Wills & Estates
Fall Term 2022

Lecture Notes No. 2

SUBSTITUTE DECISION-MAKING

5. Court-Appointed Guardians and POA Litigation

Chu v. Chang
2010 ONSC 294 (Ont. S.C.J.); cb, p.1051

Read this case for the depth of the factual analysis by which the Court determines whether a guardianship should be terminated and the need for an accounting.

6. Personal Care

Rasouli (Litigation Guardian Of) v. Sunnybrook Health Sciences Centre
[2013] 3 SCR 341 (S.C.C.); cb, p.1062

McLachlin C.J.C.

> **G. Resolving Disagreements Over Withdrawal of Life Support**
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> 77 Having rejected the physicians' arguments, it follows that the consent regime imposed by the HCCA applies in this case. I earlier outlined that regime. At this point, it may be useful to discuss in greater depth the role of the substitute decision-maker, health practitioners and the Board in cases like this.
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> **78 To recap, the HCCA** [Health Care Consent Act] **is a carefully tailored statute. It deals with patients capable of consent and patients who no longer have the power to consent. It seeks to maintain the value of patient autonomy — the right to decide for oneself — insofar as this is possible. This is reflected in the consent-based structure of the Act. If the patient is capable, she has the right to consent or refuse consent to medical treatment: s. 10(1)(a). If the patient is incapable, the HCCA transfers the right of consent to a substitute decision-maker, often next of kin (s. 10(1)(b)), who is required to act in accordance with the patient's declared applicable wishes or failing that, the patient's best interests: s. 21. Finally, it provides that a physician may challenge a substitute decision-maker's consent decision by application to the Board: ss. 35 to 37. The physician may make submissions to the Board regarding the medical condition and interests of the patient. If the Board finds that the substitute decision-maker did not comply with the HCCA, it may overrule the substitute decision-maker and substitute its own opinion in accordance with the statute: s. 37(3). To be clear, this means that, even**

in life-ending situations, the Board may require that consent to withdrawal of life support be granted.

79 Under the HCCA, the substitute decision-maker does not have carte blanche to give or refuse consent. He or she must comply with the requirements of s. 21 of the Act, which contemplates two situations. The first is where the substitute decision-maker knows of a prior expressed wish by the patient which is applicable to the circumstances. The second is where there is no such wish, in which case the substitute decision-maker "shall act in the incapable person's best interests".

(1) Prior Expressed Wishes

80 If the substitute decision-maker knows of a prior wish regarding treatment that the patient expressed when capable and over 16 years old, and that is applicable in the circumstances, the wish must be followed: s. 21(1). This reflects the patient's autonomy interest, insofar as it is possible.

81 While the HCCA gives primacy to the prior wishes of the patient, such wishes are only binding if they are applicable to the patient's current circumstances. This qualification is no mere technicality. As the Ontario Court of Appeal held in *Conway v. Jacques* (2002), 59 O.R. (3d) 737 (Ont. C.A.), at para. 31:

> **... prior capable wishes are not to be applied mechanically or literally without regard to relevant changes in circumstances. Even wishes expressed in categorical or absolute terms must be interpreted in light of the circumstances prevailing at the time the wish was expressed.**

82 Needless to say, where an incapable patient has expressed a prior wish that life support not be withdrawn, the intended meaning and scope of the wish must be carefully considered: see Fleming, at p. 94. The question is whether, when the wish was expressed, the patient intended its application in the circumstances that the patient now faces: see *Conway*, at para. 33; *Scardoni*, at para. 74. Changes in the patient's condition, prognosis, and treatment options may all bear on the applicability of a prior wish: Conway, at paras. 37-38. For example, had Mr. Rasouli expressed a prior wish regarding life support, his substitute decision-maker would have to consider whether, when the wish was expressed, Mr. Rasouli intended the wish to apply if he were in a permanent vegetative state, with recovery extremely improbable according to medical evidence, and facing the health complications associated with long-term provision of life support.

