -- the respondent's imminent death once the ventilator is removed… And where it is recommended as an adjunct to the withdrawal of life support, the two, in our view, cannot be separated. They are a ‘treatment package’ and that is how they should be viewed for purposes of the [HCCA]” at paras 51-52). For a very well-reasoned critique of why the association between palliative care and withdrawing life-support does not support consent being required to withdraw life-support, see: Hilary Young, “Why Withdrawing Life-Sustaining Treatment should not Require ‘Rasouli Consent’” (2012) 6:2 MJLH 54.
68 Rasouli SCC, supra note 2 at para 68.
69 Ibid.
70 Ibid at para 43.
71 Ibid at para 56.
physicians too much discretion to direct whether consent was required depending on the way in which treatment was proposed – individually or part of a plan of treatment.\textsuperscript{72}

The second counter-argument that McLachlin CJ addressed was that allowing treatment to include the withdrawal of life-support “could arguably compel the continuation of any treatment, regardless of its medical implications.”\textsuperscript{73} In response to this, McLachlin CJ conceded that the legislature could not have intended patients or their SDMs to have the power to compel the provision of contra-indicated treatment.\textsuperscript{74} The example she gives is that consent would not be needed for a refusal to renew a prescription for a drug that would cause the patient harm.\textsuperscript{75} She preferred a more “nuanced view” that “the withdrawal of treatment may sometimes, although not always, constitute ‘treatment’”, as this “better fits the provisions of the \textit{HCCA} and the realities of medical care.”\textsuperscript{76}

The treating physicians also put forward the objection that continuing life-support for Mr Rasouli breached their ethical, professional or legal obligations.\textsuperscript{77} McLachlin J responded by stating:

\begin{quote}
Legally, a physician cannot be faulted for following the direction of the [CCB], any more than he could be faulted for abiding by a judge’s direction at common law not to withdraw life-support. Implicit in the physicians’ request that a judge resolve the present dispute is acceptance that if a judge orders that life-support cannot be withdrawn, they must comply. Their legal position under the \textit{HCCA} is no different.\textsuperscript{78}
\end{quote}

And later she concluded that “such tensions are inherent in the medical practice” and physicians have long suffered patients’ refusals to consent to life-saving medical treatment, which likewise go against a physician’s ethical obligation to treat the patient.\textsuperscript{79}

Finally, McLachlin CJ stressed several times throughout the judgment that if a physician believes a SDM to have improperly applied the s 21 requirements, then the physician should apply to the CCB for a review.\textsuperscript{80} The CCB is “an independent, quasi-judicial body with

\begin{notes}
\item[Ibid] at para 57.
\item[Ibid] at para 58.
\item[Ibid.]
\item[Ibid.]
\item[Ibid.] at para 72.
\item[Ibid.]
\item[Ibid.]
\item[Ibid.]
\item[Ibid.]
\item[Ibid.]
\item[Ibid.]
\item[Ibid.]
\item[Ibid at paras 28, 98.]
\end{notes}
specialized jurisdiction over matters of consent to medical treatment.”\textsuperscript{81} It is thus “well placed” and “has developed a strong track record”\textsuperscript{82} to determine whether treatment will promote the patient’s best interests, given the legislative purposes of protecting patient autonomy and ensuring effective medical care.\textsuperscript{83} The right to appeal a CCB decision to the Superior Court of Justice provides additional oversight to ensure a SDM acts within her mandate.\textsuperscript{84}

Ultimately, the majority found in favour of Ms Salasel. Consequently, the treating physicians were obligated to obtain the consent of Ms Salasel before withdrawing Mr Rasouli’s life-support.

4 Decision of the Minority

Karakatsanis J delivered a bold minority judgment. Notably, Karakatsanis J looked to the common law, rather than the HCCA, to resolve the dispute.\textsuperscript{85} Her belief that the HCCA was “not intended to provide a comprehensive scheme”\textsuperscript{86} was chiefly motivated by s 8(2), which states the statute “does not affect the law relating to giving or refusing consent to anything not included in the definition of ‘treatment’.”\textsuperscript{87} This provision anticipates that the definition of ‘treatment’ is not exhaustive and some actions or decisions in the healthcare context may fall beyond its reach.\textsuperscript{88} Karakatsanis J was unable to infer from the definitions of ‘treatment’ or ‘plan of treatment’ that a physician is required to obtain consent to withdraw treatment.\textsuperscript{89}

More particularly, she reasoned that the withdrawal of life-support is done for the purpose of “discontinuing treatment” and not for any ‘health-related purpose’.\textsuperscript{90} Therefore, the issues raised in the case fell beyond the scope of the HCCA.

Furthermore, Karakatsanis J cautioned against any interpretation of the HCCA - such as the interpretation of the majority - which would grant patients or SDMs “the right to insist on the

\textsuperscript{81} Ibid at para 28.
\textsuperscript{82} Ibid at para 101.
\textsuperscript{83} Ibid at para 98-103.
\textsuperscript{84} Ibid at para 100.
\textsuperscript{85} Ibid at para 124.
\textsuperscript{86} Ibid at para 164.
\textsuperscript{87} HCCA, supra note 3, s 8(2); ibid at para 164.
\textsuperscript{88} Ibid.
\textsuperscript{89} Rasouli SCC, ibid at para 154.
\textsuperscript{90} Ibid.
continuation of a treatment that is futile, harmful, or contrary to professional medical standards of care.” To do so would be to extend the law of consent beyond the common law right to refuse medical treatment to recognize a patient’s right to receive a particular treatment. Karakatsanis J opined that if Ontario’s legislature intended such a dramatic recasting of the law of consent, it would have done so in clear terms, as it would have a “detrimental impact on the standard of care and legal, ethical and professional duties in the practice of medicine.”

Having found that the HCCA does not resolve the question of whether the withdrawal of life-support requires consent, Karakatsanis J turned to the common law for a solution. Interestingly, she found that the common law position in Canada was settled:

the common law does not entitle a patient to insist upon continuation of treatment, it does not require a patient’s consent to the withholding or withdrawal of treatment that the physician considers has no chance of being medically effective and that is no longer consistent with the professional standard of care.

Karakatsanis J based this conclusion on two key features of Canadian jurisprudence. First, there is no judicial precedent for the proposition that consent is required to withdraw or withhold treatment that is medically ineffective. Instances where the courts have intervened to prevent physicians from unilaterally withdrawing treatment - such as in Sweiss v Alberta Health Service or Sawatzky v Riverview Health Centre Inc - were injunction proceedings where the courts were not required to decide the issue. Karakatsanis J also relied on UK cases - Re J (a minor) (wardship: medical treatment), Re R(a minor) (wardship: medical treatment) and Airedale NHS Trust v Bland - to show that physicians should not be forced to provide treatment that falls outside their professional standard of care.

---

91 Ibid at para 125.
92 Ibid at para 136.
93 Ibid at para 150.
94 Ibid at para 165.
95 Ibid at para 168.
96 Ibid.
97 Ibid at para 175.
98 Ibid at paras 176 – 186.
99 Sweiss v Alberta Health Services, 2009 ABQB 691 (CanLII).
101 Rasouli SCC, supra note 2 at para 177.
Second, Karakatsanis J found that the common law supports the judiciary having a supervisory role in adjudicating end-of-life decisions. In her view:

Canadian courts should assess whether the decision to withdraw life-support accords with the physician’s standard of care and her fiduciary duty, as well as, considerations of patient autonomy and human dignity. Medical evidence about the outcome of the treatment should be the court’s primary consideration, and the patient’s values, beliefs and wishes a secondary consideration. The reason for this hierarchy is that the common law already protects patients from adverse medical practices by requiring physicians to act according to a reasonable standard of medical practice. Typically, this standard of care is satisfied where physician’s decisions are based on a careful assessment of whether the withdrawal or administration of treatment will medically benefit the patient.

Moreover, a physician’s fiduciary obligations will supplement a physician’s standard of care to ensure the physician is acting in the patient’s best interests. Karakatsanis J did not detail exactly the ambit of a physician’s fiduciary duty in the context of end-of-life decision-making, preferring instead to describe it as a flexible, open and evolving concept. However, she did note that part of the fiduciary duty will require the physician to undertake certain processes for resolving treatment futility disputes, including encouraging the patient’s family and SDM to participate in the decision-making process. Fiduciary obligations also include a duty to consult, a duty to seek a second opinion if requested, and a duty to transfer the patient to another physician in the event of a dispute.

105 Rasouli SCC, supra note 2 at paras 182-183.
107 Ibid at paras 172, 190.
108 Ibid at para 190.
109 Ibid at para 191.
110 Ibid.
111 Ibid at para 194.
112 Ibid at para 193.
113 Ibid at para 171.
114 Ibid at paras 202-203.
Karakatsanis J did not overlook the importance of personal autonomy. The prospect of death in the end-of-life context demands that the physician considers the patient’s personal values, including religious beliefs, when assessing whether treatment is in the patient’s best interests. However, “these considerations cannot prevail if a doctor considers the treatment to be outside the standard of care due to its futility or harmful effects.” Additionally, while the sanctity of life is an important legal principle, it is not absolute, and artificial extension of life will not always be in the patient’s best interests, especially where it prolongs the dying process rather than extends a patient’s meaningful existence.

Ultimately, Karakatsanis J concluded that the critical question is whether treatment is futile or not, and if the intervention is futile, then treatment may unilaterally be withdrawn by the physician without consent. If the SDM disagrees, he or she may apply to the court - not the CCB - for a determination of the issues. It followed that because there was no finding on the futility of life-support for Mr Rasouli in the first instance, Karakatsanis J directed the case back to the Superior Court of Justice for determination.

5 Impact of Rasouli SCC
5.1 The futility debate is not resolved by the HCCA

The majority judgment in Rasouli SCC is not decisive on the issue of futility in medical decision-making. Indeed, the precise ratio decidendi from the decision is unclear. McLachlin CJ firmly stated that the decision does “not stand for the proposition that consent is required under the HCCA for withdrawals of other medical services or in other medical contexts.” Thus, it seems, the decision’s precedential value is limited to situations involving the withdrawal of life-support only.

---

115 Ibid ("maintaining respect for autonomy and human dignity are particularly vital,” at para 196).
116 Ibid.
117 Ibid.
118 Ibid at para 197.
119 Ibid at para 201.
120 Ibid at para 204.
121 Ibid at para 205.
122 Ibid at para 70.
Arguably, however, the ratio could be narrowed even further because of McLachlin’s reference to “…in other medical contexts.”123 This phrase suggests the decision does not cover the withdrawal of life-support in situations different from the circumstances endured by Mr Rasouli. The argument that the ratio of this case is so confined is bolstered by McLachlin CJ’s further statement: “that treatment in the HCCA should be understood as extending to the withdrawal of life-support in the situation at issue here.”124

Despite Rasouli SCC being lauded as a ‘landmark decision’, the judgment will likely be distinguished on its facts in future futility disputes before the courts. Certainly, the majority decision does not directly resolve situations where there is disagreement over whether a DNR order should be issued, or whether treatment should be resumed once it has been withdrawn already. Rather, the majority’s reasoning is focused entirely on Mr Rasouli’s circumstances, which involves the withdrawal of a mechanical ventilator and feeding tube.

The legacy of Rasouli SCC, in my opinion, is to illustrate that futility disputes cannot be adequately resolved through the present terms of the HCCA. McLachlin CJ noted that “the HCCA is a carefully tailored statute.”125 However, both the majority and minority in Rasouli SCC had to resort to inferences as to the legislature’s intention in order to reconcile the HCCA to the facts of the case.126 These inferences drawn by the majority127 and minority128 were often in stark conflict with each other. For example, while the majority argued that “common sense suggests that the legislature cannot have intended withdrawal of life-support to require consent only in the context of a plan of treatment”,129 the minority reasoned that if the legislature had intended for the withdrawal of treatment to require consent where it occurs outside a ‘plan of treatment’, it could have made this clear in the Act.130 These polar positions highlight that the HCCA simply does not address whether consent is required to withdraw treatment not included in a ‘plan of treatment’. Hence, contrary to the Chief Justice’s conclusion, the HCCA is not a comprehensive and carefully tailored statute.

123 Ibid at para 70.
124 Ibid [emphasis added].
125 Ibid at para 78.
126 Ibid.
127 See for example: ibid at paras 39, 47 & 48.
128 Ibid at paras 155, 157.
129 Ibid at para 157.
130 Ibid at para 155.
5.2 The grey area of medical futility

5.2.1 Are SDMs required to consider medical futility?

In the majority judgment McLachlin CJ emphasized that “the medical implications of treatment for the patient” was a relevant factor in determining the s 21(2) best interests test.\textsuperscript{131} In her opinion, the best interests test “aims at advancing the values that underpin the HCCA: enhancing patient autonomy and ensuring appropriate medical treatment,” and therefore the patient’s values, beliefs and wishes “were not binding on the substitute decision-maker.”\textsuperscript{132} Thus she concluded:

As I see it, this review of s. 21(2) reveals that although a patient’s beliefs and prior expressed wishes are mandatory considerations, there is no doubt that the medical implications of a proposed treatment will bear significant weight in the analysis.

On its face, the s 21 best interests test requires the SDM to consider any evidence tendered by a physician that treatment is futile.

Nevertheless, while McLachlin CJ confirmed that a SDM must cast her mind to the medical implications of a proposed treatment, she did not hold that the SDM must consider the physician’s evidence about the medical implications. In fact, McLachlin CJ endorsed the opposite approach, where the SDM may conceptualize and interpret the medical implications of treatment however she so chooses.\textsuperscript{133} Therefore, it was open to Ms Salasel to ignore the treating physician’s opinion entirely or only focus on the medical evidence as she interpreted it. Effectively, a SDM has complete discretion whether to consider a physician’s concerns about the futility of treatment. It is difficult to see how the s 21(2) test ensures that appropriate medical treatment is provided if a SDM is free to discount a physician’s evidence about medical futility.\textsuperscript{134}

---

\textsuperscript{131} Ibid at para 88.

\textsuperscript{132} Ibid.

\textsuperscript{133} Ibid (“Ms Salasel argues that new evidence and evaluation suggests that Mr Rasouli’s condition may improve in the future, militating against removal of life support” at para 92).

\textsuperscript{134} This conclusion stands in contrast to the way in which the UK Supreme Court conceptualized the best interests test under the Mental Capacity Act 2005 (UK), c 9, where it found that both medical and non-medical circumstances must be taken to account, see: Aintree University Hospitals NHS Foundation Trust v James, [2013] UKSC 67, [2014] 1 All ER 573 at para 25 [James].
5.2.2 Do physicians have unilateral authority to withdraw futile treatment?

The majority decision stated “[t]his case does not stand for the proposition that consent is required under the HCCA for the withdrawals of other medical services or in other medical contexts.” McLachlin CJ briefly expanded on this statement by finding there are situations where a physician will not need consent to withdraw treatment because of the ‘medical implications’ of that treatment. She preferred a “more nuanced view that withdrawal of treatment may sometimes, although not always, constitute “treatment””. This finding comes in response to the physician’s concerns that including the withdrawal of life-sustaining treatment in the definition of treatment will create a precedent that patients and SDMs can compel physicians to provide futile treatment indefinitely. Thus, the decision indicates that physicians sometimes have unilateral authority to withdraw futile treatment.

The majority judgment is ambiguous about the circumstances in which a physician could employ this authority. McLachlin CJ provided just two obscure clues about when it would be appropriate for a physician to unilaterally withdraw treatment. First, McLachlin CJ stated that it is “common sense” that not all withdrawals of treatment are ‘treatment’ under the HCCA. However, common sense is an inappropriate legal standard against which to decide whether a physician can unilaterally withdraw treatment. The views of the physician, patient, SDM and patient’s loved ones about what is ‘sensible’ may be so disparate as to have little common ground. It may seem like common sense to a physician to refuse an incapacitated patient further dialysis treatment without consent if she believes the treatment is futile; yet, to the SDM it may be obvious that she sanction whether this is an appropriate treatment decision for the patient because withdrawing (or withholding) dialysis will cause renal failure and ultimately death. Hence, ‘common sense’ has no place as a legal standard in the emotionally charged healthcare context.

