

## A PROPOSAL FOR ACCESS TO TREATMENT CONTRARY TO CLINICAL JUDGMENT

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Remarkably, it is unclear in much of Canada whether physicians must provide treatment contrary to their clinical judgment when it is requested by patients. The Supreme Court of Canada held in *Cuthbertson v Rasouli* that an Ontario statute allows patients to demand certain life-sustaining treatment contrary to clinical judgment. However, much confusion remains in Ontario when non-life-sustaining treatments are at issue, and the common law across Canada remains unsettled. To assess the benefits and detriments of different approaches to the issue, the laws of Ontario and England are compared. Whereas in Ontario physicians must provide (at least) certain life-sustaining treatment contrary to clinical judgment, in England, courts have consistently held that physicians may refuse to provide treatment contrary to their clinical judgment. English physicians may withdraw even life-sustaining treatment from patients, despite opposition from patients or their families, if the physicians believe continued treatment is medically inappropriate. Each approach has benefits and detriments. Ontario's law, for example, has the benefit of promoting patient autonomy,

Remarquablement, il n'est clair dans une grande partie du Canada si les médecins doivent fournir des traitements allant à l'encontre de leurs jugements cliniques lorsqu'ils sont demandés par des patients. La Cour suprême du Canada a décidé dans *Cuthbertson c Rasouli* qu'une loi ontarienne permet aux patients de demander certains traitements de maintien de la vie contraires au jugement clinique. Cependant, une grande confusion demeure en Ontario lorsque des traitements autres que ceux du maintien de la vie sont impliqués, et la *common law* à travers le Canada demeure incertaine. Pour évaluer les avantages et désavantages des différentes approches vis-à-vis ce problème, le droit en Ontario et en Angleterre sont comparés. Alors qu'en Ontario les médecins doivent fournir (au moins) certains traitements contraires à leurs jugements cliniques, en Angleterre, les tribunaux ont uniformément décidé que les médecins peuvent refuser de fournir des traitements contraires à leurs jugements cliniques. Les médecins anglais peuvent même retirer les traitements de maintien de la vie à leurs patients, malgré l'opposition des pa-

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while England's approach recognizes that physicians' role is in part moral and helps protect patients. Opting neither for the English approach nor the Ontarian approach, I ultimately suggest that physicians should be required to provide patients with the treatment they request, even if contrary to clinical judgment, unless a court or tribunal determines the requested treatment to be unreasonable in the circumstances. Unreasonableness should be assessed based on medical criteria, the patient's values, availability of resources, and any other relevant consideration. This approach has the advantage of giving patients a large degree of autonomy and limiting the cost of access to justice, while acknowledging that the physicians should continue to have some role in limiting access to medical interventions.

tients ou de leurs familles, si les médecins croient que la poursuite du traitement serait médicalement inappropriée. Chaque approche a ses avantages et désavantages. Le droit en Ontario, par exemple, a l'avantage de promouvoir l'autonomie du patient, alors que l'approche de l'Angleterre reconnaît que le rôle des médecins est en partie moral et aide à protéger les patients. Optant ni pour l'approche anglaise ni pour l'approche ontarienne, je suggère ultimement que les médecins devraient être obligés de fournir aux patients les traitements qu'ils demandent, même s'ils sont contraires à leurs jugements cliniques, à moins qu'un tribunal administratif ou judiciaire détermine que le traitement soit déraisonnable dans les circonstances. Le caractère déraisonnable du traitement devrait être évalué sur la base de critères médicaux, des valeurs du patient, de la disponibilité des ressources, et de toute autre considération pertinente. Cette approche a l'avantage d'accorder aux patients un grand degré d'autonomie et de limiter les coûts d'accès à la justice, tout en reconnaissant que les médecins devraient continuer à avoir un certain rôle en limitant l'accès aux interventions médicales.

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*Without discretionary latitude, the physician cannot ... fulfill her obligation to use her knowledge for the patient's best interests. Without constraints on discretionary latitude, the physician's decisions can violate the patient's values or produce physical harm. The balance between too narrow and too wide a definition of discretionary space is a delicate, but increasingly important, one to strike.*<sup>1</sup>

## INTRODUCTION

When the Supreme Court of Canada struck down the criminal prohibition on medical assistance in dying (MAID) in *Carter v Canada (AG)*<sup>2</sup> and Parliament began drafting MAID legislation, questions were raised about physicians' ability to refuse to participate in the procedure on grounds of conscience. It quickly became clear that physicians would not be required to perform MAID and that, at most, they would have to refer their patients to a willing physician.<sup>3</sup> This is therefore a situation in which physicians' right to

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<sup>1</sup> Edmund D Pellegrino, "Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship" (1994) 10 J Contemp Health L & Pol'y 47 at 61 [Pellegrino, "Patient and Physician Autonomy"].

<sup>2</sup> 2015 SCC 5, [2015] 1 SCR 331 [*Carter*].

<sup>3</sup> See *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)*, SC 2016, c 3, s 3 [*MAID Act*], amending *Criminal Code*, RSC 1985, c C-46, s 241.2(9) ("nothing in this section compels an individual to provide or assist in providing medical assistance in dying"). Minister of Health Jane Philpott, debating the bill that would become the *MAID Act*, stated that "this proposed legislation does not compel any health care practitioner to provide medical assistance in dying. Practitioners will have the right to choose as their conscience dictates": *House of Commons Debates*, 42nd Parl, 1st Sess, No 45 (22 April 2016) at 2602. The College of Physicians and Surgeons of Ontario has imposed an obligation on physicians to provide an effective referral, and this is currently the subject of a judicial review based on physicians' freedom of conscience: see Amanda Pfeffer, "Ontario Doctors Challenge Policy Forcing Referrals for Medically Assisted Dying", *CBC News* (15 June 2017), online: <[www.cbc.ca/news/canada/ottawa/medically-assisted-dying-ontario-college-1.4159660](http://www.cbc.ca/news/canada/ottawa/medically-assisted-dying-ontario-college-1.4159660)>. The Québec medical assistance in dying (MAID) law enshrines a right to refuse to administer MAID based on personal convictions, without providing a direct referral, although physicians must report the request to the institution's director or the local health authority: *An Act respecting end-of-life care*, CQLR 2014, c S-32.0001, ss 31, 50.

refuse to provide treatment, based on their personal or professional ethics, is recognized in law.

In *Cuthbertson v Rasouli*,<sup>4</sup> fifteen months before *Carter* was decided, the Supreme Court adjudicated a dispute over whether a patient's life-sustaining treatment should be continued. Two doctors argued that it would place them in an "untenable ethical situation" to have to continue providing treatment to their patient if it provided "no medical benefit to, or even [harmed], the patient."<sup>5</sup> In six brief paragraphs, the Court rejected the physicians' ethical argument out of hand, essentially on the basis that ethical tensions are "inherent to medical practice."<sup>6</sup>

The law governing the refusal to provide MAID is not inconsistent with the decision in *Rasouli* – the legal bases are different, as are some of the issues raised. Nevertheless, the courts' different approaches to whether doctors must treat patients in a manner they object to on ethical grounds inspired this article.

This article focuses on whether physicians may deny treatment requested by patients or their substitute decision makers (SDMs) because the treatment is contrary to their clinical judgment. In essence, it asks whether patients should be able to receive whatever treatment they want, regardless of medical norms and subject only to minimal exceptions, such as lack of resources. Put another way, the article asks whether there is still a role for physicians as gatekeepers of "good medicine."

Although *Rasouli* clarified to some extent Ontario law on this question, as grounded in the *Health Care Consent Act (HCCA)*,<sup>7</sup> considerable uncertainty remains in Ontario and elsewhere. This is in part because the issue is relatively new. It arises because of the increasing weight given to patient autonomy in the medical sphere. Whereas traditionally, physicians would paternalistically make decisions for their patients, patients now have a much greater role in medical decision making. This can only be a good thing. Yet the pendulum continues to swing in favour of patient autonomy such that it is sometimes "elevated to the status of a trumping principle, morally as

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<sup>4</sup> 2013 SCC 53, [2013] 3 SCR 341 [*Rasouli*].

<sup>5</sup> *Ibid* at para 71.

<sup>6</sup> *Ibid* at paras 71–76.

<sup>7</sup> 1996, SO 1996, c 2, Schedule A [*HCCA*].

well as legally.”<sup>8</sup> Some speak of “patient paternalism.”<sup>9</sup> The principle of patient autonomy is being argued to ground not only negative rights against being treated against one’s will or without first receiving relevant information, but also to ground de facto entitlements to treatment. And once this door has been opened, difficult questions arise about *which* treatments must be provided. Objectively ineffective treatments, like antibiotics to treat a viral condition, may pose few problems. But treatment can be ineffective in subjective ways – for example, when is it clear that a patient will not make a meaningful recovery such that one might argue that life-sustaining treatment should be withdrawn. In addition, it can be argued that effectiveness (or medical benefit) is not the only relevant criterion. Some, for example, believe that life should always be preserved because of its sanctity or inherent value, regardless of considerations of medical benefit. Given this, determining who should have the final say about treatment contrary to clinical judgment requires considering a wide range of issues and balancing competing interests. This question often arises in the context of end-of-life treatment decisions. The present article therefore draws on these examples in outlining current approaches, but ultimately recommends a policy solution that is broadly applicable to requests for treatment contrary to clinical judgment.

The issue of who should ultimately be able to decide whether requested treatment is provided has received relatively little scholarly attention in Canada, although that may be changing in light of the Supreme Court’s decision in *Rasouli*.<sup>10</sup> Downie, Willmott, and White’s article is a notable

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<sup>8</sup> Pellegrino, “Patient and Physician Autonomy”, *supra* note 1 at 58. Pellegrino continues: “In the United States, these threats to the physician’s autonomy and conscience derive from the evolution of autonomy from a negative to a positive right” (*ibid* at 58–59).

<sup>9</sup> Judith F Daar, “A Clash at the Bedside: Patient Autonomy v. a Physician’s Professional Conscience” (1993) 44:6 *Hastings LJ* 1241 at 1244–45 [Daar, “Clash”].

<sup>10</sup> See e.g. Hilary Young, “Why Withdrawing Life-Sustaining Treatment Should Not Require ‘*Rasouli* Consent’” (2012) 6:2 *McGill JL & Health* 54 [Young, “Withdrawing Life-Sustaining Treatment”]; Hilary Young, “*Cuthbertson v. Rasouli*: Continued Confusion over Consent-Based Entitlements to Life Support” (2015) 52:3 *Alta L Rev* 745 [Young, “Continued Confusion over Consent-Based Entitlements”]; Brandon Trask, “The Economics of Life and Death: Morals and Ethics in an Environment of Medical-Resource Scarcity” (2013) 37:1 *Man LJ* 233.

exception.<sup>11</sup> There is, however, a great deal of relevant scholarship from other jurisdictions.<sup>12</sup> There is also considerable scholarship on related issues such as physician conscientious objection<sup>13</sup> and on the concept of medical futility.<sup>14</sup>

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<sup>11</sup> Jocelyn Downie, Lindy Willmott & Ben P White, “Next Up: A Proposal for Values-Based Law Reform on Unilateral Withholding and Withdrawal of Potentially Life-Sustaining Treatment” (2017) 54:3 *Alta L Rev* 803. See also Glen Rutland, “Futile or Fruitful: The *Charter* and the Decision to Withhold or Withdraw Life-Sustaining Treatment” (2009) 17 *Health LJ* 81, which predates *Rasouli* but addresses the issue of patients’ *Charter* rights to treatment contrary to clinical judgment.

<sup>12</sup> See Downie, Willmott & White, *supra* note 11 at 806 (states that PubMed literature searches for unilateral withholding and withdrawal of treatment turned up over 2000 articles). For examples from the United States, see Daar, “Clash”, *supra* note 9; Judith F Daar, “Medical Futility and Implications for Physician Autonomy” (1995) 21:2&3 *Am JL & Med* 221 at 225–27; Patrick Moore, “An End-of-Life Quandary in Need of a Statutory Response: When Patients Demand Life-Sustaining Treatment that Physicians are Unwilling to Provide” (2007) 48:2 *Boston College L Rev* 433; Amir Halevy, “Medical Futility, Patient Autonomy, and Professional Integrity: Finding the Appropriate Balance” (2008) 18:2 *Health Matrix* 261. For examples from the United Kingdom, see Jonathan Montgomery, “Conscientious Objection: Personal and Professional Ethics in the Public Square” (2015) 23:2 *Med L Rev* 200; Søren Holm & Andrew Edgar, “Best Interest: A Philosophical Critique” (2008) 16:3 *Health Care Anal* 197; John Coggon, “Best Interests, Public Interest, and the Power of the Medical Profession” (2008) 16:3 *Health Care Anal* 219; Simon Woods, “Best Interests: Puzzles and Plausible Solutions at the End of Life” (2008) 16:3 *Health Care Anal* 279; Edwina A Brown, “Ethnic and Cultural Challenges at the End of Life: Setting the Scene” (2014) 40:1 *J Ren Care* 2; Jonathan CW Youngs, “Can the Courts Force the Doctor’s Hand? *St George’s Healthcare NHS Trust v P* [2015] EWCOP 42”, Case Comment, (2015) 24:1 *Med L Rev* 99; Maria K Sheppard, “Fallacy or Functionality: Law and Policy of Patient Treatment Choice in the NHS” (2016) 24:4 *Health Care Anal* 279.

<sup>13</sup> See e.g. Daphne Gilbert, “Let Thy Conscience Be Thy Guide (but not My Guide): Physicians and the Duty to Refer” (2017) 10:2 *McGill JL & Health* 47; Jocelyn Downie, Carolyn McLeod & Jacquelyn Shaw, “Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons” (2003) 21:3 *Health L Rev* 28.