83 A prior wish need not identify every possible future development in order to be applicable: Scardoni, at para. 74; S. (K.M.), Re [2007 CarswellOnt 4883 (Ont. Cons. & Capacity Bd.)], 2007 CanLII 29956. However, a wish that is unclear, vague, or lacks precision may be held inapplicable to the circumstances. On this basis, the Board has found there were no prior wishes relating to life supportP applicable to the existing circumstances in numerous

cases: D. (D.), Re [2013 CarswellOnt 4211 (Ont. Cons. & Capacity Bd.)], 2013 CanLII 18799; P. (D.), Re [2010 CarswellOnt 7848 (Ont. Cons. & Capacity Bd.)]; B. (E.), Re [2007 CarswellOnt 745 (Ont. Cons. & Capacity Bd.)], 2006 CanLII 46624; G, Re; E., Re [2009 CarswellOnt 3258 (Ont. Cons. & Capacity Bd.)], 2009 CanLII 28625; J. (H.), Re [2003 CarswellOnt 8244 (Ont. Cons. & Capacity Bd.)], 2003 CanLII 49837. I have been unable to locate any case in which there was a prior expressed wish opposing withdrawal of life support that was held to be applicable and therefore binding in the circumstances.

84 If it is unclear whether a prior wish is applicable, the substitute decision-maker or physician may seek directions from the Board: s. 35. Alternately, if the substitute decision-maker acts on a prior wish that the physician believes is not applicable, the physician may challenge the consent decision before the Board: s. 37. The physician's submissions on the patient's condition, prognosis, and any adverse effects of maintaining life support will be relevant to the Board's assessment of applicability.

85 In addition, either the substitute decision-maker or physician may apply to the Board for permission to depart from prior wishes to refuse treatment: s. 36. The Board may grant permission where it is satisfied that the incapable person, if capable, would probably give consent because of improvement in the likely result of the treatment since the wish was expressed: s. 36(3).

86 I note that the HCCA also provides that the substitute decision-maker is not required to comply with an expressed prior wish if "it is impossible to comply with the wish": s. 21(1)2. This is not raised on the facts of this appeal, and I consider it no further.

(2) The Best Interests of the Patient

87 If the substitute decision-maker is not aware of an expressed prior wish of the patient or if the wish is not applicable to the circumstances, the substitute decision-maker must make her consent decision based on the best interests of the patient, according to the criteria set out in s. 21(2). These criteria include the medical implications of treatment for the patient, the patient's well-being, the patient's values, and any prior expressed wishes that were not binding on the substitute decision-maker. This legislative articulation of the best interests of the patient aims at advancing the values that underpin the HCCA: enhancing patient autonomy and ensuring appropriate medical treatment.

88 The substitute decision-maker is not at liberty to ignore any of the factors within the best interests analysis, or substitute her own view as to what is in the best interests of the patient. She must take an objective view of the matter, having regard to all the factors set out, and decide accordingly. This is clear from the mandatory wording of the opening portion of s. 21(2): the decision-maker "shall take into consideration" the listed factors. The need for an objective inquiry based on the listed factors is reinforced by s. 37, which allows the decision of the substitute decision-maker to be challenged by the attending physician and set aside by the Board, if the

decision-maker did not comply with s. 21. The intent of the statute is to obtain a decision that, viewed objectively, is in the best interests of the incapable person.

89 The first consideration under s. 21(2), heavily relied on by Ms. Salasel in this case, concerns the values and beliefs of the incapable person. Section 21(2)(a) provides that the substitute decision-maker must consider the values and beliefs that the incapable person held when capable and that the substitute decision-maker believes that the incapable person would still act on if capable. Here, Ms. Salasel argues that sustaining life as long as possible accords with the religious beliefs of Mr. Rasouli, and that as a result he would not have consented to the removal of life support.

90 The second consideration relates to known wishes of the incapable person that were not binding on the substitute decision-maker under s. 21(1)1. For example, wishes expressed when a person was under the age of 16 or when incapable do not bind a substitute decision-maker, but must be taken into consideration in this stage of the best interests analysis.