Second, McLachlin CJ provided the example that a physician could refuse to prescribe a harmful drug without the consent of the patient or SDM. This example does little to clarify

---

135 Rasouli SCC, supra note 3 at para 70.
136 Ibid at para 58.
137 Ibid at para 59.
138 Ibid at para 58.
139 Ibid.
the circumstances in which physicians have unilateral powers to withhold or withdraw treatment and, in fact, confuses the law even further. Problematically, McLachlin CJ does not explain what she means by “harm”. Many drugs will cause a patient harm and at the same time provide a valuable benefit to the patient. The judgment gives no indication about the type or degree of harm a drug would have to produce to supersede any benefit experienced by the patient. Indeed, the example suggests it is wholly within a physician’s discretion to determine on a case-by-case basis whether the burdens of a drug outweigh its benefits. McLachlin CJ’s reasoning contained no requirement that the views and values of the patient were relevant to a decision to withdraw a “harmful drug”. Seemingly, the majority decision grants physicians full paternalistic authority to determine whether a patient receives medication.

Moreover, it is not clear why McLachlin CJ found that “harm” justifies the withdrawal of certain treatment falling outside the HCCA’s definition of ‘treatment’. Certainly it is a concern to physicians that if compelled to provide contra-indicated treatment they may harm the patient, but this is not the only concern. Indeed, the paramount concern of the treating physicians in Rasouli SCC was that they should not be compelled to provide any treatment that is not beneficial to the patient. As discussed in Chapter One, patients in a PVS may not experience any harm – in the form of physical pain – from life-sustaining treatment. Yet, providing futile treatment may still disrespect the patient’s dignity, conflict with a physician’s ethical and professional obligations, deprive other patients of valuable healthcare resources and be a great cost to the public healthcare purse. Therefore, McLachlin CJ’s example does not comprehensively address the treating physicians’ concerns.

It could be inferred that McLachlin CJ intended physicians to have unilateral authority to withdraw medication only when the drug was harmful and futile. This inference is possible given that the example was provided in response to the physicians’ argument that if consent is required for the withdrawal of life-support, patients could arguably compel the continuation of any treatment, regardless of whether it provided a medical benefit. Moreover, McLachlin CJ states that the legislature could not have intended that patient’s could compel “the continuation of treatment, regardless of its medical implications.” 142 Use

140 FOA, supra note 47 at para 1.  
141 Rasouli SCC, supra note 2 at 58.  
142 Ibid.
of the phrase “medical implications” suggests that whether or not consent is required may depend on many factors, such as whether the treatment produces a benefit for the patient, and not just whether it causes harm. This logic would provide some reassurance to patients and SDMs that physicians could not unilaterally withdraw medication, or any other form of treatment, simply because it was harmful even though it continued to provide a benefit to the patient. Nevertheless, this reasoning is not clear in McLachlin CJ’s brief example.

Finally, the “harmful drug” example creates a distinction whereby a physician can withdraw harmful life-sustaining medication from a patient without consent but she cannot withdraw other harmful life-sustaining treatments, such as mechanical ventilation. This anomaly could lead to the deeply troubling scenario where consent is required to remove the mechanical ventilator or feeding tube from a patient in PVS, but the physician can unilaterally refuse to provide life-sustaining drugs, such as antibiotics, to that patient. In this situation, the patient would likely die a slow and unpleasant death from infection, where death from removal of the mechanical ventilator would have been quicker and more humane. Recall in the previous chapter Dr Rubenfeld’s argument that an “all-or-nothing” approach should be taken to the provision of life-sustaining treatment. It makes no clinical or moral sense to prescribe some life-sustaining treatments but refuse others, where the result would be that the patient’s biological life is maintained for as long as possible but she is forced to suffer through a prolonged dying process.

In sum, McLachlin CJ created a grey area in the law, as physicians have no certainty as to the circumstances where they have legal authority to unilaterally withdraw treatment. On the one hand, physicians do not have to obtain consent to withdraw harmful drugs (although what constitutes ‘harmful’ is not defined). On the other hand, consent is required to withdraw harmful life-support. Where a physician proposes to withdraw futile treatment that does not fit within one of these categories – such as the withdrawal of chemotherapy or issuing a DNR order – Rasouli SCC provides no certain answer.

5.2.3 What about withholding treatment?

Whether the majority decision holds that withholding life-support, or any other form of treatment, requires consent is unclear. McLachlin CJ does not explicitly discuss the legality

of a physician unilaterally deciding to withhold treatment at any point in the judgment. Presumably, McLachlin CJ wanted to ensure the focus of the judgment was confined to the question of whether consent is required for physicians to withdraw Mr Rasouli’s mechanical ventilator and feeding tube.

Elements of McLachlin CJ’s reasoning suggest, however, that withholding life-sustaining treatment also requires consent in some situations. Notably, McLachlin CJ’s harmful drug example, discussed above, illustrates the blurred line between withdrawing treatment and withholding treatment. A refusal to renew a prescription could be characterized as withdrawing a course of treatment or withholding medication. By invoking this example, McLachlin CJ is reiterating that the HCCA provides no blanket rule as to whether a physician’s action or inaction requires consent. Rather, it is to be determined on a case-by-case basis dependent on whether the physician’s action or inaction falls within the statutory definition of ‘treatment’ such that consent is required. Obviously, this reasoning does not provide physicians or SDMs much clarity about whether consent is required when a proposal is made to withhold or withdraw treatment.

McLachlin CJ also relied on s 29(3), which excludes liability if treatment has been withdrawn or withheld in good faith, to support her argument that the legislature intended ‘treatment’ to include the ‘withdrawal of treatment.’ As regards s 29(3), she stated: “this provision would serve no purpose if consent were not required for the withholding or withdrawal of treatment in some circumstances.” 144 Applying McLachlin CJ’s logic, both withholding and withdrawing life-sustaining treatment would require consent. This rationalization would also promote internal consistency within the HCCA.

Moreover, as will be discussed below, the majority relied heavily on the dominance of personal autonomy to support a finding that consent is required to withdraw life-sustaining treatment. It would be anomalous if a patient or SDM could insist on the continuation of life-support but could not insist that it be administered in the first place. Hence, if a distinction were recognized between withholding life-support and withdrawing life-support, such that the former did not require consent, this would undermine the idea that personal autonomy is critical at the end-of-life and trumps all other interests.

144 Rasouli SCC, supra note 2 at para 50.
Nevertheless, as will also be discussed below, the majority supported its conclusion that consent was required to withdraw life-sustaining treatment because it involved an interference with the patient’s body, which suggests that withholding treatment does not require consent.\textsuperscript{145} Withholding treatment - in the sense, of refusing to provide treatment - does not involve any interference with the patient’s body. Therefore, if, as the majority suggest, the doctrine of informed consent is chiefly designed to protect a patient from unwanted physical interference then withholding treatment will not require consent. However, this reliance on the touching vs. non-touching dichotomy cannot be reconciled with McLachlin CJ’s example that refusing a harmful drug does not require consent, as denying a prescription will not involve touching the patient either.

Ultimately, the issue of whether withholding life-support - or any other form of treatment such as CPR - requires consent in Ontario is yet another uncertainty in the law post-\textit{Rasouli SCC}.

\textbf{5.2.4 The minority’s view on medical futility}

The minority was also unsuccessful in articulating a proper standard of medical futility. Put simply, the minority decision concluded that a physician has unilateral power to withhold or withdrawal treatment if, in her best clinical judgment, treatment is futile. Karakatsanis J defined the concept of futility as “treatment that the physician considers has no chance of being medically effective and that is no longer consistent with the professional standard of care.”\textsuperscript{146} A physician must consider “the medical effectiveness of the course of action, which involves weighing the action’s risks and benefits, as well as its implications for the condition and well-being of the patient.”\textsuperscript{147} Effectively, the minority judgment framed futility as a physician-driven concept, albeit there must be some consideration of the views of the patient or patient’s family, such as religious and personal values, “however, they cannot be determinative.”\textsuperscript{148}

\textsuperscript{145} \textit{Rasouli SCC}, supra note 2 at paras 62-63.
\textsuperscript{146} \textit{Ibid} at para 168.
\textsuperscript{147} \textit{Ibid} at para 195.
\textsuperscript{148} \textit{Ibid} at paras 190, 196.
This conceptualization of futility is concerning as it elevates the views of the medical profession above the views of the patient. As discussed in Chapter One, whether an intervention is “medically ineffective” and hence not worth doing will not rest exclusively on clinical knowledge and observations, but also upon a physician’s personal view of the goal of the intervention, whether the probability of success outweighs the harms associated with the intervention, and, importantly, whether the patient’s life is worth saving. Karakatsanis J’s judgment failed to acknowledge the risk that physicians may abuse the concept of futility and withhold or withdrawal treatment based upon their own idiosyncratic and discriminatory views. It would have been prudent for Karakatsanis J to have discussed the ambiguities of futility and its potential for abuse given that the decision was effectively enhancing the decision-making authority of physicians vis-à-vis the withdrawal of treatment to a level reminiscent of the era of medical paternalism.

5.2.5 Summary: medical futility

In my view, neither the majority nor the minority adequately considered the concept of medical futility. The majority considered that medical futility, in its clinical sense, is not a factor the SDM must consider in applying the s 21(2) best interests test. Yet, medical futility may, in some circumstances such as where the treatment is harmful, circumvent the need for the physician to obtain consent from the SDM at all. The majority left wide open the circumstances in which this would be the case. The minority, on the other hand, concluded that medical futility (in its purely clinical sense) trumps all other considerations. Where a physician deems further treatment to be futile, and therefore not in the patient’s best interests, she may withhold or withdraw treatment without consent and without much consideration of the patient’s values, beliefs or wishes. Both the majority and minority judgments miss the mark; whilst the minority ignores the value-laden nature of medical futility, the majority ignores that the provision of futile treatment is a problem in the public healthcare system at all.

5.3 The enduring dominance of personal autonomy

5.3.1 What is personal autonomy?

The majority judgment confirms that personal autonomy is the dominant consideration in medical decision-making. The majority does not examine the dominance of personal
autonomy in the healthcare system; rather, its dominance is assumed.  

As much was made clear in McLachlin CJ’s statement: “the patient’s autonomy interest – the right to decide what happens to one’s body and one’s life – has historically been viewed as trumping all other interests, including what the physicians may think is in the patient’s best interests.”

Despite McLachlin CJ’s finding that personal autonomy is the overriding consideration in futility disputes, she characterized personal autonomy ambiguously. First, McLachlin CJ frames personal autonomy in an atomistic way. This is clear from her statement that the patient’s autonomy “trumps all other interests.” Concerns about resource allocation, the sustainability of the healthcare system or the integrity of the medical profession do not limit the scope of personal autonomy in the healthcare context. It is notable that Karakatsanis J, in contrast, endorsed a communitarian approach to personal autonomy, whereby a patient’s choices:

must be balanced against broader interests, including the nature of her condition, the implications of continuing treatment, the professional obligation of her physician and the impact on the broader health system. This reflection of the common law is evidence from the purposes, provisions and scheme of the Act.

Second, the Chief Justice defined personal autonomy succinctly as “the right to decide what happens to one’s body and one’s life.” However, this definition does not reflect how personal autonomy was applied in the judgment. For example, McLachlin CJ states that by “removing medical services that are keeping a patient alive, withdrawal of life support impacts patient autonomy in the most fundamental way.” In the case of an incapacitated patient, particularly one in a PVS, it is difficult to see how a patient’s autonomy is further infringed by the removal of life-support when the patient no longer had decisional capacity to ‘decide what happens to one’s body and one’s life’ due to permanent unconsciousness. In fact, McLachlin CJ somewhat confusingly also stated that in the case of an incapacitated patient

149 Mark Handelman, “Consent to Withdrawal of Life-support: What the Supreme Court Said in Cuthbertson and Rubenfeld v Rasouli” online: Whaley Estate Litigation <http://whaleyestatelitigation.com/resources/WEL_What_the_Supreme_Court_Said_In_Cuthbertson_and_Rubenfeld_v_Rasouli.pdf>.
150 Rasouli SCC, supra note at para 19.
151 Ibid.
152 Ibid at para 136.
153 Ibid at para 19.
154 Ibid at para 68.
individual, “the patient’s autonomy interest…is compromised or extinguished.”\textsuperscript{155} Thus, at the time of the hearing, Mr Rasouli’s autonomy was threatened by the physicians’ intention to remove his life-support even though his personal autonomy had already been extinguished by his disability. Arguably, the only way these statements can be reconciled is if they are viewed as endorsing the survival of personal autonomy beyond incapacity through the expression of the patient’s values, beliefs and wishes by the SDM.

\textbf{5.3.2 How far does the scope of personal autonomy extend?}

The majority decision indicates that personal autonomy contains positive obligations that survive incapacity of the patient. The majority’s ultimate finding that withdrawing Mr Rasouli’s life-support requires consent from his SDM creates an entitlement to receive treatment. But for Ms Salasel’s refusal to consent, Mr Rasouli’s life-support would have been discontinued; therefore, her refusal to consent is the factor compelling the physicians to continue treatment contrary to their clinical judgment. Ms Salasel is only empowered to refuse consent via the s 21 test, which she has applied with heavy focus on what she believes to be Mr Rasouli’s religious faith in the sanctity of life. The requirement that a physician obtain consent from a SDM expands the traditional law of consent to include a right to refuse life-sustaining treatment \textit{as well as} a right to demand that life-sustaining treatment is continued. Thus, under the HCCA, consent is being applied as both a shield (i.e. to prevent a physician providing unwanted treatment) and as a sword (i.e. to compel a physician to continue to provide life-sustaining treatment).

If a SDM can prevent the cessation of life-sustaining treatment does she also have an entitlement to demand life-sustaining treatment where it has not already been provided? As discussed above, the majority judgment is not clear whether consent is needed to both withdraw \textit{and} withhold life-sustaining treatment (or any other treatment). If the judgment is interpreted to mean a physician is able to withhold, but not withdraw, treatment without consent, this may caution physicians against providing a full range of life-sustaining treatments if there is a risk the physician will be unable to withdraw it at a later time. This clearly will have adverse implications for a patient’s chances of survival. In any event, as discussed in Chapter Three, the distinction between withholding treatment and withdrawing treatment is morally and clinically irrelevant. Therefore, because \textit{Rasouli SCC} holds that a

\textsuperscript{155} \textit{Ibid} at para 21.
SDM can demand the *continuance* of life-sustaining treatment, it should also stand for the proposition that a SDM can demand the *provision* of life-sustaining treatment.

Not only did McLachlin CJ suggest that the informal expression of a patient’s autonomy, via a SDM, could create an entitlement to receive treatment, but she also explicitly concluded that the formal expression of a patient’s autonomy, via a prior known wish, creates the same. The treating physicians raised the argument that if the withdrawal of futile treatment fell within the definition of ‘treatment’, a patient could compel the continuation of futile treatment through an advance directive, which, if valid, must be followed by the physician, SDM and CCB under s 21(1) of the HCCA.\(^\text{156}\) Therefore, to prevent physicians being compelled to administer futile treatment due to the existence of a valid prior known wish, the treating physicians asserted that futile treatment falls outside the scope of the HCCA.\(^\text{157}\)

McLachlin CJ did not agree that the statutory preference given to a patient’s prior known wishes meant that the legislature did not intend for ‘treatment’ to include the withdrawal of life-support. Indeed, McLachlin CJ reasoned that when “it comes to the life and death matter of withdrawal of life-support, there is every reason to think that the legislature intended a patient’s applicable wishes to be respected.”\(^\text{158}\) To counter the physicians’ concerns, McLachlin CJ relied on the fact that prior known wishes were generally interpreted narrowly by the courts or found to be invalid where the patient has an extremely poor prognosis.\(^\text{159}\) However, the possibility remains that a prior known wish will be drafted in a manner that ensures the indefinite provision of life-sustaining treatment.