<sup>14</sup> See e.g. Stuart J Youngner, “Who Defines Futility?” (1988) 260:14 *JAMA* 2094; James L Bernat, “Medical Futility: Definition, Determination, and Disputes in Critical Care” (2005) 2:2 *Neurocrit Care* 198; Lawrence J Schneiderman, “Defining Medical Futility and Improving Medical Care” (2011) 8:2 *J*

To ground a discussion of the issues, the article compares Ontario law to that in England and Wales (henceforth simply “England”). Whereas Ontario law rejects physicians’ claims not to have to practice contrary to their clinical judgment (at least for certain life-sustaining treatment), English courts have upheld such claims. That is, English courts have generally rejected patients’ claims to treatment that physicians refuse to provide because it is contrary to their clinical judgment. Despite similar legal systems generally, the laws of Ontario and England have diverged considerably and provide useful examples for assessing the benefits and detriments of unilateral decision making by physicians versus allowing patients to demand treatment contrary to clinical judgment.<sup>15</sup>

What the law in Canadian jurisdictions should be – particularly outside Ontario – is a matter for legislation informed by public debate. To contribute to that debate, I offer my own suggestion which differs from the approaches in England and Ontario. I propose a presumption in favour of patient choice that can be rebutted if a physician establishes that the requested treatment is unreasonable in the circumstances.

Note that although this article focuses on law regarding *physicians’* duties, they are by no means the only ones who have concerns about treating patients in ways they consider contrary to the dictates of their profession. According to one physician, nurses are often the ones who first experience moral distress at what they view as prolonging patients’ suffering.<sup>16</sup> Other medical professionals may also have concerns about their role in treatment. Nevertheless, the scope of this article is limited to physicians’ claims to be able to refuse to administer treatment that is contrary to their clinical judgment.

Finally, note that the article deals with treatment contrary to clinical judgment, which has been described as the “flexible, interpretive capacity that enables moral reasoners ... to determine the best action to take when

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Bioeth Inq 123; Lawrence J Schneiderman, Nancy S Jecker & Albert R Jonsen, “Medical Futility: Its Meaning and Ethical Implications” (1990) 112:12 Ann Intern Med 949; Thaddeus Mason Pope, “Medical Futility Statutes: No Safe Harbor to Unilaterally Refuse Life-Sustaining Treatment” (2007) 75:1 Tenn L Rev 1.

<sup>15</sup> For a discussion of approaches to the issue of unilaterally withholding or withdrawing treatment in other common law jurisdictions, see Downie, Willmott & White, *supra* note 11.

<sup>16</sup> See personal communication with Dr. Brian Cuthbertson (6 July 2016).

knowledge depends on circumstance.”<sup>17</sup> It implicates ethics but is a process of arriving at proposals for treatment based on available knowledge and skill. For our purposes, clinical judgment may be understood as a reasoned decision about what treatments should or should not be offered in specific circumstances.

This judgment may be based on any number of facts and opinions including purely medical or more ethical ones. In the context of withholding or withdrawing life-sustaining treatment, professional ethics will often be implicated. For example, we will see the example of physicians who considered it unethical to continue to “torture” a dying patient by keeping him alive. However, clinical judgment not to offer a particular treatment may be grounded in other considerations, such as resource allocation or the physician’s lack of skill. By focusing on clinical judgment rather than professional ethics we can consider ethical considerations as well as those other reasons for withholding or withdrawing treatment.

The standard of care, which is sometimes referred to below, is also different than clinical judgment. It refers to the fault standard of reasonableness in negligence law. In medicine, it is generally defined in terms of customary medical practice.<sup>18</sup> For our purposes, relevant differences between the standard of care and clinical judgment include that the standard of care is objectively determined whereas clinical judgment is subjective. Further, a range of treatments may be reasonable while a physician, in her clinical judgment, may approve of only a subset of these. Finally, it is possible for clinical judgment to be contrary to the standard of care.

#### I. REQUESTS FOR TREATMENT CONTRARY TO CLINICAL JUDGMENT: FOUR EXAMPLES

Generally, when patients request a particular treatment it will either be provided, because it is indicated and the physician is willing to provide it, or else it will not be provided, because it is not indicated, and another treat-

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<sup>17</sup> Kathryn Montgomery, *How Doctors Think: Clinical Judgment and the Practice of Medicine* (New York: Oxford University Press, 2006) at 4–5, citing Aristotle, *Nicomachean Ethics*, translated by Terence Irwin (Indianapolis: Hackett, 1985) at 5–6.

<sup>18</sup> See Allen M Linden & Bruce Feldthusen, *Canadian Tort Law*, 10th ed (Toronto: LexisNexis, 2015) at 184–85.

ment will be provided that satisfies the patient. Increasingly, however, as patient autonomy assumes greater importance in medical decision making, patients or their SDMs may insist on treatment that physicians do not consider medically appropriate.

In some situations in which treatment contrary to physicians' clinical judgment is requested, it is clear how such requests should be addressed. If patients request opioids despite not being in pain or request antibiotics despite having a viral infection, few would argue that doctors should have to provide these. The patients' moral claim to such treatment, grounded primarily in autonomy, is outweighed by other considerations such as not wanting to harm the patient. The Supreme Court referred to this as "common sense."<sup>19</sup>

More difficult situations arise, however, in the context of end-of-life treatment. There may be legitimate disagreements between patients (or their SDMs) and physicians as to whether life-prolonging or life-sustaining treatments should be provided or continued. What is medically indicated and what patients or family members value may conflict. What is medically indicated may not even be clear. For example, precisely when does life-support that starts out as indicated become contraindicated, as the patient fails to improve over time? There can be no single, objectively correct answer to this question. Further, even if there were a clear answer, it would not follow that providing any contraindicated treatment would be at odds with the proper practice of medicine. For example, if it became clear that continued life-support was no longer beneficial and therefore not indicated, good medical care might require spending time with family members to try to arrive at a consensus before ending treatment.

The following are four examples of litigated conflicts – or potential conflicts, in the *Burke* case – between the wishes of patients or SDMs and physicians' wishes not to be compelled to practice contrary to their clinical judgment.

#### **A. Cuthbertson v Rasouli**

Hassan Rasouli suffered complications from brain surgery and has been in a minimally conscious or persistent vegetative state since October 2010.

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<sup>19</sup> *Rasouli*, *supra* note 4 at para 58.

Despite some disagreement between his doctors and his family as to his diagnosis, it is undisputed that Mr. Rasouli needs a mechanical ventilator and artificial hydration and nutrition in order to survive.<sup>20</sup> When this article was being finalized, he had spent seven years in this state at Sunnybrook Hospital in Toronto.

Mr. Rasouli's physicians sought to withdraw his mechanical ventilation, with the virtually inevitable result that he would die. They believed there was nothing more that could be done for Mr. Rasouli medically, that continued treatment was contrary to the standard of care, and that being required to continue treating Mr. Rasouli would conflict with their views about the proper practice of medicine.<sup>21</sup> For both medical and religious reasons,<sup>22</sup> Mr. Rasouli's family refused consent to have treatment discontinued and sought a court order to prevent the doctors from doing so.

## **B. Golubchuk v Salvation Army Grace General Hospital**

Samuel Golubchuk was a very ill 84-year-old. He needed a ventilator to breathe and a feeding tube to eat. He was minimally responsive to pain and other stimuli and medical staff said Mr. Golubchuk had little if any conscious existence, although as in *Rasouli*, his family disputed this. He had a serious heart condition. His kidneys had begun to fail, although their deterioration had ceased. He had brain damage.<sup>23</sup> And yet he lived. For more than a year, Mr. Golubchuk lived in the Salvation Army Grace Hospital's intensive care unit.

After a few months, the hospital wanted to remove Mr. Golubchuk's mechanical ventilator and let him die, but the family refused based on their religious beliefs.<sup>24</sup> The case ended up in the courts where the family obtained an injunction preventing the ventilator from being withdrawn until the matter could be resolved on its merits.

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<sup>20</sup> See *ibid* at para 5.

<sup>21</sup> See *ibid* at paras 6, 71.

<sup>22</sup> See *ibid* at paras 7, 89.

<sup>23</sup> See *Golubchuk v Salvation Army Grace General Hospital*, 2008 MBQB 49 at paras 4–9, 290 DLR (4th) 46 [*Golubchuk*].

<sup>24</sup> See *ibid* at para 10.

In the meantime, doctors did what they could for Mr. Golubchuk. This included “hack[ing] away” at infected flesh “to keep infection at bay.”<sup>25</sup> Pressure sores continued to develop because Mr. Golubchuk’s circulatory system was not functioning well enough to prevent them. Doctors had to keep cutting away the sores until there was “little flesh left between his knees and the small of his back.”<sup>26</sup>

This was so upsetting to medical staff that one physician quit so he would not be forced to continue treatment that he viewed as “tantamount to torture,”<sup>27</sup> “grotesque,”<sup>28</sup> and “an abomination.”<sup>29</sup> Two other physicians refused to participate in Mr. Golubchuk’s treatment on moral grounds. This put such pressure on the intensive care unit that there was some concern about the hospital’s ability to keep it open.<sup>30</sup>

Before the matter could be decided on its merits, Mr. Golubchuk died.

### C. **Burke v General Medical Council**

Oliver Leslie Burke suffered from spinocerebellar ataxia, a degenerative brain disease that would erode his physical functions but not his mental

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<sup>25</sup> “Doctor Quits over Dispute on Whether to Treat Winnipeg Man”, *Canadian Press* (4 June 2008), online: CBC <[www.cbc.ca/news/canada/manitoba/doctor-quits-over-dispute-on-whether-to-treat-winnipeg-man-1.698422](http://www.cbc.ca/news/canada/manitoba/doctor-quits-over-dispute-on-whether-to-treat-winnipeg-man-1.698422)>.

<sup>26</sup> Michael Smith, “Special Report: Court-Ordered End-of-Life Care for Comatose Patient Deemed Torture”, *MedPage Today* (14 August 2008), online: <[www.medpagetoday.com/PublicHealthPolicy/PublicHealth/10552](http://www.medpagetoday.com/PublicHealthPolicy/PublicHealth/10552)>.

<sup>27</sup> *Ibid.*; “2 More Winnipeg Doctors Resign in Dispute over Elderly Man’s Treatment”, *CBC News Manitoba* (16 June 2008), online: <[www.cbc.ca/news/canada/manitoba/2-more-winnipeg-doctors-resign-in-dispute-over-elderly-man-s-treatment-1.722204](http://www.cbc.ca/news/canada/manitoba/2-more-winnipeg-doctors-resign-in-dispute-over-elderly-man-s-treatment-1.722204)> [CBC News, “2 More Winnipeg Doctors”].

<sup>28</sup> Smith, *supra* note 26.

<sup>29</sup> *Ibid.*

<sup>30</sup> See Jamie Komarnicki, “Two More Doctors Resign over Life-Support Case”, *The Globe and Mail* (17 June 2008), online: <[www.theglobeandmail.com/news/national/two-more-doctors-resign-over-life-support-case/article674697](http://www.theglobeandmail.com/news/national/two-more-doctors-resign-over-life-support-case/article674697)> (“critical-care doctors from the city’s other hospitals are being asked to take on shifts to support Grace Hospital’s three remaining doctors on the unit” and “chief medical officer Elizabeth Cowden expressed concern that the ICU could be forced to close if other physicians followed Dr. Kumar’s lead and resigned”).

capacity.<sup>31</sup> The prognosis was that Mr. Burke would end up dependent on artificial hydration and nutrition to survive because he would eventually be unable to swallow on his own.<sup>32</sup>

At the time of trial, Mr. Burke was not yet in need of artificial nutrition and hydration but he anticipated such a need and wanted the courts to declare that it would be provided to him – that physicians could not decide that “his life is no longer worth living” and cease providing life-sustaining treatment.<sup>33</sup> It was expected he would retain his capacity until near the very end of his life, such that he would be the one making his own medical decisions.

Mr. Burke was concerned that certain provisions of the United Kingdom’s General Medical Council (GMC) guidance on end-of-life treatment might permit physicians unilaterally to withdraw his artificial hydration and nutrition.<sup>34</sup> He therefore sought a declaration that those provisions were contrary to the *European Convention on Human Rights (ECHR)*<sup>35</sup> and that, under certain circumstances, withdrawing artificial hydration and nutrition would be contrary to the *ECHR*.<sup>36</sup>

#### **D. AVS v A NHS Foundation Trust**

Finally, consider the situation of Mr. AVS. He had Creutzfeldt-Jakob disease (CJD), a fatal condition that attacks the brain.<sup>37</sup> While still competent, Mr. AVS appointed his brother to be his attorney for personal care, but

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<sup>31</sup> See *Burke, R (on the application of) v General Medical Council*, [2005] EWCA Civ 1003 at para 2, [2005] 3 WLR 1132 [*Burke*].

<sup>32</sup> See *ibid*.

<sup>33</sup> *Ibid* at paras 5–6.

<sup>34</sup> See *ibid* at para 14, referring to UK, General Medical Council, “Withholding and Withdrawing Life-Prolonging Treatment: Guidance for Doctors” (2002, withdrawn July 2010) at paras 32, 38, 81, online: <[www.gmc-uk.org/Withholding\\_and\\_withdrawing\\_guidance\\_for\\_doctors.pdf\\_33377901.pdf](http://www.gmc-uk.org/Withholding_and_withdrawing_guidance_for_doctors.pdf_33377901.pdf)>.

<sup>35</sup> Convention for the Protection of Human Rights and Fundamental Freedoms, 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953).

<sup>36</sup> See *Burke*, *supra* note 31 at para 14.