91 Third, in addition to considering the values and beliefs of the patient and any relevant wishes, s. 21(2)(c) requires that the substitute decision-maker consider four factors that relate to the impact of the treatment on the patient's condition, well-being, and health. This stage of the best interests analysis focuses on the medical implications of the proposed treatment for the patient. The attending physician's view of what would medically benefit the patient must be taken into account.

92 The first factor asks whether receiving the treatment is likely to improve the patient's condition or well-being, prevent deterioration of the person's condition or well-being, or reduce the extent or rate of the deterioration of the person's condition or well-being: s. 21(2)(c)1. In this case, the inquiry must determine whether removing life support would improve, prevent deterioration of, or reduce the extent or rate of deterioration of, Mr. Rasouli's condition or well-being. The physicians argue that artificially prolonging Mr. Rasouli's life will lead to health complications such as bedsores, respiratory infections, and organ failure — a scenario that can be avoided if life support is removed. On the other hand, Ms. Salasel argues that new evidence and evaluation suggest that Mr. Rasouli's condition may improve in the future, militating against removal of life support.

93 The second factor requires the substitute decision-maker to consider whether, in the absence of the proposed treatment, the incapable person's condition or well-being is likely to improve, remain the same or deteriorate: s. 21(2)(c)2. In this case, the inquiry is into the likely medical outcomes for Mr. Rasouli if life support is not withdrawn. The decision-maker must cast her mind into the future and ask what the patient's condition will be in one year, five years, or ten years.

94 The third factor requires the substitute decision-maker to consider risks of harm associated with the treatment and weigh whether the

benefits from the treatment will outweigh those risks: s. 21(2)(c)3. This factor is particularly important in cases where the substitute decision-maker must decide whether to go ahead with a risky procedure, like high-risk surgery, that while offering some hope, could worsen the patient's situation. In this case, the substitute decision-maker must consider the benefits of removing life support, such as avoidance of protracted physical deterioration from bedsores, infections and organ deterioration ultimately leading to death, against the risks, which quite plainly are the hastening of death and the loss of whatever chance of recovery Mr. Rasouli has according to medical evidence.

95 The fourth factor requires the substitute decision-maker to consider alternative courses of treatment — whether less intrusive or restrictive treatment would be as beneficial as the treatment proposed: s. 21(2)(c)4. In a case such as this, the question is whether maintaining life support would be less intrusive or restrictive than its withdrawal, and if so, whether maintaining life support would be more beneficial to the patient than withdrawal.

96 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.

97 Where physicians and substitute decision-makers disagree about whether withdrawal of life support would be in the best interests of the patient, the HCCA provides the procedure for resolving this conflict. Under s. 37, the health care practitioner may apply to the Board to have the decision of the substitute decision-maker set aside on the ground that it is not in the best interests of the incapable person, having regard to the factors set out in s. 21(2) of the Act. This is an important avenue of recourse for physicians who believe that life support can no longer be ethically administered because it is not in the best interests of the patient to do so. The Board must duly consider the physician's professional opinion and submissions on what would be of medical benefit to the patient.

98 If the Board agrees that the substitute decision-maker did not act in the best interests of the patient, it may substitute its own opinion for that of the substitute decision-maker: s. 37(3). Alternatively, if the Board concludes that the substitute decision-maker did act in the best interests of the patient, it can affirm the decision of the substitute decision-maker. In making these determinations, the Board must objectively apply the same criteria that substitute decision-makers are required to consider under s. 21. The Board is well placed to make a determination of whether treatment is in the best interests of the patient, in light of the statutory objectives of enhancing patient autonomy and ensuring appropriate medical care. This was observed by the Ontario Court of Appeal in M. (A.) v. Benes (1999), 46 O.R. (3d) 271 (Ont. C.A.):

A case will come before the Board only when the health practitioner disagrees with the S.D.M.'s application of the best interests test under s. 21(2). The Board will then have before it two parties who disagree about the application of s. 21: the S.D.M., 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. The disagreement between the S.D.M. and the health practitioner potentially creates tension and the Act recognizes this by providing for a neutral expert board to resolve the disagreement. Indeed, after hearing submissions from all parties, the Board is likely better placed than either the S.D.M. or the health practitioner to decide what is in the incapable person's best interests. [para. 46]

99 The Board must apply a standard of correctness in reviewing the decision of the substitute decision-maker: Benes, at para. 36; Scardoni, at para. 36. The wording of s. 37, which provides for full representation and gives the Board the right to substitute its decision for that of the substitute decision-maker, indicates that the Board must consider the matter de novo. The critical nature of the interests at stake support the Board's obligation to review the decision of the substitute decision-maker on a correctness standard.