In my view, the Chief Justice framed the scope and authority of personal autonomy too expensively. As I argued in Chapter Two personal autonomy should not be the only consideration in medical decision-making. Giving absolute preference to a patient’s or

\(^{156}\) *FOA, supra* note 47 at paras 94-96.

\(^{157}\) *Ibid. Rasouli ONCA, supra* note 67 (the Court of Appeal were alive to this issue but somewhat nihilistically held: “[t]hat is the legislature’s will. At it involves policy considerations that come within the legislature’s purview and are best left to the legislature to sort out,” at para 60).

\(^{158}\) *Rasouli SCC, supra* note 2 at para 105.

SDM’s desire for treatment may undermine both the integrity of the medical profession and the well being of health practitioners, and deprive others of healthcare services. Moreover, the law should be cautious to unconditionally accept an SDM’s expression of a incapacitated patient’s beliefs, values and wishes in light of research that shows there is a significant chance the SDM is wrong about the patient’s views. A SDM’s articulation of a patient’s autonomy should be subjected to a high evidentiary burden before the law sanctions the prescription of aggressive and invasive treatment. At the very least the law should place a more stringent duty on SDMs to consider the views of medical professionals when applying the best interests test. At present the s 21 test works more like a substituted judgment test, which serves only to protect the values, beliefs and wishes of the SDM.

Finally, it is interesting to consider how McLachlin CJ’’s characterization of personal autonomy impacts the ‘right to die’ cases. Given the finding that a patient’s autonomous choices trump all other interests, it could be argued that an individual’s desire to be euthanized may trump the state’s interest in preserving human life at all costs. The ‘right to die’ cases involve complex issues beyond the scope of this paper, but to ensure a consistent approach to recognizing personal autonomy in the healthcare system, it is at least arguable that, in light of Rasouli SCC, euthanasia or assisted suicide should be decriminalized.

5.4 Endorsement of the touching vs. non-touching dichotomy, and the palliative care association

The majority decision supports the problematic touching vs. non-touching dichotomy. Recall that Twaddle J in Lavallee reasoned that consent is not required to withhold or withdraw treatment if there is no interference with the patient’s physical body. McLachlin CJ’s endorsement of the dichotomy is found in the following statements from Rasouli SCC:

Many of the acts involved in withdrawal of life-support entail physical interference with the patient’s body. The reality is that while “withdrawal” sounds like purely negative conduct, it typically involves physical touching or performing procedures upon the patient’s body.

…

161 For argument on why the withdrawal of life-support is an omission, rather than a positive act, see Lord Browne-Wilkinson’s comments in Bland, supra note 104 at 881-882.
Under the HCCA, as at common law, physical interference requires consent. The right to be free from unwanted physical interference goes to the heart of the law of consent to medical treatment. In these statements, McLachlin CJ suggests that discontinuing life-support requires consent because the withdrawal interferes with Mr Rasouli’s bodily integrity. This reasoning is concerning for two reasons. First, as discussed in Chapter Three, this logic ignores that consent is designed not only to protect against unwanted physical interference, but also to protect the individual’s dignity and right to self-determination. Second, McLachlin CJ indicates that if Mr Rasouli’s life-support could be withdrawn without physical interference - such as by placing a timer on his mechanical ventilator - consent would not be required. This creates an absurd anomaly whereby consent is only required for the invasive withdrawal of life-support but not in cases where life-support could be withdrawn non-invasively - even though in both situations the consequence would be the death of the patient.

In addition, McLachlin CJ supported her finding that discontinuing life-support requires consent with the argument that “palliative care will inevitably be administered in Ontario hospitals as part of the process of withdrawing life support in cases like Mr Rasouli’s.” Therefore, it is incongruous if withdrawing mechanical ventilation does not require consent but administering palliative care does. However, this reasoning is dubious in light of evidence that withdrawing mechanical ventilation will not inevitably lead to the administration of palliative care. A study of 166 patients who had mechanical ventilation withdrawn in anticipation of death revealed that 12% of patients survived long enough to be transferred out of the ICU and 3.6% even went on to be discharged. Only 87.3% of patients actually died in the ICU, meaning that just 87.3% of patients required palliative care following the

---

162 *Rasouli SCC, supra* note at paras 62-63.
164 Vardit Ravitsky, “Times on ventilators” (2005) 330:7488 BMJ 415 (Ravitsky argues in this article that placing timers on ventilators resolves the moral dilemma that accompanies the withdrawal of life-support where the physician is perceived as actively intervening to bring about the death of the patient. “These will allow a ventilator to be set for a limited time (such as a week), at the end of which it will be turned off without human intervention” at 416).
165 *Rasouli SCC, supra* note 2 at paras 67, 68.
withdrawal of mechanical ventilation.\textsuperscript{167} Therefore, it is not inevitable that all patients will require palliative care following the withdrawal of mechanical ventilation.

McLachlin CJ’s statement that the provision of palliative care is inevitably “part of the process of withdrawing life support in cases like Mr Rasouli’s”\textsuperscript{168} may not be referring to the nature of the life-sustaining treatment (i.e. mechanical ventilation) but rather the nature of Mr Rasouli’s disability (i.e. he is in a PVS state). Still, it does not follow that the palliative care is always “part of the process” of withdrawing life-sustaining treatment from a patient in a PVS. If a patient in a PVS can breathe on her own following the withdrawal of life-sustaining treatment, as some do, then it may take over a week for the patient to die from the effects of starvation and limited hydration.\textsuperscript{169} Palliative care will only be provided once the patient’s body shows signs of distress from starvation or dehydration, and it may take time once life-support has been withdrawn for these symptoms to appear. In fact, research shows that patients require very little palliative care once intravenous hydration and feeding tubes have been removed as unconscious patients experience little if any discomfort from the effects of dehydration and starvation.\textsuperscript{170} Thus, the two actions - withdrawing life-sustaining treatment and providing palliative care - are distinct and not always “part of the same process.”

Moreover, a SDM may agree to the withdrawal of artificial nutrition and hydration or a mechanical ventilator but disagree with the provision of palliative care (i.e. if the patient expressed a desire to die ‘clean’ without drugs).\textsuperscript{171} The possibility that a SDM may choose in this contrasting way also supports the view that the two actions are not so integrally linked

\textsuperscript{167} Ibid.
\textsuperscript{168} Rasouli SCC, supra note 2 at para 67.
\textsuperscript{169} Anthony Bland, the patient at the center of the infamous House of Lord’s decision Bland, supra note 104, died nine days after he was deprived of nutrition and hydration: Paquita de Zulueta & Francesco Carelli, “Permanent vegetative state: comparing the law and ethics of two tragic cases from Italy and England” (2009) 2 LJPC 125 at 126.
\textsuperscript{170} See: Robert Sullivan, “Accepting Death without Artificial Nutrition or Hydration” (1993) 8:4 JGIM 220 (“[f]asting individuals will not be likely to experience pain induced by fluid or food abstinence. Indeed, mild euphoria can be anticipated, accompanied by an increased tolerance for pain. Absence of oral fluid intake will produce a dry mouth, which can be relieved with ice chips or swabs. Problems with excessive secretions, edema, or incontinence may be alleviated” at 222).
\textsuperscript{171} Young, supra note 67 at 75.
that the requirement for consent to provide palliative care demands that consent is also required for the withdrawal of life-sustaining treatments.\textsuperscript{172}

In concluding that the withdrawal of Mr Rasouli’s life-support requires consent,\textsuperscript{173} McLachlin CJ relied foremost on the fact that the withdrawal of life-support serves a series of health-related purposes. Thus, her findings regarding physical interference and the link between the withdrawal of life-support and palliative care were secondary considerations. Had McLachlin CJ only relied on the finding that the withdrawal serves a health-related purpose then she would have arrived at the conclusion that withdrawing life-support will always require consent, because in her view, regardless of the process, withdrawing life-support will always affect the dying process (even though, as stated above, it is not inevitable that withdrawing life-support, specifically mechanical ventilation, will result in the patient’s death). However, given that it is at least arguable the ratio decidendi of the case is limited to the specific facts of the case, it may be that the purpose for mentioning the secondary considerations is to mark out the situations in which withdrawing life-support does not require consent. This provides cold comfort to non-consenting SDMs in situations where: the patient is critically ill but not in a PVS, the patient’s life-support can be discontinued in a non-invasive way or palliative care is not “part of the process” of withdrawing life-sustaining treatment. The many ways in which the judgment of the majority can be distinguished from other futility disputes in the end-of-life context shows that McLachlin CJ’s interpretation of the HCCA conflicts with the statute’s purpose “to provide rules with respect to consent to treatment that apply consistently in all settings.”\textsuperscript{174}

5.5 The common law remains unsettled

\textit{Rasouli SCC} is a province-specific decision. It remains to be seen whether the courts in other provinces and territories will find that consent is required for the withdrawal of life-sustaining treatment in light of their legislation regarding consent and incapacitated persons. In the event that provincial and territorial legislation does not provide an answer to the futility debate, it is possible that the courts in other provinces and territories will turn to Karakatsanis J’s deliberations for guidance, despite it being the dissenting judgment.

\textsuperscript{172} \textit{Ibid} at 75-77.
\textsuperscript{173} \textit{Rasouli SCC, supra} note 2 at para 61.
\textsuperscript{174} \textit{HCCA, supra} note 3, s 1(a).
To date, the minority judgment represents the most considered, astute and bold review of the common law relating to the issue of whether consent is required to withdraw futile treatment. Karakatsanis J’s review of the Canadian jurisprudence concluded there “is no common law right to insist on medical treatment that the doctor and the institution consider medically futile, harmful, and outside professional standards.” 175 Importantly, the minority decision also affirmed that in common law a physician must consult with the patient or SDM and take account of their beliefs and values, 176 and that the court was the appropriate vehicle for resolving futility disputes. 177

The majority decision may also be cited as indirectly supporting the position that there is no common law right to insist on the administration of contra-indicated treatment. Recall McLachlin CJ’s ‘nuanced view’ that the withdrawal of treatment sometimes, but not always, fits within the definition of ‘treatment’ under the HCCA. 178 If the withdrawal of treatment falls outside the definition of ‘treatment’ 179 then the common-law will govern whether consent is needed. McLachlin CJ did not examine the relevant judicial authorities to determine whether the common law requires consent to withdrawal or withhold treatment. Nonetheless, she did indicate that the “medical implications” of a particular treatment, especially its harmful implications, would require that no consent is required. 180 As stated above, McLachlin CJ did not define what she meant by “medical implications” or “harmful” but it is at least arguable that “medical implications” include the futility of treatment. Hence, the majority judgment may also support the view that at common law no consent is required to withdrawal futile treatment.

In sum, in instances where a physician proposes to withdraw or withhold treatment other than life-sustaining treatment, it is possible that Rasouli SCC will be argued to support physician-driven futility in the common law. This common law position may motivate provincial and territorial legislatures to enact statutes to protect patients from the adverse consequences of physician-driven futility. Thus, even if Rasouli SCC settles the common law position,

175 Rasouli SCC, supra note 2 at para 186.
176 Ibid at para 196.
177 Ibid at paras 187-189.
178 Ibid at para 58.
179 Ibid.
180 Ibid.
legislative intervention is still desirable to both clarify the situations where the common law does and does not apply and safeguard patient rights.

5.6 Safeguards

5.6.1 CCB
The majority judgment emphasized that the CCB was the appropriate forum for resolving futility disputes. The CCB provides “consistency and clarity to the application of the statute,” an objective and independent analysis of the issues, and its members have the sufficient expertise to balance the multitude of issues at stake. The quasi-judicial independent tribunal is “well-placed to make a determination of whether treatment is in the best interests of the patient.”

I agree with the majority decision that an objective, independent and expert tribunal is best placed to resolve treatment disputes between a physician and a patient or SDM. A tribunal is particularly useful as a safeguard because of the risk that treatment decisions made on behalf of an incapacitated patient may be inappropriately influenced by the idiosyncratic views of the decision-maker. A quasi-judicial tribunal provides objective oversight to ensure that treatment decisions are made in the patient’s best interests. Moreover, a specialized tribunal is, at least in theory, purposed to be an efficient and inexpensive vehicle to resolve treatment disputes, in comparison to the court system.

Nevertheless, the CCB is not without its flaws. Of particular concern is the CCB’s lack of expertise in resolving futility disputes. Mr Rasouli’s treating physicians argued that the CCB “lacks the expertise…to determine what types of medical treatments are indicated for a

\[181\] *Ibid* at para 103.
\[182\] *Ibid* at paras 98-104.
\[183\] *Ibid* at para 98.
\[184\] Consent and Capacity Board, *Service Standard Policy* (28 February 2012), online: Consent and Capacity Board <http://www.ccboard.on.ca/scripts/english/accountability/3-Service-Standard-Policy.pdf>: the HCCA sets out three legislated service standard for the CCB to achieve efficiency:

1. A hearing is to commence within seven days from receipt of the application;
2. The CCB must issue its Decision within one day of conclusion of the hearing;
3. Upon the request of a party, the CCB will issue written reasons for its Decision within four business days of receiving the request.
patient with complex disease processes.” Indeed, only one member of the CCB is a health practitioner from a field of medicine outside the field of psychiatry. Furthermore, the CCB process is not as expeditious as the courts would like to believe. This is because decisions from the CCB are frequently appealed to the Superior Court of Justice and so “these cases routinely take months to resolve.” On the back of the treating physicians’ concerns, the Court of Appeal noted that the CCB “may not be a perfect solution.”

Additionally, the CCB only has jurisdiction to resolve futility disputes concerning the ‘treatment’ of a patient, which in McLachlin CJ’s view sometimes, but not always, includes the withdrawal of treatment. So where the withdrawal of treatment falls outside ‘treatment’ under the HCCA, for example if a physician refuses to prescribe cancer medication which harms the patient, the CCB has no jurisdiction, and any dispute arising from the withdrawal of that treatment will have to be determined by the courts. Indeed, applying McLachlin CJ’s reasoning it will be difficult to discern whether the CCB even enjoys jurisdiction to hear the dispute at all.

Therefore, in Chapter Five, I will propose a number of recommendations to improve the efficacy and expertise of an independent and specialized tribunal for resolving futility disputes.

5.6.2 Court

Karakatsanis J concluded that futility disputes should be heard before the Superior Court of Justice and not the CCB. This conclusion was inevitable given the minority finding that the common law, and not the HCCA, governs when there is a disagreement regarding the proposed withdrawal of a treatment. Karakatsanis J also believed that judicial oversight provides a fetter on physicians’ discretion in making treatment decisions.

185 FOA, supra note 47 at 101.
186 Ibid at 100.
187 Ibid at 101.
188 Rasouli ONCA, supra note 67 at para 59.
189 HCCA, supra note 3 s 37(1)
190 Rasouli SCC, supra note 2 at para 58.
191 Ibid at para 206.
192 Ibid at para 124.
193 Ibid at para 187.
McLachlin CJ criticized this finding as she believed it heightened the vulnerability of the incapacitated patient if their family or SDM are forced to apply to the court to dispute a decision of a physician to withdraw treatment.\textsuperscript{194} As discussed in Chapter Three, the court process is expensive, time-consuming, stressful and by its very nature adversarial. Hence, I agree with McLachlin CJ that it is not ideal that families, SDMs, and most importantly an ill patient be subjected to the judicial process as they may have limited time, resources and will already be suffering a high degree of emotional stress. Where the burden is too much, the SDM or patient’s family may abandon an application, even if they disagree with the physician’s findings. This leaves the physician’s decision - which may be incorrect or influenced by discriminatory or overly paternalistic factors - unchallenged.