<sup>37</sup> See *AVS v A NHS Foundation Trust*, [2011] EWCA Civ 7 at para 3, [2011] 2 FLR 1 [*AVS*].

the litigation concerned events that occurred after Mr. AVS lost capacity. In fact, during the litigation he was in a persistent vegetative state or “very close to it” although, as in *Rasouli* and *Golubchuk*, the family disputed this diagnosis.<sup>38</sup>

Mr. AVS apparently told his brother to pursue all treatment options and to never “give up.”<sup>39</sup> The brother discovered an experimental treatment for CJD and a doctor who was willing to administer it. There was some indication of the treatment’s success in slowing down the disease’s progression but, when the pump used in the treatment failed, the hospital refused to provide the surgery needed to resume treatment. The medical evidence suggested that Mr. AVS’ condition had deteriorated to the point that the experimental treatment could have no further benefit. The treating physician determined that it would be medically inappropriate to continue the experimental treatment under the circumstances.<sup>40</sup> There was some evidence that another physician was willing to resume the treatments but it seems that no facility was found where this could take place.<sup>41</sup>

The brother sought a declaration that continued treatment, via the experimental method, was in Mr. AVS’ best interests with the intention that this declaration would force the resumption of the experimental treatment.<sup>42</sup>

Each of the above cases involves a patient’s claim to be entitled to treatment that physicians considered contrary to clinical judgment. In each, failure to provide the requested treatment would either lead to the patient’s imminent death (*Rasouli*, *Golubchuk*, *Burke*) or deny the patient a perceived opportunity to slow the progression of a fatal disease (*AVS*).

Three involve incompetent patients whose decisions were being made by SDMs (*Rasouli*, *Golubchuk*, *AVS*, although *AVS* apparently involves a prior competent wish), while one involves a competent patient (*Burke*).

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<sup>38</sup> *Ibid* at para 5.

<sup>39</sup> *Ibid* at para 9.

<sup>40</sup> See *ibid* at para 7.

<sup>41</sup> See *ibid* at para 10.

<sup>42</sup> See *ibid* at paras 35, 38.

At least three involve the withdrawal of treatment that was previously being provided (mechanical ventilation in *Rasouli* and *Golubchuk*, artificial nutrition and hydration in *Burke*). One involves withholding rather than withdrawing treatment (*AVS*). Although the experimental treatment had previously been provided, it was discontinued due to a mechanical failure. At the time the decision was made as to whether the treatment should be offered, it was a case of potentially providing a treatment that was not presently being provided.<sup>43</sup>

These examples paint a picture of a particular problem that will presumably become more common as technology for keeping patients alive improves and the role of patient autonomy in medical decision making assumes greater importance. The problem is that of conflicts between patients' (or their SDMs') interest in determining their medical treatment and physicians' and society's interest in physicians not having to practice medicine contrary to their clinical judgment. The next section examines how courts in England and Ontario have resolved those conflicts.

## II. THE LAW IN ENGLAND AND CANADA

In Canada, the common law is somewhat uncertain with regard to physicians' obligation to treat contrary to clinical judgment.<sup>44</sup> Some provinces have health care consent statutes that do not explicitly address the issue,<sup>45</sup> but as we shall see, the Ontario statute has been interpreted as requiring physicians sometimes to treat contrary to their clinical judgment. This is in contrast to the law in England, where courts have rejected patients' claims to treatment contrary to clinical judgment, even where physicians' decision not to treat would lead to death. I begin with English law, since it represents a starting point. Canadian law on this issue seems once to have been the same

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<sup>43</sup> For another case that involves withholding rather than withdrawing treatment, see *Rotaru v Vancouver General Hospital Intensive Care Unit*, 2008 BCSC 318, [2008] BCJ No 456 (QL) [*Rotaru*], discussed below.

<sup>44</sup> See *Rasouli*, *supra* note 4 at para 53.

<sup>45</sup> See e.g. *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c 181 [British Columbia Act]; *The Health Care Directives Act*, SM 1992, c 33, CCSM c H27 [Manitoba Act]; *Advance Health Care Directives Act*, SNL 1995, c A-4.1 [Newfoundland Act]; *Infirm Persons Act*, RSNB 1973, c I-8.

as current English law, although there was little case law on point, but it has since diverged in Ontario.

### *A. England and Wales*

England's courts have consistently held that doctors do not have to treat contrary to their clinical judgment. Recall that in *Burke*, a man was seeking to have the courts declare certain provisions of the General Medical Council guidance on end-of-life treatment to be contrary to the *ECHR*. Although Mr. Burke was successful at trial, the decision was overturned on appeal. The England and Wales Court of Appeal (EWCA) stated that "a patient cannot demand that a doctor administer a treatment which the doctor considers is adverse to the patient's clinical needs."<sup>46</sup> The decision rejected the notion that

provided that there are no resource implications, doctors who have assumed the care of a patient must administer such treatment as is in the patient's best interests and that, where a patient has expressed an informed wish for a particular treatment, receipt of such treatment will be in the patient's best interests.<sup>47</sup>

The court went on to endorse the following views of the General Medical Council, which are set out here in their entirety since they are clear and, as we shall see, quite contrary to Ontario law:

- i) The doctor, exercising his professional clinical judgment, decides what treatment options are clinically indicated (i.e. will provide overall clinical benefit) for his patient.
- ii) He then offers those treatment options to the patient in the course of which he explains to him/her the risks, benefits, side effects, etc involved in each of the treatment options.
- iii) The patient then decides whether he wishes to accept any of those treatment options and, if so, which one. In the vast majority of cases he will, of course, decide which treatment option he considers to be in his best interests and, in doing so,

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<sup>46</sup> *Burke*, *supra* note 31 at para 55.

<sup>47</sup> *Ibid* at paras 27, 29.

he will or may take into account other, non clinical, factors. However, he can, if he wishes, decide to accept (or refuse) the treatment option on the basis of reasons which are irrational or for no reasons at all.

iv) If he chooses one of the treatment options offered to him, the doctor will then proceed to provide it.

v) If, however, he refuses all of the treatment options offered to him and instead informs the doctor that he wants a form of treatment which the doctor has not offered him, the doctor will, no doubt, discuss that form of treatment with him (assuming that it is a form of treatment known to him) but if the doctor concludes that this treatment is not clinically indicated he is not required (i.e. he is under no legal obligation) to provide it to the patient although he should offer to arrange a second opinion.<sup>48</sup>

The clarity of the EWCA's position in *Burke* was somewhat undermined by the court's conclusion that to deny Mr. Burke artificial nutrition and hydration (ANH), given his express wish to receive it, would effectively be murder.<sup>49</sup> This followed from the fact that hospitals and doctors owe a duty of care to patients: "Where ANH is necessary to keep the patient alive, the duty of care will normally require the doctors to supply ANH."<sup>50</sup> Because of the patient's anticipated competence at the end of his life, the EWCA could not conceive of it being consistent with clinical judgment to withdraw ANH contrary to the patient's competent wishes. The point was moot as "[t]here are no grounds for thinking that those caring for a patient would ... take a decision to withdraw ANH in such circumstances."<sup>51</sup>

In *Burke*, the EWCA stated:

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*

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<sup>48</sup> *Ibid* at para 50.

<sup>49</sup> *Ibid* at para 34.

<sup>50</sup> *Ibid* at para 32.

<sup>51</sup> *Ibid* at para 13.

*founded simply upon the fact that the patient demands it. The source of the duty lies elsewhere.*<sup>52</sup>

In *AVS* six years later, the EWCA reiterated the law as espoused in *Burke*:

It is trite that the court will not order medical treatment to be carried out if the treating physician/surgeon is unwilling to offer that treatment for clinical reasons conscientiously held by that medical practitioner.<sup>53</sup>

Recall that *AVS* involved a request by a SDM to have an experimental treatment which had had some benefit declared to be in a patient's best interests. The EWCA held that it was unnecessary to decide that question because even if resuming the treatment were in Mr. AVS' best interests, physicians would not be required to continue the treatment if they considered it no longer to be indicated. In other words, a

declaration [that resuming treatment is in the patient's best interests] will not force the respondent hospital to provide treatment against their clinicians' clinical judgment. To use a declaration of the court to twist the arm of some other clinician ... is an abuse of the process of the court and should not be tolerated.<sup>54</sup>

Finally, consider *Aintree University Hospitals NHS Foundation Trust v James*.<sup>55</sup> Like *Rasouli*, it involved a disagreement between physicians and family members over whether life-sustaining treatment would be provided. *James* was an appeal of a decision of the Court of Protection, which is similar to Ontario's Consent and Capacity Board (CCB) in that it makes determinations of capacity, appoints SDMs, and makes determinations of best interests.<sup>56</sup> The hospital had sought a declaration that it would be legal to withhold three treatments (invasive support for circulatory problems,

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<sup>52</sup> *Ibid* at para 31 [emphasis added].

<sup>53</sup> *AVS*, *supra* note 37 at para 35.

<sup>54</sup> *Ibid* at para 38.

<sup>55</sup> [2013] UKSC 67, [2014] AC 591 [*James*].

<sup>56</sup> See "Court of Protection", online: Government of the United Kingdom <[www.gov.uk/courts-tribunals/court-of-protection](http://www.gov.uk/courts-tribunals/court-of-protection)>.

renal replacement therapy, and CPR) from a patient, Mr. James. Although Mr. James died before the UK Supreme Court could hear the matter, the widow's appeal was allowed to proceed in order to clarify the relevant law under the *Mental Capacity Act 2005*.<sup>57</sup>

The Supreme Court noted that as a "starting point," there is "a strong presumption that it is in a person's best interests to stay alive."<sup>58</sup> However, the Court agreed with the EWCA that the relevant issue was whether *treatment proposed to be provided* was in the patient's best interests.<sup>59</sup> This did not mean that treatment could be ordered to be provided contrary to clinical judgment because it was in the patient's best interests. The best interests inquiry only related to treatment proposed by physicians to be provided at all. The Court was clear that under the relevant legislation, "the court has no greater powers than the patient would have if he were of full capacity."<sup>60</sup>

The Supreme Court cited the 1990 EWCA decision in *Re J (A Minor) (Wardship: Medical Treatment)* for the proposition that "the court could not require the [health] authority to follow a particular course of treatment," but could "withhold consent to treatment of which it disapproves and ... express its approval of other treatment proposed by the authority and its doctors."<sup>61</sup> It also cited with approval the EWCA decision in *Burke* to the effect that "a patient cannot demand that a doctor administer a treatment which the doctor considers is adverse to the patient's clinical needs."<sup>62</sup>

From *James* it appears that the primary limit on physicians' authority to refuse to provide treatment that is contrary to their clinical judgment is the negligence standard of care. The Supreme Court acknowledged that "[o]f course, there are circumstances in which a doctor's common law duty of care towards his patient requires him to administer a particular treatment."<sup>63</sup>

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<sup>57</sup> *James*, *supra* note 55 at paras 1, 15, referring to (UK), c 9.

<sup>58</sup> *Ibid* at para 35.

<sup>59</sup> *Ibid* at para 40.

<sup>60</sup> *Ibid* at para 18.

<sup>61</sup> *Ibid*, citing [1990] 3 All ER 930, [1991] Fam 33 at 48 (CA).

<sup>62</sup> *James*, *supra* note 55 at para 18, citing *Burke*, *supra* note 31 at para 55.

<sup>63</sup> *James*, *supra* note 55 at para 18. The Court went on to say: "It also follows that (provided of course that they have acted reasonably and without negligence)

Note that in Canada, fiduciary duties owed by physicians to patients could also constitute a limitation on physician discretion, but in England, where physician-patient relationships have not tended to be considered fiduciary,<sup>64</sup> such a limitation would not exist.

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the clinical team will not be in breach of any duty towards the patient if they withhold or withdraw” treatment (*ibid* at para 22).

<sup>64</sup> In Canada, it is clear that the physician-patient relationship is fiduciary in nature. See e.g. Timothy Caulfield & Maeghan Toews, “Rare Diseases and Resource Allocation Policy: The Role of Canadian Legal and Ethical Norms” (2016) 49:1 UBC L Rev 789 at 809. Yet, “the question of how far this fiduciary duty extends” is a more recent and developing subject of “ethical and legal concern” (*ibid*). The existence of a fiduciary duty has certainly never been interpreted to mean that patients are entitled to whatever they ask of their physicians. Rather it has, for example, grounded a right to a copy of one’s medical file. See *McInerney v MacDonald*, [1992] 2 SCR 138 at 150, 126 NBR (2d) 271 [*McInerney*]. In *McInerney* at 149, Justice La Forest stated:

In characterizing the physician-patient relationship as “fiduciary”, I would not wish it to be thought that a fixed set of rules and principles apply in all circumstances or to all obligations arising out of the doctor-patient relationship. As I noted in *Canson*, not all fiduciary relationships and not all fiduciary obligations are the same; these are shaped by the demands of the situation (citing *Canson Enterprises Ltd v Boughton & Co*, [1991] 3 SCR 534, 85 DLR (4th) 129).

In England, the doctor-patient relationship tends not to be considered fiduciary at all. See e.g. Peter Bartlett, “Doctors as Fiduciaries: Equitable Regulation of the Doctor-Patient Relationship” (1997) 5 Med L Rev 193 (“English courts have been loathe in recent years to characterize the doctor-patient relationship as being of a fiduciary character” at 193). In a more recent article, Ost explains why UK courts have tended not to recognize the physician-patient relationship as fiduciary:

This judicial reluctance to connect fiduciary law with the doctor-patient relationship can be explained in part because English law has tended to view the concept of fiduciary relationship as a function of property law and equitable limitations on ownership. It comes into play, therefore, as the mechanism for controlling the abuse of property improperly obtained from relationships of trust and, as such, the concept primarily denotes a relationship with the property and/or economic interest rather than with the person (Suzanne Ost, “Breaching the Sexual Boundaries in the Doctor-Patient Relationship: Should English Law Recognise Fiduciary Duties?” (2016) 24:2 Med L Rev 206 at 223).

The best interests test is an important one in English law, but it cannot itself ground a duty to provide treatment: the test is simply that treatment proposed for an incompetent patient must be in her best interests. Another point worth noting about best interests is that in England, physicians determine a patient's best interests (subject to review by the Court of Protection), even though best interests include non-medical factors such as the patient's values.<sup>65</sup> This is in contrast to the approach in Canadian jurisdictions, where SDMs determine best interests and it is physicians who must challenge those decisions if they disagree with them.<sup>66</sup>

### **B. Canada: Common law**

In the first cases dealing with patients' requests for treatment contrary to clinical judgment, Canadian courts seemed to take the same approach as English ones, although there were few cases and none dealt with *Canadian Charter of Rights and Freedoms* (*Charter*)<sup>67</sup> arguments on their merits.