100 The legislature has given the Board the final responsibility to decide these matters. This is not to say that the courts have no role to play. Board decisions are subject to judicial review. This mechanism for court oversight ensures that the Board acts within its mandate and in accordance with the Constitution.

101 Over the past 17 years, the Board has developed a strong track record in handling precisely the issue raised in this case.

102 In some cases, the Board has upheld the decisions of substitute decision-makers to refuse withdrawal of life support as being in the best interests of the patient: W. (D.), Re [2011 CarswellOnt 2312 (Ont. Cons. & Capacity Bd.)], 2011 CanLII 18217; S. (S.), Re [2011 CarswellOnt 816 (Ont. Cons. & Capacity Bd.)], 2011 CanLII 5000; P. (D.), Re. In others, it has reversed the decision of the substitute decision-maker and required consent to be given for the withdrawal of life support: K. (A.), Re; G. (E.J.), Re; N., Re, 2009 CarswellOnt 4748 (Ont. Cons. & Capacity Bd.). The particular facts of each case determine whether withdrawal of life support is in the best interests of the patient.

103 Bringing its expertise to the issue, the Board's decisions may be expected to bring consistency and certainty to the application of the statute, thereby providing essential guidance to both substitute decision-makers and health care providers in this difficult area of the law.

…

I. Summary

116 I conclude that the following steps apply under the HCCA in a case such as this, where the substitute decision-maker and the medical health care providers disagree on whether life support should be discontinued.

1. The health practitioner determines whether in his view continuance of life support is medically indicated for the patient;

2. If the health practitioner determines that continuance of life support is no longer medically indicated for the patient, he advises the patient's substitute decision-maker and seeks her consent to withdraw the treatment;

3. The substitute decision-maker gives or refuses consent in accordance with the applicable prior wishes of the incapable person, or in the absence of such wishes on the basis of the best interests of the patient, having regard to the specified factors in s. 21(2) of the HCCA;

4. If the substitute decision-maker consents, the health practitioner withdraws life support;

5. If the substitute decision-maker refuses consent to withdrawal of life support, the health practitioner may challenge the substitute decision-maker's refusal by applying to the Consent and Capacity Board: s. 37;

6. If the Board finds that the refusal to provide consent to the withdrawal of life support was not in accordance with the requirements of the HCCA, it may substitute its own decision for that of the substitute decision-maker, and permit withdrawal of life support.

III. Conclusion

117 Applying the HCCA in the manner just discussed, we arrive at the following conclusions.

118 The appellant physicians, having determined that in their view Mr. Rasouli should be removed from life support, were obliged to seek Ms. Salasel's consent to the withdrawal. Since Mr. Rasouli had not expressed a wish within the meaning of s. 21(1)1, Ms. Salasel was required to determine whether removal of life support was in Mr. Rasouli's best interests, having regard to the factors set out in s. 21(2) of the Act.

119 If the appellant physicians do not agree that maintaining life support for Mr. Rasouli is in his best interests, their recourse is to apply to the Board for a determination as provided by s. 37(1) of the HCCA.

120 When the application is brought, it will be for the Board to determine whether Ms. Salasel's refusal to provide consent to the withdrawal of life support was in Mr. Rasouli's best interests, within the meaning of s. 21(2) of the HCCA. If the Board is of the opinion it was not, it may substitute its decision for that of Ms. Salasel, and clear the way for removal of Mr. Rasouli's life support.

121 It follows that I would dismiss the appeal. I would also dismiss the motions to adduce fresh evidence on the appeal to this Court, without prejudice to the Board receiving any evidence it deems relevant on the hearing before it.

122 This being a matter of public interest, I would not award costs.