The minority decision is also unclear on whom falls the burden of bringing the application to court. Karakatsanis J cites Bland for the proposition that “it would be desirable that physicians receive court approval before ending life-support treatments”,\textsuperscript{195} but does not go so far as to state that the physician \textit{must} be the one to apply for court approval. Rather, she finds that “[t]ypically, the courts have become engaged in end-of-life decision-making when a patient’s family has sought an injunction from withholding or withdrawing life-sustaining treatment”\textsuperscript{196} and later, “where a family member, or a substitute decision-maker, disagrees with the medical practitioner’s decision to withdraw life-support, she may apply to the court to challenge the physician’s decision.”\textsuperscript{197} It appears that the burden to bring an application to court rests with the patient’s loved ones.

Overall, the minority judgment inflates the value of judicial oversight in resolving futility disputes. Karakatsanis J’s finding that the case could be determined according to common law principles led her to believe the courts were an effective forum for resolving futility disputes. In coming to this conclusion, Karakatsanis J overlooked the instances in which the judiciary has expressed dismay at having to decide such disputes without legislative guidance.\textsuperscript{198} Troublingly, Karakatsanis J also failed to appreciate the burden the court system

\textsuperscript{194} \textit{Ibid} at para 114.
\textsuperscript{195} \textit{Ibid} at para 188
\textsuperscript{196} \textit{Ibid} at para 188.
\textsuperscript{197} \textit{Ibid} at para 204.
\textsuperscript{198} See for example: \textit{Re IHV}, 2008 ABQB 250, 449 AR 211 at para 31; \textit{Bland}, supra note 104 at 890.
places on patients, their loved ones and health practitioners. The minority judgment did not convincingly establish the judiciary as the appropriate forum for deciding futility disputes.

6 Evading consent

A recent decision from Ontario’s Court of Appeal, *Cefarelli v Hamilton Health Sciences,* illustrates how physicians can manipulate the HCCA to avoid the obligation to obtain consent to withdraw or withhold life-sustaining treatment. Here, the Court found the patient’s SDM had consented to a ‘plan of treatment’ that armed the treating physician with discretion to decide which components of cardiopulmonary resuscitation (CPR) to use. It followed that the physician’s refusal to provide cardiac compression to the patient “was simply one available to the doctor within that plan” and as such “it cannot be said to be a withdrawal of treatment from that treatment plan.”

The Court of Appeal’s findings cut across McLachlin CJ’s attempt to interpret the HCCA in a way which reduces arbitrary decision-making resulting from the discretion provided to physicians regarding how treatments or plans of treatment are presented to patients or SDMs. Indeed, McLachlin CJ described the notion of a ‘plan of treatment’ as a “thorny problem”, noting further that:

> the HCCA does not clarify whether a plan of treatment is fixed and must be fully specified in advance, or whether it permits flexible alteration in response to changes in the patient’s situation…

*Cefarelli* further exposes the trouble with the HCCA’s ‘plan of treatment’ model by illustrating how physicians can formulate plans to ensure they have full legal discretion to decide when treatment may be withheld or withdrawn.

There are three reasons why ‘plans of treatment’ should not bestow physicians’ unfettered discretion to make decisions in the end-of-life context. First, full physician discretion disempowers the voice of the patient’s loved ones and makes the role of the SDM redundant once the initial plan of treatment has been consented to. Physicians will still have a duty to

199 *Cefarelli v Hamilton Health Sciences,* 2013 ONCA 413 (available on CanLII).
200 *Handelman,* supra note 149 at 29.
201 *Cefarelli v Hamilton Health Sciences* 2013 ONCA 413 (CanLII) at para 4.
202 *Rasouli SCC,* supra note 2 at para 106.
204 *Ibid* at para 56.
consult with the patient’s family, but the physician will be permitted to make treatment decisions within the contours of the plan of treatment based entirely on clinical evidence and their own idiosyncratic views. Second, it is also highly probable that the SDM will not properly comprehend the consequences of consenting to the plan of treatment, particularly if it is ridden with medical jargon or the physician inadequately explains it.\textsuperscript{205} Third, attempts by physicians to hide discretionary authority in a plan of treatment will diminish public trust in the medical profession, as some will see the use of such authority as a mark of medical paternalism. In general, granting physicians too much discretionary authority within a plan of treatment does not promote open and amicable decision-making in the healthcare context.

\textit{Cefarelli} was decided prior to the release of \textit{Rasouli SCC} and so its precedential value remains to be seen in light of the Supreme Court’s findings. Nonetheless, the majority judgment in \textit{Rasouli SCC} is responsible for creating a perverse incentive for physicians to hide discretionary authority in a plan of treatment, because of the Court’s unwillingness to balance physician’s concerns about futility and personal autonomy. To counter the possibility that physicians may increasingly hide discretionary authority in a plan of treatment the courts should, at the very least, recognize that physicians have a strong duty to communicate any discretionary powers enjoyed by them in a plan of treatment. Even better, Ontario’s legislature should establish a process for resolving futility disputes in a fair and transparent way, regardless of whether they arise in the context of a plan of treatment.

\section*{Evaluation}

\textit{Rasouli SCC} is not a landmark decision. The majority judgment did not clarify the law in Ontario regarding when consent is required to withdrawal or withhold futile treatment. Its precedential value is limited to the withdrawal of life-support in circumstances similar, if not the same, as Mr Rasouli’s situation. Indeed, \textit{Rasouli SCC} created a large grey area in the law of medical decision-making, where there is uncertainty as to whether medical futility legally justifies withholding or withdrawing treatment and if so, what is the scope of the legal standard of medical futility that justifies this decision. It follows that post-\textit{Rasouli SCC} futility disputes will continue to be heard before the courts, including appellate courts.

\textsuperscript{205} Robert Rodriguez et al, “A prospective study of primary surrogate decision makers’ knowledge of intensive care” (2008) 36:5 Crit Care Med 1633 (less than half of surrogate decision-makers had good understanding of their family members’ intensive care and resuscitation status).
Moreover, if a withdrawal of treatment falls outside the definition of ‘treatment’ under the HCCA, the common law will govern any futility dispute regarding that withdrawal. In light of *Rasouli SCC*, the common law position favours the views of the physician above those of the patient. In the absence of any legislative safeguards, this common law balance risks violating a patient’s entitlement to have their rights and values respected and considered in the healthcare system.

The value of *Rasouli SCC* is that it illustrates the inconsistencies and ambiguities within the HCCA. The majority were unable to convincingly articulate how the statutory scheme can be applied to resolve futility disputes, and so it is not hard to imagine the difficulties faced by health practitioners, patients and SDMs in trying to apply the statute. It is also unclear how the principles of personal autonomy and medical futility are balanced in the HCCA. In short, the HCCA is not a clear and concise piece of legislation. In the next chapter, I will propose a number of amendments that I believe will help clarify the law in Ontario *vis-à-vis* futility disputes.

---

206 My conclusion that the HCCA is an inadequate piece of legislation for resolving futility disputes is not new: Young, *supra* note 67 (“[t]he issue is not addressed by statute, at least not explicitly” at 60); Glen Rutland, “Futile or Fruitful: The Charter and the Decision to Withhold or Withdraw Life-sustaining Treatment” (2009) 17 Health LJ 81 (“the question of who has the final authority when a demand for life-sustaining treatment is made has not been answered by statute” at 82.)
Chapter 5
Recommendations

Introduction

A 1983 report on euthanasia, assisted dying and cessation of treatment stated, “[t]he onus is on those suggesting a change...to show that the change is desirable and represents an improvement over the existing situation.”¹ The same report also concluded that the law should not promote or condone “the continuance or initiation of useless or inappropriate medical treatment.”² Nevertheless, as I have shown in the previous chapters, both the judiciary and Ontario’s legislature have, to date, failed to address the problem of medical futility in the public healthcare system. Therefore, in this fifth and final chapter, I propose changes to Ontario’s Health Care Consent Act 1996 (HCCA)³ that are designed both to reduce the incidence of futile treatment and ensure that any act or omission by a physician in the name of futility is for the purpose of protecting the patient’s best interests. Importantly, my recommendations aim to strike a balance between the principles of personal autonomy and medical futility.

This chapter will be split into four parts. In **Part One** I will revisit why law reform is desirable. I will emphasize that amendments to the HCCA are needed now, more than ever, in light of majority judgment in *Rasouli SCC*, which only served to convolute, rather than clarify, the law surrounding medical futility.

In **Part Two**, I will propose three amendments to the HCCA. First, I will amend the definition of ‘treatment’ under the HCCA to exclude futile treatment. I will establish a legal standard of medical futility using the definition I proposed in Chapter One. The second amendment will require that the treating physician and the patient, or substitute decision-maker (SDM), agree that treatment is futile. I will propose three

---

² Ibid at 24.
statutory criteria that the decision-making parties must consider when assessing whether treatment is futile. This amendment aims to protect patients from physicians inappropriately or incorrectly relying on medical futility to withhold or withdraw treatment. The third amendment will dictate that if the decision-making parties are unable to agree whether a particular treatment is futile or not, the futility dispute will be resolved by a new and independent Treatment Dispute Board (TDB).

In Part Three, I will explain why the TDB will be better suited to resolve futility disputes than the Consent and Capacity Board (CCB). Like the CCB, the TDB will be a quasi-judicial independent tribunal. However, unlike the CCB, the TDB will have a specific mandate to resolve treatment disputes, including futility disputes, for both competent and incapacitated patients, and it will adopt a more inquisitorial process to reduce adversary between parties and to ensure an efficient and fair hearing. Moreover, the TDB’s decision will be automatically binding, and parties will have to seek leave to appeal a TDB judgment.

Finally, in Part Four, I will discuss five consequences of my proposals that I believe will represent a profound improvement on the current state of law surrounding futility disputes. Specifically, I will show that my recommendations: (1) strike a balance between medical futility and personal autonomy; (2) encourage better communication between physicians and patients, or SDMs; (3) relieve physicians and SDMs from having to follow a patient’s prior known wish for indefinite life-sustaining treatment; (4) protect the value of personal autonomy by recognizing that the concept only survives incapacity if there is clear evidence of the patient’s specific beliefs and wishes regarding treatment; and (5) discourage physicians from manipulating a plan of treatment to give themselves full decision-making authority.

1 The Grey Area Revisited

In its current form, the law provides little clarity as to when medical futility may be used as a legal justification to withhold or withdraw treatment. In Rasouli SCC, the majority decision created uncertainty as to whether a physician is obliged to obtain consent from a patient or SDM before treatment is withheld or withdrawn. While the majority
confirmed that the withdrawal of life-sustaining treatment in the form provided to Mr Rasouli requires consent of a SDM, the Court concluded that withdrawing harmful drugs does not require the consent of a patient or SDM. The Court left open whether consent is required to withhold or withdraw other medical interventions, such as cardiopulmonary resuscitation (CPR) or chemotherapy.

The confused nature of McLachlin CJ's reasoning is heightened by her reliance on a standard of 'harm to the patient' to justify physicians having unilateral authority to withdraw medication. This threshold of 'harm' allows physicians to refuse to prescribe 'harmful' drugs to a patient without consideration of the patient's views as to whether that treatment is producing a benefit. McLachlin CJ does not define 'harm' but rather requires physicians to use their "common sense" to determine whether the burden of medication outweighs its benefit.

Moreover, the majority's reasoning does not address the primary concern of physicians that they will be compelled to provide unbeficial treatment indefinitely. Post-Rasouli SCC, physicians still have no clear legal basis to argue that futile treatment should be withheld or withdrawn. It may follow from Rasouli SCC that a physician can withdraw treatment where it is futile and harmful, but this reasoning does not empower physician's to remove life-support for a patient in a PVS who may not be experiencing any pain.

The confused aftermath of the Rasouli SCC decision is concerning given the incidence of futility disputes is increasing. Indeed, Chief Justice McLachlin began the majority judgment with the statement: "[t]his case presents us with a tragic yet increasingly common conflict." In support of this statement, a review of CCB decisions by Chidwick and colleagues revealed a rise in end-of-life care disagreements brought before the CCB – from two per year between 2003 and 2008 to five per year between 2009 and 2012.

---

5 Ibid.
6 Rasouli SCC, supra note 4 at para 1.
7 Paula Chidwick, Robert Sibbald & Laura Hawryluck, "Best interests at end of life: an updated review of decisions made by the Consent and Capacity Board of Ontario" (2013) 28 J Critical Care 22 at 23 [Chidwick – Best Interests].
These figures are small, but reveal an upward trend in the volume of futility disputes. As futility drivers (discussed in Chapter One) continue to influence Canada’s public healthcare system, it is likely that the number of futility disputes will continue to increase in the future.

Of course, the situations where consent is required to withhold or withdraw treatment could be teased out on a case-by-case basis. However, as discussed in Chapter 3 and Chapter 4, the judiciary is not the appropriate body to resolve futility disputes. The law should not encourage every futility dispute to proceed all the way to the Supreme Court, as Mr Rasouli’s case did. Ontario’s legislature should provide real alternatives for resolving these kinds of disputes such that judicial involvement is most often unnecessary.

The judiciary has on many occasions called for legislative intervention to settle the futility debate. In London Health Science Centre v RK McDermaid J stated:

Questions such as this, involving as they do complex moral, ethical, religious, and legal issues are best dealt with in a multicultural society by Parliament rather than the courts. They lie essentially within the purview of the legislative branch of government, whose function is to decide upon and enumerate policy, and not within that of the judicial branch.

The legislature should, in theory, be able to address the wider interests at play in the futility debate, including concerns about optimal resource allocation and the sustainability of the healthcare system, and determine how the law can be used to reduce futile treatment in Ontario. To achieve this, the legislature must develop a statutory standard of futility against which the appropriateness of treatment can be

---

8 See for example London Health Science Centre v RK (1997), 152 DLR (4th) 724 (available on CanLII) (ONSC) [London Health] at para 17; Sawatzky v Riverview Health Centre Inc, [1998] M J No 506, 167 DLR (4th) 359 [Sawatzky] at para 5. C.f. Alberta (Child, Youth, and Family Enhancement Act, Director) v DI, 2012 ABQB 562 (available on CanLII) (“[t]hese decisions are made in hospitals across this country every day…with the decision-makers receiving information and recommendations from medical professionals, and considering their own and their loved one’s wishes and beliefs. There is no need and there may not even by any possibility for legislative standards to given these decisions, which must be made in the best interests of each individual patient in the circumstances applying to that patient” at para 61)

9 London Health, ibid; Sawatzky, ibid (“while the courts may be an appropriate place to start the discussion of these issues in that the courts can clarify the existing state of the law in light of the Charter of Rights and Freedom, it may be for the government to resolve any moral or ethical questions that remain at the end of the day” at para 5).
measured. Any legal standard must, however, respect a patient’s autonomy and not prohibit individuals from accessing a reasonable level of medical care. If the legal standard of medical futility does not strike an adequate balance with personal autonomy, the fundamental rights of patients may be at risk in the public healthcare system.

Naturally, any statutory endorsement of medical futility will be met with some political resistance because it will involve defining the ends of medicine, which indirectly requires defining the ends of human life. Politicians may feel discomfort at having to define a concept that some people will view as sanctioning the premature death and possibly the ‘murder’ of individuals in society. Others may perceive a statutory definition of futility as placing a dollars-and-cents value on human life, which is contrary to the Medicare ethos that all Canadians should have access to healthcare services without financial barriers. 10

Nevertheless, political and emotive concerns should not deter the legislature from addressing the futility debate. After all, the legislature owes a duty to the public to draft statutes that reflect the interests of society and clearly state what the law is. Moreover, physicians will not stop arguing that further treatment is futile in some end-of-life cases. Indeed, post-Rasouli SCC futility disputes continue to be heard before Ontario’s Superior Court of Justice. 11 The HCCA, in its current form, does nothing to remedy this piecemeal judicial trend.