In *Child and Family Services of Central Manitoba v RL (Lavallee)*, decided in 1997, the Manitoba Court of Appeal held that consent was not required for a physician to refrain from treating a patient. The physician could place a "do not resuscitate" (DNR) order on a patient's chart regardless of an SDM's objection: "There is no need for a consent from anyone for a doctor to refrain from intervening."<sup>68</sup> The issue was decided on the basis that, considering the *Child and Family Services Act*<sup>69</sup> and the common law tort of battery, physicians are not legally required to provide treatment that is not medically indicated.<sup>70</sup>

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<sup>65</sup> See *James*, *supra* note 55 at para 29, interpreting UK, Office of the Public Guardian, Department of Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (London: The Stationery Office, 2007), s 5.33, online: Government of the UK <[www.gov.uk/government/publications/mental-capacity-act-code-of-practice](http://www.gov.uk/government/publications/mental-capacity-act-code-of-practice)>.

<sup>66</sup> For the approach in Ontario, see *HCCA*, *supra* note 7, s 37(1).

<sup>67</sup> Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

<sup>68</sup> *Child and Family Services of Central Manitoba v RL* (1997), 123 Man R (2d) 135 at para 13, 154 DLR (4th) 409 (CA) [*Lavallee*].

<sup>69</sup> SM 1985–86, c 8, CCSM c C80.

<sup>70</sup> *Lavallee*, *supra* note 68 at paras 12–14.

*Sawatzky v Riverview Health Centre Inc* also addressed whether a physician could place a DNR order on a patient's chart contrary to the wishes of the SDM.<sup>71</sup> Unlike *Lavallee*, the matter was interlocutory. Mr. Sawatzky's spouse requested that the court remove the existing DNR order pending the outcome of a decision on the merits of the case.<sup>72</sup>

Although interlocutory, *Sawatzky* is notable for three reasons. First, it takes seriously the claims of physicians not to have to practice contrary to their clinical judgment. The court states that the issues raised include "fundamental questions relating to a patient's right to medical treatment and a doctor's obligation to provide that treatment. Those questions raise serious legal, moral, ethical, medical and practical issues."<sup>73</sup> Justice Beard referred to the 1992 EWCA decision in *Re J (A Minor) (Wardship: Medical Treatment)* in which one judge said that it would be an abuse of power to force a doctor to practice contrary to her "bona fide clinical judgment"<sup>74</sup> and another stated that a court order forcing a doctor to treat contrary to clinical judgment would "place a conscientious doctor in an impossible position."<sup>75</sup>

A second reason why *Sawatzky* is notable is that it suggests that one's claim not to have to treat may be diminished if one had previously been willing to treat. With regard to the physician who imposed the DNR, Justice Beard stated: "If he viewed that decision as an ethical dilemma, it was clearly one that he was able to live with for some time."<sup>76</sup>

A third reason is that *Sawatzky* distinguishes between objection grounded in professional ethics, and objection grounded in personal ethics: "The treatment does not, in and of itself, raise the same type of ethical problems for the doctor that could be associated with controversial procedures like

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<sup>71</sup> (1998), 132 Man R (2d) 222 at para 1, 167 DLR (4th) 359 (QB) [*Sawatzky*].

<sup>72</sup> *Ibid.*

<sup>73</sup> *Ibid* at para 5.

<sup>74</sup> *Ibid* at para 19, citing [1992] 4 All ER 614 at 622, [1993] Fam 15 (CA), Lord Donaldson, MR [*Re J*, 1992]. Note that this England and Wales Court of Appeal case is unrelated to the one cited at note 60, though they bear the same style of cause.

<sup>75</sup> *Sawatzky*, *supra* note 71 at para 20, citing *Re J*, 1992, *supra* note 74 at 625, Balcombe LJ.

<sup>76</sup> *Sawatzky*, *supra* note 71 at para 31.

abortions.<sup>77</sup> Given that this was one of the reasons cited for removing the DNR order pending a decision on the merits of the case, the implication is that requiring physicians to perform “controversial procedures” (presumably a violation of *personal* ethics) is a greater intrusion than requiring them to treat contrary to their professional ethics, although why this would be was not explained.

Ultimately, Justice Beard required the DNR order to be removed pending a decision on the merits. She recognized that Canadian law did not seem to require physicians to provide treatment contrary to their clinical judgment, but noted that there was little case law on point.<sup>78</sup> Further, the patient’s spouse was raising *Charter* arguments that had never been considered by courts.<sup>79</sup>

Mr. Sawatzky died before the matter could be decided on its merits. *Sawatzky* therefore is not precedent on the question of any obligation to provide requested treatment, but provides valuable context in the development of Canadian law.

In the *Golubchuk* case, as in *Sawatzky*, the court granted an interim injunction requiring that treatment continue, on the basis that the law was unresolved as to who had the final say about withdrawing treatment.<sup>80</sup> Thus, although treatment was required to continue, neither *Sawatzky* nor *Golubchuk* stands for the proposition that physicians must provide non-indicated treatment to patients. Mr. Golubchuk also died before the matter could be resolved on its merits.

In 2008, the Supreme Court of British Columbia upheld a physician’s decision not to provide certain treatment. In this case, *Rotaru v Vancouver General Hospital Intensive Care Unit*, a daughter sought a court order requiring her mother’s treatment, including dialysis, to resume.<sup>81</sup> Physicians had discontinued treatment because, according to one of them, “[t]o continue life-support, in my opinion, is unethical, as it has no chance of

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<sup>77</sup> *Ibid.*

<sup>78</sup> *Ibid* at para 26.

<sup>79</sup> *Ibid* at para 28.

<sup>80</sup> *Golubchuk*, *supra* note 23 at paras 25, 32.

<sup>81</sup> *Supra* note 43 at paras 1, 5.

changing the prognosis, and it does do harm in that it is prolonging Mrs. Priboi's suffering."<sup>82</sup> The court denied the order in part because it considered intervention to be inappropriate on the facts. The court was convinced that the patient's daughter was mistaken about her mother's medical situation and that continued treatment would not have been in the patient's best interests.<sup>83</sup>

In *obiter*, however, the court discussed whether it would ever be appropriate for a court to require a physician to treat contrary to her clinical judgment. It noted that the issue was unresolved in Canada and referred to a range of foreign and secondary authorities. Justice Burnyeat quoted *Legal Liability of Doctors and Hospitals in Canada* for the proposition that

once a doctor-patient relationship is formed, the doctor's obligation is to treat the patient. However, this does not mean that the doctor has a duty to provide (and the patient a correlative right to receive) whatever treatment the patient may request. If a patient requests treatment which the doctor considers to be inappropriate and potentially harmful, the doctor's overriding duty to act in the patient's best interests dictates that the treatment be withheld. A doctor who accedes to a patient's request (or demand) and performs treatment which he or she knows, or ought to know, is contraindicated and not in the patient's best interests, may be held liable for any injury which the patient suffers as a result of the treatment.<sup>84</sup>

Justice Burnyeat then quoted an excerpt from an EWCA decision:

It is trite law that in general a doctor is not entitled to treat a patient without the consent of someone who is authorised to give that consent. ... However consent by itself creates no obligation to treat. It is merely a key which unlocks a door. ... 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 emer-

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<sup>82</sup> *Ibid* at para 6.

<sup>83</sup> *Ibid* at para 18.

<sup>84</sup> *Ibid* at para 11, citing Ellen I Picard & Gerald B Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed (Toronto: Thomson Carswell, 2007) at 345–46.

gency, he has the consent of someone who has authority to give that consent.<sup>85</sup>

Then, like Justice Beard in *Sawatzky*, Justice Burnyeat referred to the 1992 English case *Re J* in concluding that the court could not order treatment to resume contrary to the physician's duty to her patient:

[T]he Lord Justices in *Re J*, were of the view that they could not conceive of any circumstances in which it would be other than an abuse of power to require a medical practitioner to act contrary to the fundamental duty which that practitioner owed to his or her patient. ... I agree with that view.<sup>86</sup>

Note, however, that the *Rotaru* court distinguished its decision from that in *Golubchuk* on the basis that *Rotaru* involved a request for treatment to be resumed, while *Golubchuk* involved a family's objection to discontinuing treatment.<sup>87</sup> Thus, Justice Burnyeat seems to have been drawing a distinction between withholding treatment – as in *Rotaru* – and withdrawing it – as in *Golubchuk*.

The first Canadian decision to seriously question the legal authority of physicians not to have to treat contrary to their clinical judgment was *Sweiss v Alberta Health Services* in 2009.<sup>88</sup> A physician had placed a DNR order on Mr. Sweiss' chart and sought to discontinue mechanical ventilation because, in his "firm belief," "forcing anything but palliative care and comfort measures upon Mr. Sweiss would be medically futile and ethically inappropriate."<sup>89</sup> In Dr. Williams' view, "[a]llowing the mechanical ventilation support to continue and requiring that CPR be performed was contrary to [the guiding principle that physicians should do no harm] and bordering on inhumane."<sup>90</sup> Thus, as with cases discussed above, the physician's rationale was partly grounded in the ethical practice of medicine.

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<sup>85</sup> *Rotaru*, *supra* note 43 at para 12, citing *Re R (A Minor) (Wardship: Medical Treatment)*, [1992] Fam 11, [1991] 4 All ER 177 at 184, 187 (CA).

<sup>86</sup> *Rotaru*, *supra* note 43 at para 16, citing *Re J*, 1992, *supra* note 74 at 622.

<sup>87</sup> *Rotaru*, *supra* note 43 at para 15.

<sup>88</sup> 2009 ABQB 691, 483 AR 340 [*Sweiss*].

<sup>89</sup> *Ibid* at paras 8, 12.

<sup>90</sup> *Ibid* at para 13.

There was evidence, however, of Mr. Sweiss' beliefs as a Muslim and what such beliefs meant in the context of medical treatment. Specifically, there was evidence that according to the Muslim faith, it was impermissible to remove life-support in Mr. Sweiss' circumstances.<sup>91</sup>

The Alberta Court of Queen's Bench addressed head on the issue of what to do where a patient's wishes or values are contrary to a physician's judgment that certain treatment should not be provided. That said, the court was primarily concerned with the test for granting an injunction, rather than the test for resolving the matter on its merits. The court noted that, unlike other motions for injunctions, cases like Mr. Sweiss' are not likely ever to be litigated on their merits, and that applying the traditional test for granting an injunction would therefore be inappropriate.<sup>92</sup> It held that the test should instead be whether the injunction is in the patient's best interests, as defined similarly to the best interests test in substitute decision making, including consideration of the patients' values, medical situation, and what is "just and equitable."<sup>93</sup> As such, neither the physician's clinical judgment nor the patient's values automatically prevail. On the facts, Justice Ouellette granted an injunction to prevent mechanical ventilation from being discontinued, but denied an injunction to remove the DNR order from Mr. Sweiss' chart. This could be viewed as drawing a distinction between withholding treatment – in this case, CPR – and withdrawing it – in this case, mechanical ventilation – but the court did not explicitly draw this distinction in making its order.

Given that the *Sweiss* court was discussing the basis for granting an injunction as opposed to interpreting the law governing medical decision making generally, caution is warranted. Nevertheless, three points are worth noting. First, Justice Ouellette explicitly disagrees with the proposition, as reflected in the law of England, that physicians should never have to treat contrary to their clinical judgment.<sup>94</sup> Rather, their clinical judgment is but one factor. Neither it nor patient values trump the other.

Second, Justice Ouellette interprets the *Personal Directives Act* as meaning that where there is a valid personal directive requesting indefinite

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<sup>91</sup> See *ibid* at paras 10–11.

<sup>92</sup> *Ibid* at paras 51–52.

<sup>93</sup> *Ibid* at para 73.

<sup>94</sup> *Ibid* at para 62.

life-support, it must be provided, even if contrary to clinical judgment: “[T]he direction must be followed despite the fact that life-support may be required for an indefinite period of time.”<sup>95</sup> Presumably, then, the best interests analysis set out in *Sweiss* is inapplicable where there is a valid personal directive. In that case, the patient’s wishes prevail and physicians may be made to treat contrary to their clinical judgment.

This is in contrast to the reasons in *Lavallee* and *Sawatzky*, which suggest a strong legal distinction between patients’ right to refuse treatment and their right to demand it. And it is certainly contrary to the law in England, which maintains a clear distinction between refusing and demanding treatment.

In my opinion, Justice Ouellette errs in *Sweiss* in interpreting the *Personal Directives Act* to require treatment contrary to clinical judgment. He relies on the language of the statute, which states that where there is a valid personal directive, medical professionals “must . . . follow any clear instructions in the personal directive that are relevant.”<sup>96</sup> Yet surely this must be understood to mean that instructions *that the patient could have given if competent* must be followed. If a competent patient cannot insist on treatment contrary to clinical judgment, putting the instruction in a personal directive cannot render it legally effective any more than a directive for the physician to stand on his head would be legally effective. Justice Ouellette is either implying that competent patients may insist on contraindicated treatment (and therefore a personal directive to the same effect is valid), or that the *Personal Directives Act* gives patients the right to dictate treatment in a personal directive that they could not dictate while presently capable. Both of these propositions lack a clear legal foundation.<sup>97</sup>

Third, given the court’s recognition that these injunction cases concerning life-sustaining treatment rarely go to trial, Justice Ouellette’s best

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<sup>95</sup> *Ibid* at para 48.

<sup>96</sup> *Personal Directives Act*, RSA 2000, c P-6, s 19(1).

<sup>97</sup> As an editor of this article noted, this point was made in *James* regarding the *Mental Capacity Act 2005*, *supra* note 57:

This Act is concerned with enabling the court to do for the patient what he could do for himself if of full capacity, but it goes no further. On an application under this Act, therefore, the court has no greater powers than the patient would have if he were of full capacity (*supra* note 55 at para 18).

interests test is the de facto law in Alberta governing whether incompetent patients are entitled to life-sustaining treatment contrary to clinical judgment. Whereas the common law, as recognized in *Lavallee* and *Sawatzky*, allows patients to refuse but never to demand treatment physicians do not offer to provide, the *Sweiss* best interests test allows treatment found to be in a patient's best interests to be demanded on behalf of incompetent patients, even if the treatment is contrary to physicians' clinical judgment.