2 Recommendation One – entrench medical futility in statute

The law regarding medical futility post-Rasouli SCC cries out for legislative reform to provide clarity on how to resolve futility disputes. The central problem with the HCCA vis-à-vis futility disputes is that the statute does not achieve its purpose “to provide rules with respect to consent to treatment that apply consistently in all settings.” 12 McLachlin CJ asserted that her “nuanced view” - where withdrawing treatment “sometimes, although not always, constitute[s] ‘treatment’” - accords with the

10 Canada Health Act, RSC, 1985, c C-6, s 3 [CHA].
11 See for example Ackie et al v Manocha, 2014 ONSC 669 (available on CanLII) [Ackie].
12 HCCA, supra note 3, s 1(a).
provisions of the HCCA and the realities of medical care.\textsuperscript{13} Yet, she provides no guidance for decision-makers on how to determine whether withdrawing or \textit{withholding} treatment fits the HCCA’s definition of ‘treatment’. By contrast, the amendments to the HCCA detailed below will provide a clear process for resolving futility disputes that can be consistently applied to diverse factual situations. The amendments will absolve the need for a judicial case-by-case assessment of whether withdrawing or withholding treatment is ‘treatment’ for the purposes of the HCCA.

\textbf{My first amendment} is to extend the list of actions excluded from the definition of ‘treatment’ under s 2(1) of the HCCA to include:

(i) any intervention that is withheld or withdrawn in circumstances where there is no reasonable probability it will create an effect that the patient is able to experience as a health benefit, having regard to the criteria set out at s 3(4).

The effect of this amendment will be to firmly entrench the concept of medical futility within the HCCA and remove the need for physicians to obtain the consent of a patient or their SDM to withdraw treatment that is medically futile. The amendment also relieves the judiciary from having to continually debate the meaning of medical futility and whether it is an influential consideration in medical decision.

This statutory standard of futility has four important features. First, the definition does not use the word ‘futility’. The term ‘futility’ may be perceived by patients and SDMs as suggesting that the patient’s case is hopeless, and this risks inviting a fearful or defensive attitude, which would not help to promote amicable and reasonable decision-making. Removing the term ‘futility’ from the statute focuses the attention of the decision-makers on the core purpose of the standard, namely to consider whether treatment is providing a benefit to the patient, and if so, to what extent.

Second, the definition directs that treatment is only withdrawn or withheld where the patient does not experience a health benefit. As discussed, the majority’s finding in \textit{Rasouli SCC} that treatment could only be withdrawn where it ‘harmed’ the patient\textsuperscript{14} is an inappropriate standard. Focusing an assessment of whether treatment should be administered on the \textit{benefit} as opposed to the \textit{harm} of treatment better fits the goal of

\textsuperscript{13} \textit{Rasouli SCC}, supra note 4 at para 59.
\textsuperscript{14} \textit{Ibid} at para 58.
Canada’s public healthcare system, which is designed to “protect, promote and restore the physical and mental well-being of residents of Canada.”\textsuperscript{15}

Third, the scope of the proposed statutory standard of medical futility extends beyond end-of-life cases where the patient is incapacitated. While futility disputes usually arise between physicians and SDMs over the provision of life-sustaining treatment to an incapacitated patient,\textsuperscript{16} it is also possible that a competent patient and a physician will disagree as to whether other forms of treatment are futile. An example would be where a physician refuses to provide further chemotherapy to a competent cancer patient with a terminal diagnosis. To ensure that the HCCA comprehensively addresses futility disputes in a range of different contexts, the definition of futility should apply to situations involving competent and incapacitated patients. Consequently, a physician will be able to rely on the statutory standard of medical futility to avoid the need to obtain consent from a competent patient under s 10(1) of the HCCA.

Fourth, the standard of medical futility directs the decision-maker’s attention to criteria set out at s 3(4), which will be discussed further below. Suffice for the current purposes this subsection requires that an assessment of futility takes into account: clinical evidence of how the treatment will affect the patient’s condition and well-being; the patient’s subjective beliefs and wishes regarding treatment, if known; and whether treatment will serve the patient’s overall best interests. These criteria aim to ensure the values of the physician and the patient are both central to a determination of futility.

The standard of futility that I have proposed does not set out who should decide whether the patient is experiencing a health benefit. Therefore, my second amendment directs that medical futility is determined by agreement from the treating physician and the patient, or SDM, via inclusion of the following subsections in s 3 of the HCCA:

\begin{quote}
\textbf{Agreement that treatment is not beneficial}
\begin{itemize}
\item[(3)] The health practitioner responsible for treating the patient cannot rely on clause (i) of the definition of “treatment” in subsection 2(1) unless the person, or
\end{itemize}
\end{quote}

\textsuperscript{15} \textit{CHA, supra} note 10, s 3.

\textsuperscript{16} Thaddeus Mason Pope, “Dispute Resolution Mechanisms for Intractable Medical Futility Disputes” (2013-2014) 58 NYL Sch L Rev 347 at 349.
if the person is incapable, his or her substitute decision-maker, agree that the clause applies to the circumstances.

(4) When considering whether clause (i) of the definition of “treatment” in subsection 2(1) applies to the circumstances, the person, or, if the person is incapable, his or her substitute decision-maker, must consider:

(i) evidence of the incapable person’s beliefs and wishes regarding the intervention;

(ii) information from the health practitioner(s) responsible for treating the person as to whether the intervention is likely to:

(A) improve the person’s condition or well-being;

(B) prevent the person’s condition or well-being from deteriorating; or

(C) reduce the extent to which, or the rate at which, the person’s condition or well-being is likely to deteriorate; and

(iii) whether the provision of the intervention will be in the best interests of the person.

Subsection 3(3) requires that the physician and the patient, or SDM, agree that treatment is futile, so that no party has unilateral authority to withdraw or withhold treatment. This amendment safeguards the patient’s rights by ensuring that a determination of futility is measured against both the values of the patient and the medical profession. The corollary, of course, is that the views of the patient cannot veto those of the physician either. Ultimately, it is hoped, the requirement for a consensus between the treating physician and patient, or SDM, will encourage clear and substantive engagement between the parties about the patient’s further medical care.

The benefit of s 3(4) is that it establishes clear criteria that the physician and patient, or SDM, must consider when assessing futility. It may seem obvious that the patient, or SDM, will take account of the patient’s beliefs and wishes, and, likewise, the physician will consider medical evidence; however, the object of this proposal is to make it clear to all the decision-making parties that both the patient’s subjective views on the proposed intervention and the treating physician’s opinion are relevant to any assessment of futility and must be balanced against each other. As discussed in Chapter Two, SDMs habitually consider only the patient’s values, beliefs and wishes and ignore the medical evidence about the implications of treatment.17 Indeed, post-Rasouli SCC, there is no requirement that a SDM consider the treating physician’s evidence about the

17 Sarah Jones, "Determining Best Interests in End-of-life Decisions" (2011) 69:1 UT Fac L Rev 8 (by contrast, physicians tended not to give evidence about the patient’s wishes, values and beliefs and focused only on the medical evidence, at para 16).
implications of further treatment at all when applying the s 21 best interests test. The effect of s 3(4) is that the opinion of the decision-making parties will only have legal force if they can justify the opinion against both clause (i) and (ii) criteria.

Moreover, clause (iii) provides an umbrella requirement that any finding of futility must be made in accordance with the patient’s best interests. For example, a SDM may know that a terminally-ill patient previously expressed a wish that heroic efforts be made to sustain her life, and the SDM may believe that life-support is providing a health benefit to the patient because it is prolonging the patient’s life. Yet, the SDM may still conclude against clause (iii) it is not in the patient’s best interests to receive further life-sustaining treatment because such treatment has harmful, undignified and gruesome side effects without actually improving the patient’s condition.

The first two amendments that I have proposed establish medical futility as an important consideration in medical decision-making and clarify the criteria a decision-maker must refer to when assessing futility. However, these two amendments alone would not eliminate the possibility of an impasse between the decision-making parties as to whether treatment provides a health benefit, as application of the criteria in the proposed s 3(4) may lead to different conclusions in the minds of the physician and the patient or SDM. Therefore, my third amendment directs that s 3 should be amended to include fifth and sixth subsections, which will read:

**Application to determine reliance on clause (i) of the definition of “treatment” in subsection 2(1)**

(5) Where no agreement can be reached in subsection (3), the health practitioner responsible for treating the person will apply to the Treatment Dispute Board for a determination as to whether clause (i) of the definition of “treatment” in subsection 2(1) applies.

(6) The Treatment Dispute Board will determine whether clause (i) of the definition of “treatment” in section 2(1) applies using the criteria set out in subsection (4) of this section.

The effect of this amendment is that a newly formed Treatment Dispute Board (TDB) will have jurisdiction to hear futility disputes in place of the Consent and Capacity Board (CCB). Traditionally, the CCB has adjudicated futility disputes, as it is an “independent, quasi-judicial body with specialized jurisdiction over matters of consent to medical
treatment.”\textsuperscript{18} However, as the treating physicians argued in \textit{Rasouli SCC}, the CCB “lacks the expertise, as it lacks the mandate, to determine what types of medical treatments are indicated for a patient with complex disease processes, whether in the context of critical care medicine or otherwise.”\textsuperscript{19} The courts are of course an alternative means of recourse, but they are expensive, time-consuming and suffer a lack of medical expertise and thus are also unsuitable for resolving futility disputes. Therefore my second recommendation will explore how the CCB’s independent quasi-judicial model can be improved to develop the TDB into a forum capable of effectively, efficiently and fairly resolving futility disputes.

3 Recommendation Two – creation of the Treatment Dispute Board

3.1 Mandate to resolve futility disputes

The current mandate of the CCB is:

\begin{quote}
\begin{itemize}
\item to adjudicate on matters of capacity, consent, civil committal, substitute decision-making, disclosure of personal health information and mandatory blood testing.\textsuperscript{20}
\end{itemize}
\end{quote}

This mandate does not give the CCB jurisdiction to adjudicate disputes about treatment. Rather, the CCB is designed to resolve issues arising from the incapacity of the patient, such as whether the patient should be committed and who should assume the role of the SDM. But, as Mr Rasouli’s treating physicians pointed out, it is not the CCB’s role to determine if the patient will benefit from medical treatment.\textsuperscript{21}

Counsel for Mr Rasouli argued that even if the CCB was not specifically designed to resolve disputes about whether or not treatment is appropriate in the circumstances, it had nonetheless proven itself over the past 16 years since its inception to be capable of

\begin{thebibliography}{9}
\bibitem{18} Rasouli SCC, supra note 4 at para 28.
\bibitem{19} Cuthbertson v Rasouli, 2013 SCC 53, [2013] 3 SCR 341 (Factum of the Appellant at para 37) [FOA]
\bibitem{21} FOA, supra note 19 at paras 88-103.
\end{thebibliography}
resolving such disputes.\textsuperscript{22} In support of this argument, counsel noted that Justice Himel, who heard Mr Rasouli’s case in the lower court, found that “the current practice of many doctors is to seek consent for end of life decisions, and if they disagree with the decision of a substitute decision-maker refer the decision to the CCB.”\textsuperscript{23} In other words, the task of resolving futility disputes forms part of a customary mandate of the CCB in the absence of it being part of its formal mandate.

In my view, the independent board responsible for resolving futility disputes should have a specific mandate directed towards that task. Such a mandate would have both symbolic and practical benefits. Symbolically, a specific mandate would embolden public confidence that the law is providing a targeted scheme for resolving treatment disputes. The practical benefit of a specific mandate would be to clearly distinguish which healthcare disputes should be governed by TDB and which should be heard by the courts or the CCB. Hence, I propose the following mandate for the TDB:

\begin{quote}

to adjudicate matters on whether a treatment should be administered or continued in light of the best interests of the patient.
\end{quote}

Critically, this mandate directs that disputes heard before the TDB must be resolved in keeping with the patient’s best interests. Other interests or concerns – e.g. optimal resource allocation or the personal views of the physician - will be subordinate to the patient’s best interests. Nonetheless, following Ouellette J’s reasoning in \textit{Sweiss}, a determination of the patient’s best interests will consider the patient’s values, beliefs and wishes, as well as clinical evidence about the medical implications of treatment.\textsuperscript{24} Ultimately, the paramount duty of the TDB is to ensure any treatment decision preserves and protects the well-being of the patient.

The proposed mandate grants the TDB jurisdiction over a wide range of medical disputes. The TDB is not confined under the mandate to only resolve futility disputes; rather the TDB will have jurisdiction to hear a wide range of disputes about a patient’s

\textsuperscript{22} \textit{Cuthbertson v Rasouli}, 2013 SCC 53, [2013] 3 SCR 341 (Factum of the Respondent at para 103) [\textit{FOR}].

\textsuperscript{23} \textit{Ibid}; \textit{Rasouli v Sunnybrook Health Sciences Centre}, 2011 ONSC 1500, 105 OR (3d) 761 at para 50 [\textit{Rasouli ONSC}].

\textsuperscript{24} \textit{Sweiss v Alberta Health Services}, 2009 ABQB 691 (available on CanLII) [\textit{Sweiss}] at para 63.
medical care, for example where parents are refusing to consent to life-sustaining treatment for a child. The mandate also anticipates the TDB will adjudicate disputes involving both competent and incompetent patients. The TDB will not, however, have jurisdiction over disputes relating to mental health matters, such as whether a patient lacks capacity because of a mental disorder or disability, or whether the patient is receiving appropriate treatment for her disorder or disability. These matters will continue to fall within the jurisdiction of the CCB. In sum, any discord between decision-makers about whether treatment is in the patient’s best interests may be brought before the TDB for determination.

3.2 Change in membership

Ontario’s Court of Appeal in M(A) v Benes stated:

The Board will then have before it two parties who disagree about the application of s21 the SDM, who may have better knowledge than the health practitioner about the incapable person’s values, beliefs and non-binding wishes; and the health practitioner, who is the expert on the likely medical outcomes of the proposed treatment...Indeed, after hearing submissions from all parties, the Board is likely better placed than either the SDM or the health practitioner to decide what is in the incapable person's best interests.

Despite this prior judicial sentiment, the treating physicians in Rasouli SCC argued that the CCB lacked the expertise to understand the medical implications of treatment and how this would affect the patient. In support of this claim, the treating physicians asserted at the time of the hearing that only one member of the CCB was a health practitioner from a field of medicine outside the field of psychiatry, and the remaining members were either lawyers, psychiatrists or lay members.

Indeed, the inclusion of a psychiatrist illustrates that the CCB’s mandate is focused on issues involving management of incapacitated persons - such as who should act as the SDM - rather than whether further treatment is in the patient’s best interests. In T(I) v L(L), Ontario’s Court of Appeal held that the qualifications of the CCB in mental health

---

26 M(A) v Benes (1999), 46 OR (3d) 271, 180 DLR (4th) 72 (ONCA) at para 46 [Benes].
27 FOA, supra note 19 at para 100.
28 Ibid.
proceedings are essential for applying the best interests test.\textsuperscript{29} The Court stated, “[t]he best interests test...in part requires medical expertise because medical outcomes are included in that test.”\textsuperscript{30} However, the current members of the CCB do not have general medical knowledge or expertise. Therefore, it is difficult to see how the members could properly apply the best interests test for a non-psychiatric patient when they do not have the expertise to understand medical evidence outside the field of psychiatry.

Momentum is gathering in many jurisdictions to hear cases with a medical theme in specialized courts or tribunals. Many jurisdictions, including New Zealand,\textsuperscript{31} Australia\textsuperscript{32} and South Africa,\textsuperscript{33} have established quasi-judicial forums, similar to the CCB, with jurisdiction to hear matters regarding individuals with mental health concerns. These specialized panels will contain at least one member with expertise in the field of psychiatry to ensure expertise on mental health related issues.\textsuperscript{34} In the United States, the Harvard School of Public Health has proposed that medical malpractice cases should be heard in specialized Health Courts.\textsuperscript{35} The role of a Health Court judge is to deliberate with a court-appointed medical expert and together decide whether the accused

\textsuperscript{29} \textit{T(I) v L(L)} (1999), OJ No 4237 (available on CanLII) at paras 17-20, 46 OR (3d) 284 (ONCA) \textit{[T(I)]}.
\textsuperscript{30} \textit{Ibid} at para 21.
\textsuperscript{31} See: \textit{Mental Health (Compulsory Assessment and Treatment) Act 1992} (NZ), 1992, s 101-104 \textit{[MH(CAT)A]}, under which the Mental Health Review Tribunals are established to consider the mental condition of certain criminal offenders and persons subject to compulsory treatment orders.
\textsuperscript{32} Australia has a federal system of government and so the tribunals vary state by state. For an overview of the functions of mental health review tribunals across Australia see generally: Terry Carney, “Australian mental health tribunals – ‘Space’ for rights, protection, treatment and governance” (2012) 35 Int J Law Psychiat 1.
\textsuperscript{33} See: \textit{Mental Health Care Act}, 2002, (S Afr), No 17of 2002, s 18-24 \textit{[MHCA]}, under which the Mental Health Review Boards are established to consider a wide range of issues relating to persons suffering from a mental disease or disability.
\textsuperscript{34} \textit{MH(CAT)A}, supra note 31 (“[e]very Review Tribunal shall comprise 3 persons appointed by the Minister, of whom 1 shall be a barrister or solicitor, and 1 shall be a psychiatrist” s 101(2)); \textit{MHCA}, \textit{ibid} (“[t]he Review Board must at least consist of a – (a) mental health care practitioner; (b) magistrate, an attorney or an advocate admitted in terms of the law of the Republic; and (c) member of the community concerned, s 20(2)); Carney, \textit{supra} note 32 (“Mental Health Tribunals were intended to be more sensitive to health considerations than their judicial antecedents by virtue of their multi-disciplinary membership (incorporating psychiatric and other mental health-related expertise in addition to lawyers” at 1).
physician has met her professional standard of care.\textsuperscript{36} The anticipated benefit of these Health Courts over jury trials is that “verdicts and settlements will be more rational and more fair because health courts will rely on specialized judges, [and] “neutral” experts.”\textsuperscript{37} Specifically regarding substitute decision-making, the state of Iowa has created the Substitute Medical Decision-Making Board, which is designed to make decisions for incompetent individuals who do not have a SDM or family member to make decisions on their behalf.\textsuperscript{38} The inclusion of physicians on the Iowa Board reflects judicial sentiment that previous methods of resolving treatment disputes in Iowa suffered from lack of medical expertise.\textsuperscript{39} The increasing interest in the concept of specialized medical tribunals supports the view that medical disputes should not be determined in the general court system, but rather adjudicated by a specialized body with sufficient expertise to understand complex medical issues.

Thus, to ensure that the members of the TDB have the medical expertise to apply the best interests test for non-psychiatric patients, I propose that the membership of the TDB consists of physicians trained in acute hospital care, professional health ethicists and lay-members. The inclusion of a physician ensures that the TDB will always have one member with clinical expertise to determine whether withholding or withdrawing treatment is in the best medical interests of the patient, taking into account the patient’s diagnosis and prognosis. Input from the lay-member and the health ethicist will ensure that a determination of what is in the patient’s general best interests is not solely determined from the worldview of a physician and also includes consideration of the patient’s values, beliefs and wishes.

The skills and expertise of a health ethicist are particularly suited to ensuring the interests of physicians and patients are fairly balanced. In 2010, a Taskforce on Working Conditions for Bioethics stated that part of a health ethicist’s role is to promote ethical decision-making within hospital and healthcare settings, and to consult with patients,

\textsuperscript{36} Ibid at 230.
\textsuperscript{37} Ibid at 231.
\textsuperscript{39} Bassel, ibid at 526.
families, health practitioners and administrators on “clinical patient-specific ethics issues.”

The duty of a health ethicist is “not to advocate for any particular stakeholder, but rather serves as an advocate for fair decision-making processes and the creation of a thriving moral community.” Thus, ethicists are trained to weigh and balance the ethical and moral concerns of both physicians and patients, or SDMs, with regards to whether treatment should be withheld or withdrawn.

Of course, the health ethicists sitting on the panel must not be employed or in any way affiliated with the hospital or healthcare provider responsible for treating the patient. Ideally the ethicist will come from an academic background to avoid any biases in favour of the medical profession infecting the decision.

I have excluded lawyers from being members of the TDB as all members of the TDB should be well versed in the law involving treatment disputes. Indeed, as is the current practice with CCB members, the members of the TDB will participate in an intensive training program, including: undertaking a classroom-based training program provided by senior members of the TDB and legal counsel, observation of TDB hearings, and participation in mock training hearings. All members of the TDB will also partake in annual education sessions, designed to keep members up to date with developments in the relevant law, and reinforce their knowledge and skill base.

It is difficult to estimate the precise volume of cases that the TDB will likely hear. Chidwick and colleagues revealed an average of five end-of-life futility cases were heard

---

41 Ibid at 38.
42 It is interesting to note that in some US states a hospital’s ethics committee has the final say where there is a treatment dispute between a physician and a patient or patient’s surrogate decision-maker, such as in Texas via the Texas Advance Directive Act Texas Health and Safety Code Ann §166.046(a) (West 1999).
43 At the inception of the TDB the senior members of the CCB will help with TDB training.
45 Ibid.
by the CCB annually between 2009 and 2012. However, because the TDB’s jurisdiction will also cover futility disputes outside the end-of-life context, non-futility treatment disputes and medical disputes involving competent patients, I anticipate the TDB’s workload to significantly exceed the number of end-of-life futility cases presently heard by the CCB. It is unlikely that the number of cases before the TDB will match the volume heard by the CCB, which in 2011/2012 amounted to 2797 hearings. The high volume of cases heard by the CCB reflects its broad mandate to deliberate a wide range of issues relating to mentally disordered and disabled patients.

I envisage that the smaller number of cases heard by TDB, compared with the CCB, will make it possible for the TDB panel to consist of at least a three members at all times, or five members where a case is considered particularly difficult. By contrast, the CCB may at times consist of only one member, presumably in order to work through its large caseload. Finally, each TDB panel must contain at least one physician, one ethicist and one layperson at any given hearing to ensure the panel has the requisite medical and ethical expertise to determine the dispute.

### 3.3 Change in procedure

The Rules of Practice adopted by the CCB are adversarial in nature. The CCB’s processes do not mirror exactly the strict rules of civil procedure that govern court proceedings. However, the processes promote an adversarial environment by mandating a strict order of appearance, which encourages a party to address and rebut the evidence and arguments that the opposing party has just tendered, and by allowing for cross-examination and re-examination of witnesses. This adversarial process promotes an “us versus them” attitude that stands in marked contrast to the purpose of

---

46 Paula Chidwick, Robert Sibbald & Laura Hawryluck, "Best interests at end of life: an updated review of decisions made by the Consent and Capacity Board of Ontario" (2013) 28 J Critical Care 22 at 23 [Chidwick – Best Interests].

47 CCB Annual Report 2012, supra note 44.


the HCCA to “promote communication and understanding between health practitioners and their patients or clients.”

The CCB Rules of Practice may also harm the doctor-patient relationship. Health practitioners may become intimidated by the CCB’s court-like processes and become overly defensive of their own judgment or hostile towards SDMs who set out to discredit their medical judgment. Similarly, patients or their families may feel like their values, beliefs and wishes are being undermined if tested through cross-examination. Importantly, the adversarial environment prevents the patient or the patient’s family seeing the physician as a caring and compassionate advocate acting in the patient’s best interests. Hence, the adversarial processes may cause irreparable harm to the physician’s relationship with the patient and the patient’s loved ones.

Therefore, I suggest that the TDB adopt a more inquisitorial model. Like the CCB, the HCCA will direct that the TDB has statutory discretion to develop its own rules of procedure in accordance with the Statutory Powers Procedures Act 1971 (the SPPA). The SPPA provides that statutory tribunals adopt court-like adversarial procedures, but tribunals are able to use discretion to tailor rules of procedure to “ensure the just, most expeditious and cost-effective determination of every proceeding on its merits.” Thus statutory tribunals such as the TDB have discretion to formulate rules in consonance with an inquisitorial frame so long as the rules comply with the standards of fundamental justice and procedural fairness.

The benefits of an inquisitorial model over an adversarial model are that it typically allows for a more efficient hearing, and the outcome is less dependent on the resources of the party. There is also less reliance on cross-examination and re-examination.

---

51 HCCA, supra note 3, s 1(d).
52 Hoffman, supra note 50 at 155.
54 Ibid, s 25.1, s 2.
56 Ibid at 12.
Inquisitorial hearings empower tribunal members to determine the facts and issues in dispute, the type of evidence, and the order in which evidence is given.\textsuperscript{58} Hence, parties build their case in response to the targeted queries of the tribunal members, instead of presenting a case which, for the most part, is designed to undermine the views of the opposing parties. Therefore, by adopting inquisitorial processes, the TDB will help preserve the doctor-patient relationship by limiting the need for SDMs and physicians to vehemently discredit the other's opinions.

The TDB’s rules of procedure will observe the rules of natural justice, which include the right to a fair hearing, unbiased adjudication and, importantly, a fair procedure.\textsuperscript{59} These rights are protected through s 7 of the Canadian Charter of Rights and Freedoms.\textsuperscript{60} The common law also imposes a duty of fairness in administrative proceedings.\textsuperscript{61} The content of the duty of fairness differs depending on the nature of the decision, the rights, privileges or interests that are affected, the statutory scheme under which the decision is made, the legitimate expectations of the parties, and the procedural choices open to the tribunal that will allow it to achieve its mandate.\textsuperscript{62} At a minimum, the hearing must be fair and impartial and ensure “effective, expeditious and efficient decision-making.”\textsuperscript{63} In the past, the courts have found that an inquisitorial process

---

\textsuperscript{57} Ibid at 10.
\textsuperscript{58} Ibid.
\textsuperscript{59} Peter Hogg, “Constitutional Law of Canada” loose-leaf (consulted on 2013) (Toronto: Carswell, 2007) at para 47-21 (natural justice is a component of fundamental justice which is protected by s 7 of the Charter).
\textsuperscript{61} Knight v. Indian head school division no. 19, [1990] 1 SCR 653 at 654-655, 1990 CanLII 138 (SCC) (the duty of fairness will only be invoked with the circumstances satisfy three criteria:
\begin{enumerate}
\item the nature of the decision must be sufficiently administrative or quasi-judicial;
\item the relationship between the individual and the body must be based on a statutory exercise of power; and
\item the decision must affect the individual’s rights, privileges or interests).
\end{enumerate}
\textsuperscript{63} Halsbury Laws of Canada, “Administrative Law” (Markham, Ont: Lexis Nexis Canada, 2013) at para HAD-74 “Determining Content”.}
allows for fair adjudication of individual rights so long as a high degree of procedural protection can be tailored to fit the informal and investigatory nature of the hearing.\textsuperscript{64}

Arguably, the subject matter of treatment disputes – i.e. the life of the patient – demands that strict civil procedure rules be followed to satisfy concerns regarding a fair process. However, the goal of the TDB is to not to decide which party – the physician or the patient/SDM – is right or wrong; instead, the TDB must determine whether treatment is in the patient’s best interests and if so, what form that treatment should take. The TDB must therefore take an investigatory role in the hearing to deduce from the polarized arguments before it whether treatment is in the patient’s best interests. An inquisitorial model will best ensure the TDB achieves its mandate to arrive at a decision that will enhance the patient’s overall well-being.

In my view, the recently reformed procedures adopted by Ontario’s Human Rights Tribunal (OHRT) provide a procedural model that could be embraced by the TDB.\textsuperscript{65} The process applied by the OHRT is set out under its Rules of Procedure, which have been formulated in consonance with the Human Rights Code.\textsuperscript{66} The Code provides that the SPPA’s adjudicative-style rules \textit{prima facie} apply to the proceeding, but it is open to the OHRT to:

- adopt practices and procedures, including alternatives to traditional adjudicative or adversarial procedures that, in the opinion of the Tribunal facilitate fair, just and expeditious resolutions of the merits of the matters before it.\textsuperscript{67}

These provisions grant the OHRT authority to dictate its own hearing procedures in an inquisitorial manner. Using this authority, the OHRT has given itself discretion under its Rules of Procedure to: define the issues to be decided at the hearing, direct the order in which issues and evidence will be considered at the hearing, request provision of records or other documents for examination if it believes such evidence is pertinent, direct a party to adduce evidence or produce a witness, question a witness, and limit the evidence or submissions on any issue.\textsuperscript{68}

\textsuperscript{64} See: \textit{Thamotharem v Canada (Minister of Citizenship and Immigration)}, 2007 FCA 198, [1008] 1 FCR 385.
\textsuperscript{65} Ontario, Human Rights Tribunal, \textit{Rules of Procedure} [OHRT Rules].
\textsuperscript{66} Human Rights Code, RSO, 1990, c H19.
\textsuperscript{67} \textit{Ibid}, s 41-42.
\textsuperscript{68} \textit{OHRT Rules, supra} note 65, r 1.7.
The TDB should be given the same powers as the OHRT to shape how the hearings are conducted. At a minimum, both the patient, or SDM, and the treating physician should be afforded an opportunity to present written and oral submissions before the TDB. The TDB members will then be expected to engage with each party’s arguments by asking questions based on information, or the absence of information, before them. The parties will have automatic right to provide any evidence pertaining to the patient’s best interests, including information about the patient’s medical condition or the patient’s beliefs and wishes regarding treatment. The treating physician must provide a copy of the full medical records of the patient. Any other evidence will be allowed only at the discretion of the TDB. Additionally, any right to call, examine or cross-examine witnesses will be allowed only at the discretion of the TDB, based on witness statements submitted to the TDB prior to the hearing. Ultimately, the TDB should be granted sufficient discretion to enable it to make an informed and fair decision, and to decrease animosity between the physician and the patient, or SDM.

Nevertheless, there are some aspects of the CCB’s Rules of Practice that the TDB should adopt. Once the TDB has received an application it must, within seven days, fix a time and place for a hearing, unless the parties agree to a postponement. This will ensure that treatment disputes - which may involve life or death situations - are considered promptly. The treating physician and the patient, or SDM, will be parties to the hearing by right. Any other individual or body must have permission from the TDB to obtain party status. The TDB must release its decision to each party within 24 hours of the hearing, and if any party requests the reasons for the decision within 30 days of the hearing, the TDB must issue written reasons to each party.

### 3.4 Right of appeal

Any party to a CCB hearing has an automatic right to appeal the CCB’s decision to Ontario’s Superior Court of Justice. Nevertheless, on appeal the Court will defer to the CCB’s findings “unless it is unreasonable in light of the finding of fact on which it is

---

69 *HCCA, supra* note 3, s 80. See for example: *Scardoni v Hawryluck* (2004), 69 OR (3d) 700, 12 Admin LR (4th) 67 (ON SC) [*Scardoni*]. Chidwick Best Interests, *supra* note 44 (on average over a quarter of the cases bought before the CCB regarding end-of-life decision-making are appealed, at 23).
based or dependent on an incorrect determination of a question of law.” In *T(I) v L(L)*, Ontario’s Court of Appeal cited among its reasons for deferring to the opinion of the CCB the need for expeditious decision-making and the desirability that delay caused from appeals should be avoided. In short, the Court will not review the merits of the CCB’s decision unless unreasonable or based on an incorrect legal finding.

In *Rasouli SCC*, the treating physicians criticized the automatic right of appeal from a CCB’s judgment. They asserted that the CCB was not expeditious because its decisions are frequently followed by an appeal to Ontario’s Superior Court of Justice and “[i]n this result, these cases routinely take months to resolve.” Indeed, it is questionable whether an automatic right of appeal is warranted if in most cases an appeal will lengthen the dispute rather than overturn the CCB’s decision.