Thus in *Sweiss*, perhaps for the first time in Canada, a court stated that the law will sometimes require physicians to provide treatment that is contrary to their clinical judgment. Justice Ouellette explicitly rejects English law on this issue.

### **C. Ontario: The Health Care Consent Act**

Finally, we come to *Cuthbertson v Rasouli*, in which the Supreme Court of Canada addressed on the merits a conflict between patient values and physicians' clinical judgment. Recall that Mr. Rasouli was unconscious and needed mechanical ventilation and artificial hydration and nutrition to live. His doctors wanted to stop providing life-support and his SDM disagreed.

The Court took a novel approach, requiring physicians sometimes to provide life-sustaining treatment contrary to their clinical judgment and their professional ethics. The legal basis for the Court's decision was the law of informed consent. The Ontario *HCCA* requires consent to "treatment,"<sup>98</sup> and the Court interpreted the statutory definition of "treatment"<sup>99</sup> broadly enough to encompass withholding and withdrawing treatment.<sup>100</sup> Thus, the Court held that consent – either that of the patient, expressed before capacity was lost, or that of the SDM – was required to withdraw Mr. Rasouli's mechanical ventilation.<sup>101</sup>

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<sup>98</sup> *HCCA*, *supra* note 7, s 10.

<sup>99</sup> *Ibid*, s 2(1).

<sup>100</sup> *Rasouli*, *supra* note 4 at para 50.

<sup>101</sup> *Ibid* at para 118.

I have written elsewhere about problems with the Court's reasoning<sup>102</sup> and do not repeat those arguments here. What is important to understand is that patients or their SDMs can effectively demand certain treatment – even harmful treatment – by refusing to consent to the treatment being withheld or withdrawn. That is, by requiring consent to withhold or withdraw treatment, the Court created a de facto entitlement to treatment. Further, the Court found this to be the case even where the treatment in question is harmful,<sup>103</sup> is contrary to physicians' professional ethics,<sup>104</sup> or offers no medical benefit.<sup>105</sup> This is essentially because the statutory definition of "treatment," for which consent is required, is unrelated to the standard of care<sup>106</sup> and to professional ethics.<sup>107</sup>

It has been suggested that *Rasouli* only applies to withdrawing treatment and not to withholding it.<sup>108</sup> However, the *HCCA* draws no distinction between withholding and withdrawing treatment. Further, the Ontario Health Professions Appeal and Review Board has since interpreted *Rasouli* as applying to both withholding and withdrawing.<sup>109</sup>

The de facto entitlement to treatment created in *Rasouli* is not unlimited, however: "[T]he withdrawal of treatment may sometimes, although not always, constitute 'treatment' [for which consent is required]."<sup>110</sup> In addition to potential resource constraints, which the parties in *Rasouli* did not address at all,<sup>111</sup> the Court recognized problems inherent in allowing

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<sup>102</sup> Young, "Withdrawing Life-Sustaining Treatment", *supra* note 10; Young, "Continued Confusion over Consent-Based Entitlements", *supra* note 10.

<sup>103</sup> *Rasouli*, *supra* note 4 at paras 6, 71–72.

<sup>104</sup> *Ibid* at paras 71–76.

<sup>105</sup> *Ibid* at paras 34–44.

<sup>106</sup> See *ibid*.

<sup>107</sup> See *ibid* at paras 73–76.

<sup>108</sup> See Chris Kaposy et al, "The Distinction between Withholding and Withdrawing Treatment in *Rasouli*: Providing a Solution to an Ethical Problem" (2014) 21 Health LJ 29 at 30.

<sup>109</sup> *EGJW v MGC*, 2014 CanLII 49888 at para 51 (Ont HPARB).

<sup>110</sup> *Rasouli*, *supra* note 4 at para 59.

<sup>111</sup> *Ibid* at para 4.

patients to demand whatever they want. The Court suggested that common sense must guide the interpretation of the legislation.<sup>112</sup> For example, patients cannot insist on the renewal of a prescription for a harmful drug.<sup>113</sup> The Court therefore attempted to distinguish situations in which patients' or SDMs' consent is required from those in which it is not, but considerable confusion remains.

As for the actual *ratio* of *Rasouli*, it is that the *HCCA*'s definition of "treatment" extends to withdrawing – and, as suggested above, likely to withholding – life-support in Mr. Rasouli's particular situation.<sup>114</sup> The Court notes that the "[t]his case does not stand for the proposition that consent is required under the *HCCA* for withdrawals of other medical services or in other medical contexts."<sup>115</sup> At a minimum, this means that consent is required to withdraw treatment where (1) mechanical ventilation is being administered; (2) turning off the ventilator will lead to imminent death; and (3) between the time the ventilator is turned off and the patient dies, palliative care drugs will have to be administered. I have suggested that, given the Court's "treatment package" reasoning, consent could be required to withhold or withdraw other life-sustaining treatments, especially if palliative care or other interventions involving touching are necessary.<sup>116</sup>

A further point to note is that where a patient lacks capacity and an SDM requests treatment, it must be in the patient's best interests. If patients with capacity or advance directives request that life-sustaining treatments be administered as long as possible,<sup>117</sup> doctors must presumably comply,

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<sup>112</sup> *Ibid* at para 58.

<sup>113</sup> See *ibid*.

<sup>114</sup> *Ibid* at para 70 ("'treatment' in the *HCCA* should be understood as extending to withdrawal of life-support in the situation at issue here and as that process is described in these proceedings").

<sup>115</sup> *Ibid*.

<sup>116</sup> Young, "Continued Confusion over Consent-Based Entitlements", *supra* note 10 at 753.

<sup>117</sup> It is very unlikely that physicians would ever want to stop providing life-sustaining treatment to a patient with present capacity who wants the treatment. See e.g. *Burke*, *supra* note 31 at para 13. It is much more likely, however, that a physician would eventually recommend stopping life-sustaining treatment in the context of an advance directive requesting that all possible measures be taken to prolong life.

or else they violate the *HCCA* as interpreted by the Court in *Rasouli*.<sup>118</sup> But if the patient lacks capacity and a substitute decision is required, that decision must be in the patient's best interests according to subsection 21(2) of the *HCCA*.<sup>119</sup>

Though one might think that the best interests requirement would solve the problem of physicians having to treat contrary to their clinical judgment in cases like those of Mr. Sawatzky, Mr. Golubchuk, Mr. Rasouli, or Mr. AVS, this is not necessarily so. First, any wish, expressed while the patient was capable, to have treatment continue as long as possible would be determinative: a best interests analysis would not be undertaken. Advance directives continue to gain in popularity and, where there is a valid advance directive, a best interests analysis is not undertaken. Thus, Mr. AVS' prior expressed wish to pursue all treatment avenues would arguably be determinative if these facts were to arise in a Canadian case.

Second, the statutory test for determining a patient's best interests takes into account (1) wishes the patient expressed while incompetent, (2) the medical implications of treatment (or non-treatment), and (3) the patient's values.<sup>120</sup> With no priority given to any of these, a wide range of decisions could be found to be in a patient's best interests. Given the Jewish and Muslim religious beliefs of Mr. Golubchuk and Mr. Rasouli respectively, it may be that continued treatment contrary to a physician's clinical judgment would be found to be in their best interests. Even in Mr. Sawatzky's case, evidence that he was a fighter or would not want to quit could be enough to satisfy a court that continued life-sustaining treatment was in his best interests. If physicians believe that treatment is not in a patient's best interests, the onus is on the physicians to prove it.<sup>121</sup> Given this onus and the nature of the best interests test, it will often be difficult for physicians to establish that treatment contrary to clinical judgment is *not* in a patient's best interests. There is some evidence that the Ontario CCB was inclined to side with

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<sup>118</sup> This is presumably subject to resource considerations, but *Rasouli* does not address this issue.

<sup>119</sup> *Supra* note 7. See also *Rasouli*, *supra* note 4 at paras 87–88.

<sup>120</sup> See *HCCA*, *supra* note 7, s 21(2).

<sup>121</sup> This follows from the fact that it is the SDM who determines the patient's best interests. That determination would apply unless someone (such as a physician, another family member, or the patient herself) challenged that decision before the Consent and Capacity Board. See *ibid*, s 21.

physicians on best interests assessments, but there is also evidence that, even before *Rasouli* was decided, this was changing.<sup>122</sup>

To be clear, the Court did not require the *Rasouli* physicians to continue treatment, but rather offered “practical solutions” such as transferring the patient to another hospital.<sup>123</sup> This is an acknowledgement that if doctors’ concerns can be addressed without undue inconvenience to the patient, that would be permissible. However, such transfers will often be hard to obtain. Where the objection to treatment is grounded in clinical judgment, other physicians may also not want to take on the patient’s care for the same reason. In Mr. Rasouli’s own situation, doctors were unable to find another hospital to which to transfer Mr. Rasouli,<sup>124</sup> despite this occurring in Toronto – a large city where transfer options are presumably as numerous as anywhere in Canada. Recall that in Mr. Goluchuk’s situation, three physicians refused to treat Mr. Golubchuk, causing disruptions in the intensive care unit. That said, according to Jeff Blackmer, then executive director of the Office of Ethics at the Canadian Medical Association, “someone will always step forward.”<sup>125</sup>

In response to the physicians’ argument in *Rasouli* that being required to treat contrary to their professional ethics placed them in an “untenable ethical position,”<sup>126</sup> the Supreme Court simply noted that ethical tensions are “inherent to medical practice.”<sup>127</sup> It compared the physicians’ ethical concerns to those of physicians wanting to impose treatment in accordance with the standard of care on patients who wish to refuse it. Notably, the

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<sup>122</sup> According to a study of Ontario Consent and Capacity Board (CCB) decisions, before 2009 the CCB always agreed with physicians’ assessments of best interests. However, between 2009 and 2012, the CCB sided with the SDM in five cases (38% of cases). After *Rasouli*, which places such weight on patient values at the end of life, it will be interesting to see whether SDMs begin to succeed even more often when it comes to best interests determinations. See 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 Crit Care 22 at 23–24.

<sup>123</sup> *Rasouli*, *supra* note 4 at para 75.

<sup>124</sup> See *Rasouli*, *supra* note 4 (Factum of the Appellant at para 19).

<sup>125</sup> Smith, *supra* note 26.

<sup>126</sup> *Rasouli*, *supra* note 4 at para 71.

<sup>127</sup> *Ibid* at para 73.

Court analogized to *Malette v Shulman*, in which a doctor performed a blood transfusion on a patient who was a Jehovah's Witness and who possessed a card indicating her refusal to have a blood transfusion under any circumstances.<sup>128</sup> On this point, the Court affirmed, the law is clear: a physician cannot force a blood transfusion on a patient just because it is medically indicated, or because it would implicate the physician's professional ethics *not* to provide it.<sup>129</sup> Therefore, the Court reasoned, the physicians' ethical argument cannot prevail over the autonomy interests of patients.

In essence, then, the Supreme Court rejected the distinction between acts and omissions in this context: it equated *requiring* physicians to treat contrary to their professional ethics with *not allowing* them to treat according to their professional ethics. By the same token, the Court dismissed the claim that inflicting harmful treatment would necessarily conflict with the fundamental duty of physicians not to harm their patients:<sup>130</sup> so long as the course of treatment is determined in accordance with the framework of the *HCCA*, a physician cannot be faulted.<sup>131</sup>

In addition to dismissing the doctors' ethical concerns as "inherent to medical practice," the Court noted that the physician's clinical judgment may conflict with the standard of care or fiduciary duties in which case, as under the *HCCA*, the law may require the physician to treat contrary to her professional ethics.<sup>132</sup> This is a red herring. While true that such a conflict could exist and could require treatment contrary to a doctor's clinical judgment and ethics,<sup>133</sup> that was not the situation in cases like *Rasouli*, *Golubchuk*, and *Sawatzky*. Rather, the refusal to provide treatment

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<sup>128</sup> *Ibid*, citing *Malette v Shulman* (1990), 72 OR (2d) 417, 67 DLR (4th) 321 (CA).

<sup>129</sup> *Rasouli*, *supra* note 4 at para 73.

<sup>130</sup> Also known as the principle of nonmaleficence, the obligation to do no harm is described in Tom L Beauchamp & James F Childress, *Principles of Biomedical Ethics*, 6th ed (New York: Oxford University Press, 2009) at 149.

<sup>131</sup> *Rasouli*, *supra* note 4 at paras 71–72.

<sup>132</sup> *Ibid* at para 73.

<sup>133</sup> Imagine, for example, that a physician decided not to offer her patients a new cancer drug, despite its potential effectiveness, because she holds a minority view that it has not been sufficiently tested. Assuming the standard of care required prescribing the drug, the physician could be negligent in failing to do so despite an objection grounded in professional ethics.

in the cases canvassed above seemed to be consistent with the standard of care<sup>134</sup> and fiduciary duties.<sup>135</sup> *James*, discussed above, suggests that in England, a physician's clinical judgment will not prevail if it is unreasonable (i.e., contrary to the standard of care), but *Rasouli* is not a case that raises such conflicts.

Thus, notwithstanding the possibility of "practical solutions," the Court was dismissive of the physicians' claims not to have to provide treatment contrary to their professional ethics. It did not engage with English law and dismissed Canadian common law as "not at all settled."<sup>136</sup>

Nothing in the legislative history suggests that the Ontario legislature intended for the *HCCA*, which was based in large part on the common law, to create entitlements to treatment contrary to clinical judgment.<sup>137</sup> Yet its language, combined with the Court's reasoning in *Rasouli*, makes this inevitable. Ontario law now requires doctors to provide certain treatment requested by patients or SDMs, even if contrary to clinical judgment and professional ethics and even if harmful to patients.<sup>138</sup> The fact that a substitute decision to insist on treatment must be in a patient's best interests does not negate the possibility of treatment contrary to clinical judgment being legally required. Such situations will presumably not arise often, but the law of Ontario allows for them to arise.