Moreover, the unfortunate reality of appealing futility disputes in the end-of-life context is that the patient frequently dies before the appeal is decided. As Joaquin Zuckerberg states: “[w]aiting for an appeal to be heard will inevitably keep the status quo and sometimes defeat the effect of the decision of the tribunal, as patients may be suffering pain or simply may not survive the appeal period.” Even if abandoned, the appeal has a high cost attached to it. For every day the decision to withdraw life-support is delayed, the public health system spends roughly CAD$3000 to maintain the patient in the ICU. If the appeal is not abandoned, it will take an average of three to four months for the court to give its ruling. Hence, the average CCB appeal costs CAD$360,000 per patient. At the time of writing, Ontario has spent approximately CAD$4 million on life-sustaining treatments to accommodate eleven end-of-life CCB appeals. Only once has

---

70 *Scardoni*, *ibid* at para 35.
71 *T(I)*, *supra* note 29 at para 21(c).
72 *FOA*, *supra* note 19 at para 101.
the Court overturned the CCB’s decision and it was on a point of law, not a factual finding.\textsuperscript{80}

The cost of CCB appeals is not only fiscal in nature. Treating physicians and other health practitioners in the ICU will have to spend time preparing for the court hearing, which may reduce the time they are able to spend doing their job. They will also be subject to the emotional strain of being part of the litigation process where their professional judgment and integrity may be called into question. Moreover, the patient is unlikely to benefit greatly from the appeal process because of the low probability that the Court will overturn the CCB’s decision.

I therefore propose that parties will not have an automatic right to appeal a TDB decision. Instead, a party must seek leave to appeal a TDB judgment from Ontario’s Superior Court of Justice.\textsuperscript{81} In keeping with the current practice for CCB appeals, a TDB decision may be appealed on a question of law or fact, and an application for leave to appeal must be made within seven days of the TDB releasing its decision. The decision of the TDB will be stayed while the Court considers the application for leave to appeal.

By removing the automatic right of appeal, the rights of the parties to fundamental justice and fair process will be upheld. The parties will still be able to appeal the decision of the TDB, but only where the party is able to show that there is a \textit{prima facie} case to argue that the TDB has made an unreasonable finding of fact or an incorrect determination of law. This is after all currently the standard an appellant party has to prove to successfully appeal a CCB’s decision. Tightening the capability of a party to appeal a TDB decision will ensure that the appeal process does not unnecessarily prolong the dispute at the expense of the healthcare system.

3.5 Compliance with CCB’s decision

At present, a SDM’s consent is still required even if the CCB has rendered a decision that life-sustaining treatment must be withdrawn. If a SDM refuses to comply with the CCB’s

\textsuperscript{80} Scardoni, supra note 69 at para 35.

\textsuperscript{81} Leave to appeal will be granted in accordance with \textit{Rules of Civil Procedure}, RRO, Reg 194, r 61, (1990).
order to consent to withdraw or withhold treatment, the physician must work through
the hierarchy of SDMs to find one that will give consent.82 The CCB cannot order that
treatment be withdrawn or removed, even though this result is inevitable if the
physician is forced to ask the Public Guardian and Trustee for consent where no consent
is forthcoming from any other SDM. Therefore, once the CCB has reached a decision,
further consent from the SDM is illusory.

In contrast, the TDB’s decision will be immediately binding on the parties. The decision
of the TDB will take effect once it has been released and the parties must act in
accordance with its directions. The TDB will have powers to put conditions on the
decision, for example a decision to withdraw life-support may not take effect for a
certain period of time to allow for loved-ones to say goodbye to the patient. Nonetheless, the immediately binding effect of a TDB decision will reduce the
physician’s burden of having to find and contact alternate SDMs whose authority will
not alter the patient’s fate.

4 Five Consequences

My recommendations have five consequences worthy of mention. First, the procedural
solution I have offered balances the concepts of medical futility and personal autonomy.
This balance is achieved via the s 3(4) criteria for resolving treatment disputes, which
demand that the decision-makers consider both the physician’s opinion and the
patient’s views regarding whether the treatment will benefit the patient. Ultimately, the
criteria are designed to ensure that the patient’s best interests are paramount.

Striking a statutory balance between personal autonomy and medical futility in the way
I have proposed will promote the delivery of public healthcare services in a manner
satisfactory to the state, health practitioners and patients. The state will be assured that
patients are not making expensive and disproportionate demands on the healthcare
system but at the same time, an individual’s right to access a reasonable level of
healthcare services commensurate to their needs is protected. Health practitioners will
benefit from having a legal platform that helps preserve their duty to administer

82 HCCA, supra note 3, ss 37(6)-(6.1).
treatment according to professional standards and ethical obligations. Lastly, patients will be assured that any healthcare decision made on their behalf is consistent with their best interests and will take into account their personal views, as well as their medical needs.

The second consequence is that by providing that treatment is futile only by agreement, the amendments encourage treating physicians to clearly communicate with the patient, or SDM, about the patient’s ongoing medical care. Futility disputes, at least in part, arise from ineffective communication by the physician about the patient’s clinical status. Indeed, it has been estimated that less than half of SDMs properly comprehend clinical information and the consequences of the treatment options proposed. In other words, many good physicians are bad communicators. Therefore the requirement that the physician and patient, or SDM, agree that treatment is futile incentivizes physicians to substantively engage with the patient, SDM or the patient’s loved ones about the patient’s diagnosis and prognosis, the treatments available for the patient and the burdens and benefits of each treatment. In this sense, my proposed standard of medical futility in the HCCA works to prevent futility disputes from occurring.

The onus on physicians to consult with patients and their loved ones and respect their views is already a central component of a physician’s ethical and professional obligations. The College of Physicians and Surgeons of Ontario’s policy statement on decision-making for the end-of-life states that a physician must engage in early discussions about the diagnosis and prognosis of the patient, and the benefits and burdens of treatment. The physician should “advocate for meaningful and/or realistic goals of care” but should also, where appropriate, help patients and families “cope with

---

83 Pope, supra note 16 at 218
84 Rasouli SCC, supra note 4 (Karakatsanis J, in her dissenting opinion, emphasized it was part of a physician’s fiduciary duty to “consult the patient (or the patient’s substitute decision-maker) in arriving at a decision regarding what constitutes the patient’s best interests in the circumstances” at paras 190-191)
physical, psychological, social and spiritual needs.”\textsuperscript{86} As part of the process in trying to reach an agreement on futility the physician will also be obliged to seek secondary medical opinions if requested, and make efforts to transfer care to another institution that is willing to continue treatment.\textsuperscript{87} Thus, my proposition that all parties agree on a finding of futility ensures physicians do not make short shrift of their professional obligations to consult with the patient or patient’s SDM.

The third noteworthy consequence of my proposals is that they clarify the law surrounding whether a patient’s prior known wishes could compel a physician to provide futile treatment indefinitely. Recall that under s 21(1) a SDM must give or refuse consent to a treatment in accordance with a patient’s prior known wishes.\textsuperscript{88} The effect of my amendments is that withholding or withdrawing futile treatment does not fall within the definition of ‘treatment’ under the HCCA. It follows that where the SDM and physician agree further medical intervention is futile, the SDM is not bound to follow the patient’s prior known wishes because these wishes only bind the SDM so far as ‘treatment’ decision are concerned.

Some may argue that this consequence will undermine the value the patient places on being able to express a wish for future care in the event of incapacity. A prior known wish is a clear extension of the patient’s autonomy when the patient is incapacitated and allowing physicians or SDMs to ignore a prior known wish depreciates the patient’s autonomy. In turn, individuals may not trust that in the event of incapacity the healthcare system will provide medical care in way that respects their mental or bodily integrity.

Nevertheless, in my view, a patient’s prior known wishes should only be determinative if they are reasonable and appropriate in the circumstances. The patient’s autonomy \textit{qua} her prior known wish should not allow the patient to make demands for treatment that is futile and provides no health benefit to the patient. The patient’s autonomy must be respected but only in the communitarian sense, where the patient’s choices may be

\textsuperscript{86} \textit{Ibid.}
\textsuperscript{87} Rasouli SCC, supra note 4 at para 204.
\textsuperscript{88} HCCA, supra note 3, s 21(1).
constrained by the interests of the state (i.e. fair resource allocation) and others (i.e. a cardiac patient who needs an ICU bed). Hence, a patient should still trust that the physician and SDM will adhere to any prior known wish but only if the wish is reasonable, proportionate and directed to achieve a health benefit.

The fourth important consequence of my recommendations is that they serve to protect the value and meaning of personal autonomy. My amendments to the HCCA require the SDM to consider evidence about the patient’s beliefs and wishes regarding treatment held when competent when making a futility determination under s 3(3). Therefore, the patient’s autonomy will only be relevant to determining whether treatment is futile if there is some evidence of the patient’s autonomous choices specifically in relation to the proposed treatment. Of course, in some cases it will be enough that the SDM recalls a conversation with the patient regarding whether she would choose to have the proposed treatment or a similar treatment. It is not realistic that the SDM produce indisputable, hard evidence of a patient’s beliefs and wishes as most conversations between loved ones about life and death occur informally and privately. However, a SDM will not be able to rely on a general belief or value held by the patient to argue that the patient would have wanted a specific treatment. For example, the criteria will not be satisfied if the SDM argues a patient is Roman Catholic and therefore would want life-support provided indefinitely. The SDM would still have to cite specific evidence that the patient wanted her life to be prolonged at all costs.

The purpose of this requirement is to prevent SDMs from transposing their own views as those of the patient. The incapacitated patient and SDM may share a general belief - e.g. they are both Roman Catholics - but this does not mean that they share the same specific beliefs - e.g. that a person’s life should be artificially maintained as long as possible. Under the present best interests test, a SDM can draw an inference from a general value or belief held by the patient regarding the patient’s treatment choices. Indeed, in Rasouli SCC, evidence was tendered that, to Muslims “life is sacred. A person is entitled to remain alive until all signs of life are gone. Preventable death must be prevented.” Therefore, it was assumed that Mr Rasouli, as a Muslim, must want mechanical ventilation and tube-feeding to continue. By contrast, in the case of SWeiss v FOR, supra note 22 at para 16.
Alberta Health Services, it was argued that according to the Islamic faith, life-support could be withdrawn when the brain starts to disintegrate, even if there are still some signs of life, such as a heartbeat. On this interpretation, it could be inferred that Mr Rasouli would want life-support to be discontinued given he had suffered “extensive death of brain tissue.” These cases illustrate that an incapable patient’s general beliefs may not reflect the views of the patient regarding treatment. Instead, general beliefs are open to manipulation by the SDM seeking to support her own opinion on whether treatment should be provided. As discussed in Chapter Two, there is a significant chance that the views of the SDM will not align with the views the patient would have held if competent. Therefore, my proposals will ensure that in treatment decisions involving incapacitated patients, the patient’s autonomy will only be relevant where there is evidence of the patient’s specific choices regarding the treatment. This will help ensure the personal views of the SDM, disguised as those of the patient, do not trump the true views of the patient or those of the medical profession in the decision-making process.

The fifth important consequence of my proposals is that they reduce the incentive for physicians to formulate a plan of treatment that gives them full discretion to withdraw or withhold treatment as occurred in the case of Cefarelli v Hamilton Health Sciences (discussed in the previous chapter). The statutory standard of medical futility I have recommended provides physicians with a legal basis to argue that treatment does not provide a health benefit and therefore it is inappropriate to provide it. This statutory recognition of medical futility, together with the physician’s ongoing duty to consult clearly and substantively with the patient or SDM, will reduce the physician’s inclination to manipulate a plan of treatment in their managerial favour.

Evaluation

The recommendations I have proposed above resolve the problem of medical futility in two ways. First, they help prevent futility disputes from erupting. By requiring physicians and SDMs or patients to agree whether treatment is futile, I have created an

---

90 *Sweiss, supra* note 24 at Appendix 2.
91 *FOR, supra* note 22 at para 11.
92 *Cefarelli v Hamilton Health Sciences*, 2013 ONCA 413 (CanLII).
incentive for physicians to engage substantively and clearly with patients and SDMs from an early stage in the patient’s care. Second, I have established a comprehensive procedural solution for resolving futility disputes. This procedural solution arms the decision-making parties with clear legislative criteria to assess whether treatment is futile. In the event there is an intractable disagreement between the parties, the dispute will be heard by the TDB, which is purposed to find a solution that foremost protects the patient’s best interests.

My recommendations are not designed to resolve futility disputes only in the end-of-life context involving incapacitated patients. It is possible that a futility dispute will arise between a physician and a competent patient. The legal criteria I have proposed can be applied more broadly to resolve other forms of treatment disputes. The establishment of the TDB will help relieve the courts of having to make many complex and expert medical decisions. Nevertheless, if the case presents a complex question of law, such as a Charter concern, the parties may seek leave to appeal.

Critically, my recommendations strike a balance between the concepts of medical futility and personal autonomy in the healthcare context. Entrenching a standard of medical futility in statute makes salient the problem that healthcare resources are sometimes being deployed in an inefficient and ineffective manner. It dispels any mythical suggestion that Canada’s healthcare system is capable of funding all and any treatment a patient demands for an indefinite period of time. Yet, the procedural safeguards work to ensure that recognition of medical futility is not occurring at the expense of patient rights. Physicians will not be able to act on a finding of futility unless the patient or SDM, having considered medical implications of treatment and the patient’s beliefs and wishes regarding treatment, agree with the physician’s opinion.

It remains to be seen whether Ontario’s legislature will make amendments to the HCCA akin to what I have proposed so as to clarify the law surrounding futility disputes. If the status quo remains then the courts will continue to be faced with futility disputes; Rasouli SCC will do little to stem this tide of cases.\(^93\) Alternatively, physicians may begin

\(^{93}\) Ackie, supra note 11.
to assert that *Rasouli SCC* provides authority for them to withdraw treatment that is harmful to the patient, regardless of whether the treatment is in the patient’s view producing a benefit. The legal indeterminacy in futility disputes cries out for a practical statutory solution in the manner that I have outlined.
Conclusion

I posed a question at the beginning of this paper whether there is a future for medical futility in Ontario? This is an important issue as the provision of futile treatment: will not produce a health benefit for the patient and may even cause the patient more harm; contributes to the escalating annual cost of Canada’s public healthcare system; undermines the ethical and professional responsibilities of physicians; and absorbs scarce public healthcare resources which could be utilized more effectively elsewhere in the public healthcare system. These negative impacts are heightened in the end-of-life context where life-sustaining treatments are particularly expensive and invasive. Yet, futile treatment is a product of influences within Canada’s public healthcare system itself. Modern medical advances, the fee-for-service reimbursement model and the states failure to fund universal residential and palliative care programs, all contribute to the concerning volume of futile treatment being provided to patients. Moreover, patients or substitute decision-makers (SDMs) are demanding access to medical care in the hope it will provide a cure despite a physician’s prognostication that it will not. In turn, physicians are increasingly acquiescing to these demands to mitigate the threat of accusations of malpractice. To stymy the influence of these futility-drivers and reduce the harm caused by futile treatment, law reform is required to articulate what is futile treatment and when it is legally permissible to withdraw or withhold such treatment.

Legal intervention is hampered by controversy surrounding the meaning of medical futility. A finding of futility requires consideration of whether the treatment provides a health benefit to the patient, and what counts as a ‘benefit’ is a value-laden judgment. If futility decisions are considered only from the perspective of physicians, then a decision to withdraw treatment may depend on the incorrect, discriminatory or overly paternalistic views of the treating physician. Thus, I have argued it is preferable for any legal standard of medical futility to be based on medical evidence of the physiological effects of treatment, as well as the patient’s subjective views, if known, as to whether treatment is achieving a health benefit. If the patient’s views are not known, and the SDM and the physician cannot agree whether treatment is futile, then it should be left to a quasi-judicial, specialized tribunal – namely, the Treatment Dispute Board (TDB) to determine whether further treatment is in the patient’s best interests.
Nevertheless, any legal recognition of medical futility may still be resisted, regardless of its form, because of the dominance of the principle of personal autonomy in the medico-legal arena. Personal autonomy safeguards a patient’s right to make reasoned decisions for herself based on personal values, beliefs and wishes. In some cases, a patient’s intractable spiritual or secular views, expressed personally or through a SDM, will compel her to want treatment even when the objective probability of the treatment improving her condition is extremely low or non-existent.