This is a new situation for physicians. Before *Rasouli*, Canadian doctors arguably owed no legal duties to treat contrary to their clinical judgment – at least so long as that judgment was consistent with the standard of care and

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<sup>134</sup> In *Rasouli*, *supra* note 4 at para 38, the Court effectively acknowledged that the withdrawal of treatment was consistent with the standard of care: "The issue here is not the correctness of the physicians' professional opinion that sustaining life in Mr. Rasouli's situation confers no medical benefit. In fact, their opinion appears to reflect a widely accepted view in the medical community."

<sup>135</sup> In fact, the majority in *Rasouli* says that since the law of fiduciary duties has not been used to condemn physicians' "good-faith treatment decisions," it is unlikely to protect patients in Mr. Rasouli's situation (*ibid* at para 111).

<sup>136</sup> *Ibid* at para 53.

<sup>137</sup> The Court stated that the *HCCA* was not simply a codification of the common law (*ibid* at para 52). But see Young, "Withdrawing Life-Sustaining Treatment", *supra* note 10 at 68.

<sup>138</sup> See e.g. *Rasouli*, *supra* note 4 at paras 71–72.

fiduciary duties.<sup>139</sup> Patient autonomy meant that patients always had a say in their treatment, but there was a clear dividing line between their right to refuse treatment, which was almost absolute, and their right to have it, which was limited in a number of ways. Treatment could not be withheld discriminatorily or unreasonably, as this would constitute negligence, violate rules of professional conduct, or violate human rights law, but doctors apparently enjoyed considerable discretion in which treatments they proposed to provide.

This may still describe the common law, but in Ontario per the *HCCA*, doctors' clinical judgment carries little weight – at least when it comes to whether to continue certain life-sustaining treatment. Physicians will sometimes be required to practice contrary to clinical judgment unless they can arrange for the patient to be treated by another doctor.

The trend toward greater patient autonomy means that the boundary between refusing and demanding treatment has been blurred. And as a result, there may increasingly be demands for treatment that physicians consider contrary to their clinical judgment. Some will continue to refuse to provide such treatment on the basis that they have no obligation to provide it, but particularly where end-of-life care is at issue, their right to do so is uncertain.

One final thing to note is that the scope of the *Rasouli* decision is unclear. It is grounded in Ontario legislation. I have written elsewhere about the extent to which *Rasouli* is likely to be considered binding or persuasive in other Canadian jurisdictions.<sup>140</sup> Essentially, given that legislation similar to the *HCCA* exists in British Columbia, Prince Edward Island, and Yukon, *Rasouli* should be highly persuasive in those jurisdictions.<sup>141</sup> In Manitoba, Newfoundland and Labrador, and the Northwest Territories, *Rasouli* may be persuasive because of their health care directives statutes,<sup>142</sup> but I have

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<sup>139</sup> *Sweiss* could be viewed as authority to the contrary, but it dealt with the test for injunctions only.

<sup>140</sup> Young, “Continued Confusion over Consent-Based Entitlements”, *supra* note 10.

<sup>141</sup> British Columbia *Act*, *supra* note 45; *Consent to Treatment and Health Care Directives Act*, RSPEI 1988, c C-17.2; *Care Consent Act*, s 3, being Schedule B to the *Decision Making Support and Protection to Adults Act*, SY 2003.

<sup>142</sup> Manitoba *Act*, *supra* note 45; Newfoundland *Act*, *supra* note 45; *Personal Directives Act*, SNWT 2005, c 16.

argued that the statutes are sufficiently different than the *HCCA* that *Rasouli* should not govern their interpretation.<sup>143</sup> The remaining common law jurisdictions (Alberta, New Brunswick, Nova Scotia, Saskatchewan, and Nunavut) have legislation even less similar to the *HCCA*, so *Rasouli* should not guide the interpretation of those jurisdictions' statutes at all. Finally, since Québec has no statute like the *HCCA* and is not governed by the common law, it is least likely to be affected by *Rasouli*, as is reflected in *Centre hospitalier de l'Université de Montréal c WL*, discussed below. That said, it may be that courts will interpret other provinces' statutes or develop their common law to reflect the Supreme Court's reasons in *Rasouli*.

#### ***D. Canada: Civil law (Québec)***

Since *Rasouli*, the only relevant reported decision from a jurisdiction other than Ontario is from Québec. A court there held that a Montréal doctor was entitled to remove mechanical ventilation from a patient in a persistent vegetative state (“état neurovégétatif”) despite the objections of the patient’s SDMs and despite arguments based on *Rasouli*.<sup>144</sup> The court implicitly considered continued life-support not to be in the patient’s best interests. It noted that substitute decisions in Québec must be in a patient’s best interests and that being kept alive is not always in a person’s best interests.<sup>145</sup> Since in Ontario substitute decisions must also be in a patient’s best interests, it is not clear whether and to what extent relevant Québec law differs from that in Ontario.

To summarize, Canada has a patchwork of statutory and common law approaches, with the common law being largely unsettled. Although confusion remains as to the interpretation of statutes, including the *HCCA*, the law in Ontario is settled on the point that physicians must sometimes provide treatment if a refusal to do so would lead to imminent death preceded by a need for palliative care. This is so even if the treatment is contrary to the standard of care or contrary to a physician’s professional ethics, although subject to the requirement that substitute decisions be in a patient’s

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<sup>143</sup> Young, “Continued Confusion over Consent-Based Entitlements”, *supra* note 10 at 751.

<sup>144</sup> *Centre hospitalier de l'Université de Montréal c WL*, 2014 QCCS 1864 at paras 1, 2, 7, 12, 16, [2014] JQ no 2991 (QL).

<sup>145</sup> *Ibid* at paras 4, 10.

best interests. In addition, all such treatment requested by competent patients (in an advance directive, for example) must be respected. This is in contrast to the law of England under which physicians' clinical judgment prevails. In general, this means that if a physician decides that treatment is not indicated, it need not be provided even if requested by a patient or SDM and even where life-sustaining treatment is at issue.

### **III. REASONS FOR AND AGAINST ALLOWING PHYSICIANS TO LIMIT ACCESS TO TREATMENT BASED ON THEIR CLINICAL JUDGMENT**

The law in Ontario is relatively settled, although unclear in some of its details. That does not preclude legislative amendment, although that seems unlikely in the near future. But in many parts of Canada, legislators or courts will have to confront the issue of whether physicians must provide treatment contrary to clinical judgment – especially at the end of life. In arriving at a principled approach, it will be useful to assess the benefits and detriments of the different options. To help structure the analysis, I set out the benefits of allowing clinical judgment to prevail (essentially, the law of England) and of allowing patient/family wishes to prevail (the law of Ontario regarding life-sustaining treatment, but not necessarily other treatments).

#### ***A. Reasons for allowing clinical judgment to prevail***

##### **1. Physicians have a moral claim to practice according to their clinical judgment**

Practicing according to one's clinical judgment has profound moral implications for physicians. It is not simply a matter of wanting to avoid professional disciplinary proceedings. Unlike performing MAID or abortions, these implications are not grounded in personal values, but rather in the values and ethics of the medical profession.<sup>146</sup>

The moral claim to practicing according to clinical judgment flows from the nature of the profession and its role in society. Doctors share a "common

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<sup>146</sup> See e.g. Pellegrino, "Patient and Physician Autonomy", *supra* note 1 at 51–52; TA Cavanaugh, "Professional Conscientious Objection in Medicine with Attention to Referral" (2010) 9:1 Ave Maria L Rev 189 at 191; Montgomery, *supra* note 12 at 201; Daar, "Clash", *supra* note 9 at 1244–45.

purpose and a common set of ethical ideals” that are “morally grounded.”<sup>147</sup> According to Pellegrino, autonomy as a physician is grounded in the inequality of the doctor-patient relationship, the nature of medical knowledge and decision making, and the moral complicity of physicians in what happens to their patients.<sup>148</sup> These factors suggest that

the physician [must] be free to use [her knowledge] according to her best judgment. If the physician is to fulfill the moral requirement to make her knowledge available to those who need it, she must be allowed sufficient discretionary latitude to apply that knowledge as rationally, efficiently, and safely as possible.<sup>149</sup>

Pellegrino continues:

For patients to claim a right to any procedures they wish is to challenge a conscientious physician’s integrity as a physician. It depreciates his expertise, reduces his discretionary latitude in decision-making, and makes him a technical instrument of another person’s wishes. . . . Such demands violate the internal morality of medicine as a practice.<sup>150</sup>

Montgomery notes that the medical profession is “ethically as well as scientifically orientated,” and claims that protecting professional discretion is not simply a matter of deference to professional skill, but of “ensur[ing] that professional morality can prevail.”<sup>151</sup>

Few could doubt that physicians have a moral claim to practicing their profession in a certain way, but of course that does not mean that such a claim should prevail in law. Like all moral claims, claims to practice according to clinical judgment must be assessed in light of the interests of others.

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<sup>147</sup> Edmund D Pellegrino, “The Medical Profession as a Moral Community” (1990) 66:3 Bull NY Acad Med 221 at 226.

<sup>148</sup> *Ibid.*

<sup>149</sup> Pellegrino, “Patient and Physician Autonomy”, *supra* note 1 at 52–53.

<sup>150</sup> *Ibid* at 59.

<sup>151</sup> Montgomery, *supra* note 12 at 204.

## 2. Physicians' clinical judgment protects patients

One might think that the claim of physicians to practice according to their professional standards is relatively weak in light of the fact that the patient is the one with the most at stake – their interests must generally prevail as physicians must put patients' interests first. However, physicians have argued that allowing them to practice according to their clinical judgment is justifiable precisely because that approach is the best for patients. Montgomery argues:

[T]he consistent and persistent protection of clinical judgement in medical and healthcare law ... is related not to the personal expertise and morality of doctors ... but to the way in which they are thought to embody a tradition of both technical expertise and moral values. The normative legitimacy of this extensive respect for professional discretion lies principally in the belief that protecting this embodied tradition provides a reliable protection for patient interests. These are understood as being more than merely the expression of individual patient wishes.<sup>152</sup>

Pellegrino adds that simply allowing patients to have whatever treatment they want, without regard to professional ethics, can be bad for patients:

[Patient demands] can redound to the patient's harm by undermining the physician's moral obligation to provide sound advice and sound practice and to avoid medically useless or futile treatments.<sup>153</sup>

This is, of course, paternalism. Physicians are saying that they know better than patients what is good for them. This approach to medicine has largely been discredited in the refusal context. That is, patients may refuse any treatment regardless of whether physicians believe it is in the patient's medical interests. The law has recognized that patients are the best judges of their own best interests.

Yet the issue being examined in this article is not the refusal context, it is the demand context. We must therefore consider whether there is some role for paternalism in a demand context, notwithstanding the fact that in

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<sup>152</sup> *Ibid* at 209.

<sup>153</sup> Pellegrino, "Patient and Physician Autonomy", *supra* note 1 at 59.

law there is virtually none in the refusal context. A system that rejects paternalism completely in favour of patient autonomy must give capable patients whatever they want, including antibiotics for a viral infection and opiates when they are not in pain. And capacity is a low threshold that can be met despite serious mental illness, for example.<sup>154</sup> I think that most would agree that physicians should be allowed to deny prescriptions for antibiotics and opiates for the good of the patient. If so, we have not abandoned paternalism completely.

Arguably, there is still a role for clinical judgment to prevail so as to prevent patients from being able to demand whatever they want. It is well established that patients can and should be able to refuse treatment regardless of clinical judgment. But there should perhaps be a sharp line between the demand and refusal contexts – between acts and omissions.

The Supreme Court in *Rasouli* was not persuaded by the moral relevance of this distinction, since it equated the impact of forcing physicians to treat contrary to their clinical judgment with denying them the opportunity to treat according to their clinical judgment. Although the distinction between acts and omissions is not always of great moral significance, there are important differences between requiring a doctor to act contrary to her clinical judgment and not permitting her to act in a manner supported by her clinical judgment.

There is an important difference in both the nature of the interference with the physician's freedom and the nature of the impact on the patient. Requiring physicians not to intervene in circumstances where they would like to help raises ethical issues, but presumably not to the same degree (all other things being equal) as forcing them to intervene in a manner they feel violates their professional obligations.<sup>155</sup>

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<sup>154</sup> See *Starson v Swayze*, 2003 SCC 32 at paras 55, 77, [2003] 1 SCR 722.

<sup>155</sup> This conclusion is based on the general proposition that prohibiting acts is less of an infringement on liberty than requiring acts. That said, this statement should not be understood to mean that physicians can have no ethical objection to being denied the ability to practice in a certain way. See Jacqueline Shaw & Jocelyn Downie, "Welcome to the Wild, Wild North: Conscientious Objection Policies Governing Canada's Medical, Nursing, Pharmacy and Dental Professions" (2014) 28:1 *Bioethics* 33 at 34 ("[t]ypically, healthcare conscientious actions are negative, involving 'conscientious refusals' of requested procedures. However, objection may also involve positive activity").

But the rule that patients may refuse but not demand treatment is not primarily grounded in the moral distinction *for physicians* between acts and omissions (i.e., being *forced* to treat contrary to clinical judgment versus not being *allowed* to treat). Rather, the rule has more to do with the serious nature of imposing unwanted medical treatment *on the patient*. Patients' negative right against interference with their bodily integrity is of profound importance. The issue is quite different where a positive claim of entitlement to treatment is raised: there is no prospect of forcing unwanted treatment on someone and at least arguably no issue of interference with bodily integrity.<sup>156</sup> It is therefore problematic, in my view, for the Supreme Court simply to dismiss physicians' claims not to have to practice contrary to their professional ethics by analogizing this tension to their inability to impose unwanted medical treatment on unwilling patients.

The other important difference between the demand and refusal contexts is that only in the former is there any realistic possibility of treatment being offered contrary to the standard of care. Assuming that doctors only offer treatments that are indicated, the patient may refuse to her physical detriment and it is her underlying condition that will cause her physical harm. She will not, however, receive treatment that is not indicated and that may harm her, unlike in the demand context. This is another reason why requiring doctors to act contrary to their clinical judgment is not morally equivalent to not permitting them to treat at all.

The different nature and consequences of allowing physicians to select the range of options from which a patient may choose versus allowing physicians to impose unwanted treatment on patients justify a different legal approach to each. The former may be justifiable even if the latter is not.

Some have made a different kind of argument to the effect that allowing physicians to practice according to clinical judgment is good for patients. It is that to require physicians to simply do whatever patients ask of them would have such a detrimental effect on the medical profession as a whole that all patients would be worse off. Bleich states that requiring doctors to do what their patients want them to do, regardless of clinical judgment, is "likely to have a corrosive effect upon the dedication and zeal with which

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<sup>156</sup> I say "arguably" because part of the Court's reasoning in *Rasouli* relied on the fact that removing the ventilator would require touching and that giving palliative care drugs definitely requires touching (*supra* note 4 at paras 62–64). In other words, the Court's reasoning relied in part on the claim that bodily integrity *is* implicated when certain life-sustaining treatment is withdrawn.

[a physician] ministers to patients.”<sup>157</sup> He argues that the more a physician becomes simply the instrument of her patient’s wishes, the less able she will be to carry out the full range of roles that make the medical profession what it is.

Yet one should not take this argument too far. A similar point might once have been made against allowing patients unlimited discretion to refuse treatment. That too might have been argued to interfere with the physician’s complex role and affect their “zeal.”

### **3. A publicly-funded medical system should not provide “bad medicine”**

Another argument in favour of allowing physicians to practice according to clinical judgment is that a medical system funded by taxpayers should not provide medically inappropriate interventions simply because patients want them.

There are two aspects to this argument. One relates to resources. Rationing is necessary in our publicly funded system. We cannot give every patient every medically useful intervention in a timely manner, so why would we expend public resources on medically useless or harmful ones? One answer to this is that what is medically useful is not the sole consideration when it comes to medical decision making, and this is incontrovertible. Patients may refuse treatment for non-medical reasons. But there is a difference between, on the one hand, taking patient values into account in deciding whether to have one or another (or neither) of the proposed, medically endorsed treatments, and, on the other, allowing patient values to justify providing treatment that is not medically endorsed. The fact that health

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<sup>157</sup> J David Bleich, “The Physician as a Conscientious Objector” (2002) 30:1 Fordham Urb L J 245 at 245. See also Daar, “Clash”, *supra* note 9 at 1245:

At the very least, ignoring the moral, ethical, and professional make-up of the physician can only serve to chill communications between doctors and patients. That is, stripped of their ability to advocate based on their own belief system, doctors may begin to perceive themselves as “medical vending machines” whose only role is to dispense medical treatments. This image of a physician as a mere purveyor of medical “goods” belies the notion that an essential element of the doctor-patient relationship is open communication about treatment options.

care resources are finite is an additional reason for allowing only medically endorsed treatments to be provided.

The other aspect of the argument is that, beyond the issue of resources, the state should not participate in a system that administers potentially harmful interventions solely because they have been requested. If a system of unconstrained autonomy – or autonomy constrained only minimally (by lack of resources, for example) – can be harmful to patients, as suggested above, then the state should not condone this through its regulation and funding of the health care system.

One may accept these points in principle but disagree about whether a particular treatment is medically appropriate. What constitutes “bad medicine” is subjective and contentious. The literature on futility demonstrates how difficult it is to objectively determine whether treatment is beneficial. This point is discussed further in Part III(B)(3) below.

#### **4. A life-sustaining treatment exception is difficult to justify**

One might agree that patients should not *generally* be able to demand whatever medical interventions they want, regardless of how harmful or expensive, but still conclude that there should be a narrow entitlement only to *life-sustaining* treatment. Although this is currently the law in Ontario, I do not view such a distinction as principled.

The Supreme Court in *Rasouli* justified an entitlement to life-sustaining treatment, but not to other kinds of treatment (e.g., a prescription for harmful drugs) in part on the basis that life-and-death decisions implicate autonomy in a fundamental way, such that a different approach to them could be justified.<sup>158</sup> But there are two problems with this assumption. The first is the effect of incapacity on autonomy. The *Rasouli* Court stated that autonomy interests are diminished in incapable patients:

If a patient is incapable ... [t]he focus shifts from the patient’s autonomy interest, *which is compromised or extinguished*, to whether receiving treatment is in the best interests of the patient.<sup>159</sup>

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<sup>158</sup> *Supra* note 4 at paras 51, 57, 68.

<sup>159</sup> *Ibid* at para 21 [emphasis added].

Many, if not most, decisions about whether life-sustaining treatment should be withheld or withdrawn will involve patients who lack capacity. SDMs, not patients, will make these decisions, at least in the absence of an advance directive.

The second problem in the Court's reasoning is that it cannot account for why certain interventions like a prescription for a harmful drug would *not* be considered treatment, given that autonomy is clearly implicated. Although the Court implies it, it is not self-evident that life-and-death decisions are inherently more autonomy-implicating than other kinds of medical decisions. Decisions about whether to withhold or withdraw life-sustaining treatment tend to involve people who are extremely ill. It is misleading to frame these simply as decisions about whether a patient lives or dies. They are often better thought of as decisions about *when* a patient dies and about *how* she will spend her final days. These are, of course, important decisions. It is not obvious to me, however, that they are necessarily more autonomy-implicating, or otherwise worthy of respect, than other kinds of treatment decisions.

Consider, for example, the situation of a competent patient who, due to mental illness, wants a healthy limb amputated or an addicted patient who wants a prescription for a large quantity of opiates. These scenarios certainly implicate patient autonomy, arguably to a greater extent than the situation in *Rasouli*, since in these examples the patient is competent, aware, presently suffering, and will continue to suffer – perhaps for years – if the requested intervention is not provided. It is therefore difficult to create a principled, autonomy-based rationale that grounds patients' entitlement to life-sustaining treatment contrary to clinical judgment but not to other kinds of treatment.<sup>160</sup>

To summarize, arguments in favour of allowing physicians to deny access to treatment contrary to their clinical judgment include:

- (1) physicians have a moral claim to practice according to their clinical judgment;
- (2) physicians' clinical judgment protects patients;
- (3) a publicly-funded medical system should not provide "bad medicine"; and

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<sup>160</sup> For more on this argument, see Young, "Continued Confusion over Consent-Based Entitlements", *supra* note 10 at 755–57.

(4) a life-sustaining treatment exception is difficult to justify.

## **B. Reasons for allowing patient/family wishes to prevail**

### **1. Respecting a patient's wishes promotes autonomy**

The strongest argument against letting physicians limit treatment based on their clinical judgment is that giving patients what they want advances a patient-centered approach to medical decision making. It extends what patients already have in the refusal context – that is, virtually absolute control over decision making – to the demand context. The law has long acknowledged that competent patients may refuse treatment for non-medical reasons<sup>161</sup> – for religious reasons, for example, or because they value being free of significant pain over simply being alive. Yet patients' values affect decisions not only to refuse offered treatment but also to receive certain treatments that may not be offered. *Rasouli* acknowledges this by extending patient autonomy in medical decision making beyond the refusal context and into to the demand context, albeit in limited circumstances.

This is consistent with the development of the law of consent in recent decades. Consent to medical treatment began strictly as a matter of protecting bodily integrity. Consent was a defence to battery just as in non-medical contexts.<sup>162</sup> Later, the law of *informed* consent developed into a matter of the standard of care in negligence: it is negligent not to include the patient in decision making. Specifically, failing to provide relevant information before obtaining permission to treat is a breach of the standard of care in negligence.<sup>163</sup> Requiring physicians to provide requested treatment contrary to their clinical judgment therefore simply reflects the trend, widely considered positive, toward greater recognition of patient autonomy in medical decision making.

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<sup>161</sup> According to Pellegrino, citing *Schloendorff v Society of NY Hosps*, 105 NE 92, 93 (NY 1914), patients' right to make medical decisions that reflect their values, in the form of a right to refuse treatment, dates to 1914 (though this date may only reflect the US context) ("Patient and Physician Autonomy", *supra* note 1 at 59).

<sup>162</sup> See e.g. *Non-Marine Underwriters, Lloyd's of London v Scalera*, 2000 SCC 24 at para 6, [2000] 1 SCR 551.

<sup>163</sup> See *Reibl v Hughes*, [1980] 2 SCR 880, 114 DLR (3d) 1.

Although I argued against this point above, there is support for the proposition that at least where decisions have life-and-death consequences, patient autonomy justifies limiting physicians' discretion to withhold or withdraw treatment. The Supreme Court stated in *Rasouli* that "[t]he values of autonomy – *critical where life is at stake* – ... support regarding withdrawal of life-support as 'treatment' requiring consent."<sup>164</sup> The Court continued: "By removing medical services that are keeping a patient alive, withdrawal of life-support impacts patient autonomy in the most fundamental way."<sup>165</sup> Although the Court provides no support for this proposition, treating it as self-evident, I think many would agree. Thus, patient values could arguably ground entitlements to certain life-sustaining treatment but not to other kinds of requested treatment, even if the treatment is contrary to a physician's clinical judgment.

Some have argued for such an approach, based largely on the importance of patient autonomy. In their article, Downie, Willmott, and White argue that physicians should not be able to withhold or withdraw potentially life-sustaining treatment from patients unless the situation falls within a narrow range of exceptions. These include impossibility (e.g., the doctor is not trained to provide the requested procedure); ineffectiveness (e.g., the patient requests antibiotics to cure her viral infection); and government resource allocation policies.<sup>166</sup> This proposal is similar in its effect to the law of Ontario, although it is clearer and more principled. That said, in my view it goes too far in terms of allowing patients and families to receive treatment contrary to clinical judgment.

## 2. Allowing physicians to decide could veil improper decisions

A second reason to support physicians being compelled to provide requested treatment contrary to their clinical judgment is that to do otherwise increases the risk that discriminatory or other improper decisions will be protected under the guise that the physician is applying clinical judgment.

Physicians have significant power. If they can unilaterally choose to withhold certain treatments from patients, how is one to know whether those decisions are grounded in objective medical science (e.g., in cases where

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<sup>164</sup> *Rasouli*, *supra* note 4 at para 51 [emphasis added].

<sup>165</sup> *Ibid* at para 68.

<sup>166</sup> Downie, Willmott & White, *supra* note 11 at 824–28.

antibiotics will not help someone with a viral condition) or in *personal* values. It may be that the physician would not want to live in the patient's state herself or that such pain would be intolerable to her. The physician's assessment that continued treatment is inappropriate could even be influenced – subconsciously, one hopes – by her views of particular patients. Perhaps fewer efforts would be made for a poor person than for a wealthy one, for a well-educated one than for an uneducated one, or for one without a loving family than for one with such a family. Indeed, “a high degree of discretion enables the prejudices of professionals on ‘deserving’ and ‘undeserving’ supplicants for services to go unchecked.”<sup>167</sup>

Whereas it may be justifiable for physicians to deny treatment based on objective medical facts, it is not justifiable for them to deny treatment based on their personal value judgments. The physician has no special moral authority and “has no standing as an expert in human values.”<sup>168</sup>

And yet, “[p]ersonal and professional ethics are not fully separable from each other.”<sup>169</sup> Particularly where the decision is whether to withhold or withdraw life-sustaining treatment, value judgments are hard to avoid. Permitting physicians not to treat because of their clinical judgment means that decisions not to treat for other reasons may be impossible to detect.

This is a serious concern. Yet it might be somewhat mitigated by the fact that decisions about what is medically appropriate – particularly where life-sustaining treatment is involved – are often made by teams of physicians and other health care professionals rather than by individuals. This helps to protect against decisions that reflect the personal biases of individual doctors. Further, second opinions and the patient's opportunity to change doctors could help prevent such abuses. Nevertheless, physicians and the medical profession in general may share certain values and biases not shared by their patients.

### 3. Clinical judgment is often subjective

A related point concerns the issue of medical futility. As a matter of principle, few think that doctors should be required to provide truly futile

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<sup>167</sup> Montgomery, *supra* note 12 at 205.

<sup>168</sup> Pellegrino, “Patient and Physician Autonomy”, *supra* note 1 at 53.

<sup>169</sup> *Ibid* at 51.

medical treatment. But in practice, what constitutes futile treatment is controversial and subjective.<sup>170</sup> It may be incontrovertible that providing antibiotics to a patient with a viral infection is futile, in the sense that it cannot be of medical benefit. But other applications of clinical judgment are more subjective. *Rasouli* provides a good example. Mr. Rasouli's wife, a physician herself, believed that continuing mechanical ventilation was of medical benefit to her husband. Doctors Cuthbertson and Rubenfeld disagreed. It is an ancient principle of medical ethics "to desist from treatment when the limits of medicine's power had been reached,"<sup>171</sup> but since there are often no objective criteria for assessing these limits, the question of when to stop treating is open to debate.

The physicians in *Rasouli* were initially willing to provide mechanical ventilation and other life-sustaining treatment because it was indicated. However, the longer patients like Mr. Rasouli go without any improvement in their condition, the less likely it is that they will recover.<sup>172</sup> At what point does the treatment go from being indicated to being contraindicated? Reasonable physicians can disagree. Although grounded in professional standards, the claim to practice according to clinical judgment is individual. Given this uncertainty and variability, the patient's values and wishes should arguably take on greater importance. Again, this risk might be mitigated somewhat by the ability to obtain second opinions and to change doctors. That said, this option will often be more theoretical than real, given power disparities between physicians and SDMs and issues of limited access to physicians in many Canadian communities.

#### 4. Physicians make mistakes

Another reason not to allow physicians to limit treatment options based on their clinical judgment is that doctors make mistakes. They make

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<sup>170</sup> See e.g. *ibid* at 59–60. See also sources discussing medical futility, *supra* note 14.

<sup>171</sup> Pellegrino, "Patient and Physician Autonomy", *supra* note 1 at 60.