In this paper, I have argued that personal autonomy should not empower a patient or SDM to demand any or all treatment they desire. Rather, personal autonomy should be recognized in a narrow, communitarian manner, which holds that individual choice may be circumvented by other compelling interests, such as the state’s interest in preserving the integrity of the medical profession. Ultimately, any delivery of public healthcare services must be aimed at promoting the patient’s best interests (unless, of course, the patient refuses consent to treatment). Thus, if a patient’s choices do not align with what is in her best interests then they may be discarded; especially if those choices would result in the inefficient use of scarce healthcare resource. The communitarian theory of personal autonomy supports the best interests model of delivering healthcare services by holding that a patient’s choices are valid in treatment decisions only if they reflect a health benefit for the patient.

Nevertheless, my discussion reveals that the influence of personal autonomy in the healthcare context has greatly expanded and has supremacy even when the patient is incapacitated. Under Ontario’s Health Care Consent Act 1996 (HCCA), the beliefs, wishes and values of an incapacitated patient are expressed through the patient’s SDM. However, research suggests that SDMs are frequently poor decision-makers for the patient as they fail to properly understand and consider the patient’s medical status when making proxy treatment decisions. In addition, there is a significant risk SDMs will make treatment decisions based on their own views, rather than those of the incapacitated patient, meaning that the patient may receive more or less treatment than they would have desired. The law should therefore adopt a cautious approach to accepting a SDM’s expression of the patient’s autonomy, especially where there is evidence that further treatment is futile and harmful to the patient.

My review of the common law demonstrates that the Canadian courts give primacy to personal autonomy above other considerations in medical decision-making. The courts are
reluctant to recognize medical futility if it conflicts with the patient’s views on treatment, including when expressed by the patient’s SDM. But the Canadian line of authorities involving futility disputes is unsettled. Some cases support the view that physicians have unilateral authority to withdraw treatment they deem to be futile and others hold that physician must get approval from the patient’s SDM or the court before withdrawing or withholding life-sustaining treatment. This piecemeal line of authorities indicates legislative intervention is desirable to settle the futility debate and articulate how medical futility and personal autonomy are to be balanced.

The Supreme Court of Canada was granted the opportunity to settle the debate in the case of Mr Rasouli. Unfortunately, the Supreme Court only added confusion to the law of medical futility. The issue before the Court was whether withdrawing life-support fell within the definition of ‘treatment’ under the HCCA so that a physician must obtain consent before discontinuing the treatment. McLachlin CJ, for the majority, found the withdrawal of Mr Rasouli’s life-support did fit within the definition and thus consent from Mr Rasouli’s SDM was required before his life-support was withdrawn.

The judgment left open the possibility, however, that a physician could without consent withdraw other forms of treatment, including other forms of life-sustaining treatment. McLachlin CJ reasoned that the ‘medical implications’ and the ‘harmful’ effects of a particular intervention would direct whether consent was required. This finding is a nod to the treating physicians’ concerns that defining ‘treatment’ to include the withdrawal of life-support would force physicians to indefinitely provide futile treatment contrary to their professional and ethical judgment and at a great expense to the public healthcare purse. But, McLachlin CJ did not clarify what sort of ‘harm’ or the kind of ‘medical implications’ that would justify a physician unilaterally withdrawing treatment. Therefore, I have predicted that futility disputes involving the withdrawal of interventions dissimilar to the treatment provided to Mr Rasouli will continue to come before the courts. In short, the majority judgment did not clarify the legal principles for resolving future futility disputes.

The majority decision in Rasouli was at least clear on one point, namely that personal autonomy must be a central feature in medical decision-making. However, in my view this is at the expense of other important considerations, such as whether the patient is actually receiving a health benefit from the expensive public healthcare resources being providing to
her. A patient’s values, beliefs and wishes are given priority in the decision-making process even where there is no evidence of the patient’s views aside from the opinion of the patient’s SDM. The Court’s confirmation of the dominance of personal autonomy left little room for consideration of the medical implications of maintaining Mr Rasouli’s life support.

It was also open to the majority to find that withdrawing life-sustaining treatment fell outside the definition of ‘treatment’ under the HCCA, such that the common law governed whether Mr Rasouli’s treating physicians could withdraw his life-support. Indeed, this was the approach adopted by the minority judges in the case. Karakatsanis J’s interpretation of the common law found that a physician has no legal obligation to provide treatment that in her clinical judgment is futile, albeit they have a duty to consult with the patient’s family regarding any proposal to withhold or withdraw treatment. If a patient or patient’s loved one disagrees with the physician’s assessment they can apply to Ontario’s Superior Court of Justice for a review of the decision.

In my view, the minority decision, like the majority decision, does not achieve an adequate balance between medical futility and personal autonomy in medical decision-making. Unlike the majority decision, however, the minority places too much weight on a physician’s finding of futility as a justification for withholding or withdrawing treatment. Therefore, a patient’s subjective wishes to receive treatment will have very little impact once a physician has decided to withdraw treatment. Moreover, the adversarial and expensive court system does not provide patients or their families an effective, expedient or inexpensive forum to dispute the physician’s findings.

In contrast to the confused state of Ontario’s law regarding medical futility, the United Kingdom’s courts and legislature have made a more definitive effort to establish a legal process for resolving futility debates. In the UK a physician cannot be compelled by the patient, the patient’s family or the courts to provide treatment which the physician believes is not in the patient’s best interests to receive. The UK legislature has endorsed this approach in the Mental Capacity Act 2005 (MCA). To protect patient’s rights from a physician’s inappropriate or inaccurate decisions, the patient’s family or SDM can apply to the Court of Protection, which was created specifically to resolve legal matters involving incapacitated individuals, including futility disputes and the withdrawal of treatment from a patient in a permanent vegetative state. The UK courts have also imposed a stringent duty on physicians
to consult with a patient’s family about end-of-life decisions. Overall, physicians, patients and their loved ones in the UK benefit from clear legal principles directing how futility disputes should be resolved.

The confused state of Ontario’s law regarding medical futility demands legislative attention. I have proposed two recommendations to clarify the law in Ontario. First, the definition of ‘treatment’ under the HCCA should be amended to exclude: any intervention that is withheld or withdrawn in circumstances where there is no reasonable probability it will create an effect that the patient is able to experience as a health benefit. This standard of medical futility may be applied when a patient is competent or incapacitated. When assessing whether a proposed measure satisfies the standard the treating physician must consider the medical evidence, the patient’s subjective beliefs and wishes regarding treatment, and whether treatment is in the patient’s best interests. These criteria ensure both the views of the patient and the physician are paramount considerations in the decision-making process. The treating physician will not be able to rely on the exclusion unless the patient or the SDM also agree, by taking account of the same criteria, that the treatment offers no health benefit. The requirement for agreement will encourage clear and substantive communication between the decision-making parties about whether treatment is in the patient’s best interests.

The formation of the TDB is my second recommendation. If no agreement can be reached between the treating physician and the patient, or SDM, as to whether treatment is futile, the treating physician will apply to the TDB for a determination. The TDB will have a specific mandate to adjudicate whether it is in a patient’s best interests that to prescribe a treatment, taking account of the views of the treating physician and the patient, if known. The members of the TDB will be physicians, ethicists or lay-people. This membership combination will ensure the TDB is equipped to understand complex medical evidence, as well as weigh the ethical and moral concerns of the medical profession, the patient and the patient’s loved ones. The sitting TDB panel will have authority to determine the facts and issues in dispute, the type of evidence, and the order in which evidence is given. It is hoped this inquisitorial approach will encourage efficient and expeditious hearings and discourage adversary between the parties at the hearing. Finally, there will be no automatic right of appeal from the TDB’s decision. Rather a party must seek leave to appeal on the basis the TDB’s decision was unreasonable because of a finding of fact on which it is based or an incorrect
determination of law. Restricting the right to appeal will ensure that the appeal process does not unnecessarily prolong futility disputes.

My proposed recommendations elevate medical futility as an important consideration in treatment decisions made on behalf of an incapacitated patient. At the same time the amendments guarantee a patient’s beliefs and wishes regarding treatment are not overlooked in the decision-making process. Importantly, the amendments encourage decision-makers to agree on a course of medical care that will be in the patient’s best interests.

In sum, legal recognition of medical futility is not an attempt to deny individuals access to medicine. Death is, after all, an inevitable consequence of life. Granting patients full and indefinite access to healthcare resources will not starve off death. Medical futility simply gives expression to a physician’s views whether medical care is achieving a health benefit. As a legal tool it helps direct public healthcare resources in a way that ensures maximum health benefits for the most people. I hope that legal recognition of medical futility will encourage society to accept there is an end to the power of medicine. As the ancient Hippocratic tradition holds: “whenever the illness is too strong for the available remedies the physician surely must not even expect that it could be overcome by medicine”.¹

BIBLIOGRAPHY

DOMESTIC LEGISLATION


Canada Health Act, RSC, 1985, c C-6.


Personal Directives Act, RSA, 2000, c P-6.


FOREIGN LEGISLATION


Human Rights Act 1998 (UK), c 42.

Iowa Admin Code § 641-85.3(1) 2008.

Mental Capacity Act 2005 (UK), c 9.


DOMESTIC JURISPRUDENCE


Ackie et al v Manocha, 2014 ONSC 669 (available on CanLII).


A W (Re) 2004 CanLII 48655 (ON CCB).


Carter v Canada (Attorney General), 2012 BCSC 886 (available on CanLII).

Cefarelli v Hamilton Health Sciences 2013 ONCA 413 (available on CanLII).


Children’s Aid Society of Ottawa-Carleton v MC (2008), 301 DLR (4th) 194 (CanLII) (ON SC).


Fleming v Reid (1991), 4 OR (3d) 74, 82 DLR (4th) 298 (ONCA).

Golubchuk v Salvation Army Grace General Hospital et al, 2008 MBQB 49 (CanLII), 227 Man R (2d) 290.

Hill v Church of Scientology of Toronto, [1995] 2 SCR 1130, 24 OR (3d) 865.


London Health Science Centre v RK (1997), 152 DLR (4th) 724 (available on CanLII) (ONSC).

M (A) v Benes, 1999 CanLII 3807 at para 36, 46 OR (3d) 271 (ONCA).

Malette v Shulman, 72 OR (2d) 417, 67 DLR (4th) 321 (ONCA).


R v Morgentaler, [1988] 1 SCR 30, 63 OR (2d) 281.


R (on the application of Nicklinson and Anor) v Ministry of Justice, [2013] EWCA Civ 961, [2014] 2 All ER 32

Rasouli v Sunnybrook Health Sciences Centre, 2011 ONSC 1500 (available on CanLII), 105 OR (3d) 761.

Rasouli v Sunnybrook Health Sciences Centre, 2011 ONCA 482, 107 OR (3d) 9.

Re D, 2005 CanLII 57868 (ON CCB).

Re DD, 2013 CanLII 18799 (ON CCB).

Re E, 2009 CanLII 28625 (ON CCB).

Re Grover, 2009 CanLII 16577 (ON SC).

Re HJ, 2003 CanLII 49837 (ON CCB).

Re IHV, 2008 ABQB 250 (CanLII), 449 AR 211.

Re LIC, (Dependent Adult), 2006 ABQB 130 (available on CanLII).

Re N, 2009 CanLII 42576 (ON CCB).

Re TC, 2011 CanLII 12485 (ON CCB).

Reibl v Hughes, [1980] 2 SCR 880 at 891, 114 DLR (3d) 1.


Roach v Canada (Minister of State for Multiculturalism and Citizenship), [1994] 2 FC 406, 113 DLR (4th) 67.


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


Scardon v Hawryluck, 2004 CanLII 32326, 69 OR (3d) 700 (ONSC).


Stoffman v Vancouver General Hospital, [1990] 3 SCR 483, 76 DLR (4th) 700.

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

T(I) v L(L) (1999), OJ No 4237 (available on CanLII), 46 OR (3d) 284 (ONCA).


W (By her litigation friend, B) v M (by her litigation friend, the Official Solicitor) [2011] EWHC 2443 (Fam), [2012] 1 WLR 1653.

Wakeford v Canada 166 DLR (4th) 131, 55 CRR (2d) 56.
FOREIGN JURISPRUDENCE

Aintree University Hospitals NHS Foundation Trust v James, [2013] UKSC 67, [2014] 1 All ER 573.


Pretty v United Kingdom (App 2346/02), (2002) 35 EHRR 1, [2002] 2 All ER (D) 286.

Primary Care Trust v CW, [2010] EWHC 3448 (Fam).


Schloendroff v the Society of New York Hospitals 211 NY 125, 105 NE 92 (1914).


INTERNATIONAL MATERIALS


SECONDARY MATERIALS

TEXTS


Dodge, David & Richard Dion. Chronic Healthcare Spending Disease: A Macro Diagnosis and Prognosis (Toronto: C D Howe Institute, 2011).


Drummond, Don & Derek Burleton. Charting a Path to Sustainable Health Care in Ontario: 10 Proposals to Restrain Cost Growth without Compromising Quality of Care (Toronto: TD Financial Group, 2010).


Hoffman, Brian. The Law of Consent to Treatment in Ontario, (Markham, Ontario: Butterworths, 1997).


**ARTICLES**


Bishop, Jeffrey et al, "Reviving the Conversation around CPR/DNR" (2010) 10:1 AJOB 61.

Bramstedt, Katrina. “Questioning the decision-making capacity of surrogates” (2003) 33 Internal Med 257


Bulak, Begum & Alain Zysset. "'Personal autonomy' and 'Democratic Society' at the European Court of Human Rights: Friends or Foes?" (2013) 2 UCLJLJ 230.


de Zulueta, Paquita & Francesco Carelli. “Permanent vegetative state: comparing the law and ethics of two tragic cases from Italy and England” (2009) 2 LJPC 125.
Evans, Robert G. “Don’t believe claims Medicare is becoming unaffordable” (2010) 17(3) The CCPA Monitor 1.
Harmon, Louise. "Falling of the Vine: Legal Fictions and the Doctrine of Substituted Judgment" (1990) 100 Yale LJ 1
Miles, Steven H. "Medical Futility" (1992) 20 L Med & Health Care 310.
Schneiderman, Lawrence. "Defining Medical Futility and Improving Medical Care" (2011) 8 Bioethical Inquiry 123.


NEWSPAPER ARTICLES


Mandel, Michelle. “Doctors do not have ultimate say on life-support: Supreme Court” (18 October 2013) online: Toronto Sun <http://www.torontosun.com/2013/10/18/supreme-court-to-rule-on-life-support-case>.


ONLINE MATERIALS


Canadian Association of Radiologists, Do you need that scan? (2009), online: <http://old.car.ca/Files%5C200903_Do_you_need_that_scan.pdf>.


Canadian Institute for Health Information, Health Care in Canada 2004 (2005), online: <https://secure.cihi.ca/free_products/hcic2004_e.pdf>.


Handelman, Mark. “Consent to Withdrawal of Life-support: What the Supreme Court Said in Cuthbertson and Rubenfeld v Rasouli”, online: Whaley Estate Litigation <http://whaleyestatelitigation.com/resources/WEL_What_the_Supreme_Court_Said_In_Cuthbertson_and_Rubenfeld_v_Rasouli.pdf?sfvrsn=0>.


Zucker, Marjorie & Howard Zucker, eds. Medical Futility and the Evaluation of Life-Sustaining Interventions (Cambridge University Press, 2013), online: <http://dx.doi.org/10,1017CBO9780511530227.015>.

OTHER
Interview of Claudia Wong by Catherine Deans (9 April 2014).