<sup>172</sup> See Steven Laureys, "Eyes Open, Brain Shut", *Scientific American* (May 2007) 32 at 34, online: <[www.scientificamerican.com/article/eyes-open-brain-shut](http://www.scientificamerican.com/article/eyes-open-brain-shut)> ("After a month [in a vegetative state], however, the patient is said to be in a persistent vegetative state (PVS) and the probability of recovery diminishes as more time passes").

mistakes about diagnosis and prognosis, and they may misjudge the standard of care. Given that the medical knowledge grounding clinical judgment is imperfect and given that what constitutes sound medical care is contextual and can change over time, it could be argued that patients should have access to treatment even if contrary to a physician's clinical judgment.

That said, this argument might suggest that clinical judgment should prevail where there is certainty (or near certainty) about diagnosis, prognosis, treatment, etc. but not where there is less certainty. A rule based on such a distinction would, I think, be unwieldy and undesirable.

To summarize, arguments in favour of allowing patients to determine their treatment, even when contrary to a physician's clinical judgment, include:

- (1) respecting a patient's wishes promotes autonomy;
- (2) allowing physicians to decide could veil improper decisions;
- (3) clinical judgment is often subjective; and
- (4) physicians make mistakes.

#### IV. WHAT APPROACH FOR CANADA GOING FORWARD?

I have set out some of the arguments for and against allowing physicians unilaterally to withhold or withdraw treatment on the basis that it is contrary to clinical judgment. What policy, then, should Canada's legislatures adopt?

I offer a novel approach. My own view is that the law took a misstep with *Rasouli*. The law of informed consent, in statute or at common law, should never be interpreted as creating a duty to treat contrary to clinical judgment. Duties to treat might reasonably be found in the law of negligence (duty or standard of care), in equity (fiduciary duties), or in professional standards. That said, it may be going too far to give physicians discretion limited only by fiduciary duties and professional standards (the standard of care generally being a question of customary practice).

My suggested approach would provide a middle ground. It offers some of the benefits of English and Ontario law while avoiding some of the worst drawbacks of each. I take as my starting point that there must be

*some* paternalism in the system: patients should not be entitled to any treatment they like, limited only by resource or effectiveness considerations, and perhaps also public health reasons.<sup>173</sup> In addition, my proposal relies on the view, discussed above, that it is unprincipled to have a distinct set of rules for life-sustaining treatments and other treatments. I do not think such a bright line, implicit in the Court's reasoning in *Rasouli*, is justifiable on the basis of autonomy or otherwise on the basis of the finality or gravity of death. My proposal would therefore apply to all treatment decisions.

In essence, my view is that where patients, or their SDMs, and physicians disagree about whether a treatment should be withheld or withdrawn, the test should be one of reasonableness. Unlike in negligence law, however, the question should not be whether a physician's treatment decision is reasonable. Rather, the question should be whether it is unreasonable to provide the treatment requested by the patient or her SDM in the circumstances. This makes the inquiry different from that in negligence law in three ways. First, the onus would be on physicians to show that providing a requested treatment is unreasonable in the circumstances. This decreases the burden on patients and SDMs. The second difference from a negligence analysis is that many more treatment options would be available to patients, while still allowing for truly harmful or otherwise unreasonable treatments (e.g., opioids for a patient who is not in pain) to be denied to patients. More options are available because anything that is not unreasonable is permitted, whereas under negligence law the physician's treatment decision is lawful unless it is unreasonable. Third, reasonableness would not be measured solely (or even primarily) with regard to professional standards. Where patient values, resources, or other non-medical criteria are at issue, they should inform the reasonableness analysis. This follows from the fact that the question is whether what the patient or SDM wants is unreasonable, as opposed to whether the physician's acts were reasonable. The latter implicates professional standards of care, whereas the former does not.

The best interests test would apply only in the refusal context for substitute decisions. That is, the proposed approach would apply to both capable and incapable patients where treatment is demanded by patients or their SDMs. In the refusal context, existing law would apply.

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<sup>173</sup> The idea for a public health exception emerged out of conversations with Jocelyn Downie and Michael Hadskis.

### A. Reasonableness

Several aspects of this proposal require elaboration. The first is the reasonableness assessment. This would emphatically *not* be a typical negligence analysis. Although a negligence analysis should take into account anything relevant to reasonableness, in practice, where a profession such as medicine is involved, much deference is given to customary practices.<sup>174</sup> This makes sense where the issue is whether a procedure was competently performed: how much tissue to remove during a breast reduction surgery or how long a procedure should take, for example.<sup>175</sup> However, it makes less sense when the issue necessarily implicates non-medical considerations. As we have seen, decisions about whether patients should have access to treatments contrary to a physician's clinical judgment implicate a range of interests. If the issue were resolved according to customary medical practice, the outcome would almost inevitably be that the physician's clinical judgment prevailed. This would defeat the purpose of having a reasonableness standard as opposed to simply adopting the standard of clinical judgment, as in England.

Thus, courts would have to consider the reasonableness of the requested treatment in light of the patient's values (expressed or implied), the medical prognosis, the potential harm to the patient, the professional medical standards (including ethical considerations), and any other factor relevant to whether it is reasonable to provide the treatment requested by the patient or SDM. Courts should not assume that life-sustaining treatment is always reasonable, nor that offering treatment of minimal or arguable medical benefit is always unreasonable.

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<sup>174</sup> The standard of care is that of reasonableness and reasonable medical practice is not limited to what is medically indicated or to what professional standards dictate. For example, it would be contrary to the standard of care to provide a blood transfusion to a competent patient who refused it, even though the transfusion is medically indicated. Another example is that Canadian courts have found it unreasonable not to disclose material risks of treatment, even though professional standards at the time did not necessarily require all material risks to be disclosed. See e.g. *Hopp v Lepp*, [1980] 2 SCR 192 at 208–09, 22 AR 361. Nevertheless, in most circumstances, the standard of care is assessed with regard to professional norms.

<sup>175</sup> See e.g. *White v Turner* (1981), 31 OR (2d) 773 at paras 30–32, 55, 120 DLR (3d) 269 (H Ct J), aff'd 1982, 47 OR (2d) 764, 12 DLR (4th) 319 (CA).

Whether the patient's family's wishes and values should be taken into account should be considered by legislatures in formulating this approach. There is some support in the *HCCA* and *Rasouli* for the proposition that the family's wishes are important.<sup>176</sup> My view is that they should either not be considered at all or should be given only very little weight. This is consistent with the individualistic approach to patient autonomy that prevails in Canadian health law.

Resources must be considered: a patient cannot be entitled to a transplant kidney if no suitable one is available, nor should a patient be able to insist on access to other medical resources like tests, drugs, or access to specialists, if it is not reasonable to provide them due to cost or availability. Whether this is to be determined as part of the reasonableness assessment (e.g., it is not reasonable to have a transplant kidney if no suitable one is available) or whether resource considerations are to be assessed separately would need to be determined. This may or may not be a separate inquiry so long as it is clear that a lack of resources can justify withholding or withdrawing treatment from a patient.<sup>177</sup>

Legislative presumptions could be applied. In England, for example, there is a presumption in favour of maintaining life.<sup>178</sup> It is, however, only a starting point. As we have seen, English courts have often found that being

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<sup>176</sup> *HCCA*, *supra* note 7, s 1(e); *Rasouli*, *supra* note 4 at paras 43, 51.

<sup>177</sup> It is not controversial that physicians may deny treatment that is unavailable – transplant organs or diagnostic tests, for example. Much more controversial is whether it is negligent for physicians to limit access to available resources in order to preserve access to them for more needy patients. Some cases have held that since physicians' duties are to their patients and not to the medical system, they must not consider resource allocation issues in deciding how to treat. See *Law Estate v Simice*, 21 CCLT (2d) 228, 1994 CanLII 3068 (BC SC), *aff'd* (1995) 17 BCLR (3d) 1, 19 CCLT (2d) 127 (CA). Other cases, however, acknowledge that resource considerations can be factored into the standard of care analysis. See *Manary v Strban*, 2013 ONCA 319 at para 73, 362 DLR (4th) 550.

<sup>178</sup> See *James*, *supra* note 55 at para 35:

The authorities are all agreed that the starting point is a strong presumption that it is in a person's best interests to stay alive. As Sir Thomas Bingham MR said in the Court of Appeal in *Bland*, at p 808, "A profound respect for the sanctity of human life is embedded in our law and our moral philosophy". Nevertheless, they are also all agreed that this is not an absolute.

kept alive is not in a patient's best interests and have sided with physicians who wish to stop providing life-sustaining treatment. The test would still be reasonable.

Another potential presumption is one in favour of promoting the patient's best interests. This would be true both of competent and incompetent patients.<sup>179</sup> What competent patients, or incompetent patients with valid advance directives, say they want is very strong evidence of their best interests but may not be determinative. For example, where a person with a drug addiction wants a prescription for opioids, it may not be in their best interests to have it. This is different than the refusal context, where it is well established that competent patients determine their own best interests. The proposed approach is paternalistic, but I have set out above why I think some paternalism must be retained in such decision-making contexts. For incompetent patients, determining what is in their best interests would presumably resemble the approach that currently exists at Canadian common law and in certain statutes, such as Ontario's *HCCA*.<sup>180</sup> That is, it would involve balancing medical considerations, patients' values, and patients' wishes expressed while competent. Contrary to the refusal context, however, there would only be a presumption in favour of best interests.

The proposed test would therefore require courts to consider a range of factors in assessing reasonableness. These include the patient's best interests – values, medical considerations, and expressed wishes – but would consider other factors as well. These include resource allocation, any effects on members of the health care team, who are sometimes traumatized by what they perceive as their complicity in prolonging patients' suffering,<sup>181</sup> and effects on the practice of medicine or on the health care system more broadly. What patients want or what is in their best interests should be given considerable weight, but should not be determinative in the demand context.

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There are cases where it will not be in a patient's best interests to receive life-sustaining treatment.

<sup>179</sup> Recall that this test would only apply where treatment contrary to clinical judgment was requested. Refusals of offered treatment would still be resolved in the usual way, with competent patients being able to refuse for any reason and decisions for incompetent patients being determined based on their best interests.

<sup>180</sup> *Supra* note 7, s 21(2).

<sup>181</sup> See e.g. Smith, *supra* note 26; CBC News, "2 More Winnipeg Doctors", *supra* note 27; *Rotaru*, *supra* note 43 at para 6.

## **B. Onus**

The issue of who should bear the onus amounts to determining what the presumption or default position should be. Should the presumption be that clinical judgment prevails, with patients or SDMs having to prove otherwise? Or should the default position be that patients may have whatever treatment they like, with physicians having to prove the treatment is unreasonable in order to avoid having to provide it?

As a practical matter, physicians are gatekeepers. The issue is whether physicians can be required to treat in a manner they consider medically inappropriate. They may be unwilling to do so without a court order. This results in a de facto primacy of clinical judgment, with patients having to get court orders to require physicians to treat.

Nevertheless, I think the default could and should be that physicians should have to give patients the treatment they want. The onus would therefore be the opposite of that in England, where patients must challenge physicians' treatment decisions if they disagree with them.<sup>182</sup> My proposal is that physicians who object to having to provide particular treatment, for whatever reason, would have the onus of establishing that the requested treatment is unreasonable. This onus has at least two benefits. First, it helps patients who may have less information and fewer resources than physicians. Unless a physician is willing to challenge the default position, the patient will not have to expend any resources and will not suffer the additional stress and inconvenience of a conflict with her health care provider.

Of course, it will still be a burden for patients to have to defend against a physician's challenge. This seems unavoidable unless we are to simply give patients whatever they request, a situation that I have argued is undesirable. The impact of the patient's burden to defend could be reduced by having special tribunals like Ontario's CCB decide these matters. This seems unlikely, however, in that other jurisdictions have shown no inclination to create their own CCBs. In Ontario, a legislative amendment would be required for the CCB to apply rules such as those proposed here.

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<sup>182</sup> That said, physicians in England do have to get a court order to withdraw artificial nutrition and hydration from a patient in a persistent vegetative state. This originated with the House of Lords decision in *Airedale NHS Trust v Bland*, [1993] AC 789, [1993] 1 All ER 821.

The second benefit is that this onus places a high value on patient autonomy while maintaining some limitations on patients' ability to receive the treatment they request.

### C. *Legislation versus common law*

A third point for elaboration is whether the proposed approach should be legislated or be developed at common law. In Ontario, of course, any such change would have to be legislated given the *HCCA* and the Supreme Court's interpretation of it. In other provinces and territories, jurisprudential developments may be possible but legislation is preferable for two reasons. First, my proposal represents a significant change from the status quo and such non-incremental changes are generally best left to legislatures. Second, the question of who gets to decide whether requested medical treatments are provided is a complex social issue with implications for patients, families, the medical profession, and the publicly funded health care system. Canadian courts have noted that complex issues of social significance are better addressed by legislatures than by courts.<sup>183</sup> A legislative approach to this issue is also advocated by Downie, Willmott, and White.<sup>184</sup>

To summarize, the principal benefits of the proposed approach are that it gives considerable weight to patient autonomy and patient best interests. It provides clear rules that apply broadly and do not rely on what I have argued is an untenable distinction between life-sustaining treatment and other kinds of treatment. This makes the approach both more principled and clearer than that in Ontario law. The rule of law is promoted when laws are clear

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<sup>183</sup> See *Alberta v Hutterian Brethren of Wilson Colony*, 2009 SCC 37 at para 53, [2009] 2 SCR 567, McLachlin CJ (“[T]he courts accord the legislature a measure of deference, particularly on complex social issues where the legislature may be better positioned than the courts to choose among a range of alternatives”). See also *R v Malmo-Levine*, 2003 SCC 74 at para 133, [2003] 3 SCR 571 (the Court stated, albeit in the criminal law context, that when a social issue involves harm, “the precise weighing and calculation of the nature and extent of the harm is Parliament’s job.” This is because legislators “have access to a broader range of information, more points of view, and a more flexible investigative process than courts do”); *R v Schmidt*, 2011 ONCJ 482 at paras 93, 99, 248 CRR (2d) 91.

<sup>184</sup> Downie, Willmott & White, *supra* note 11 at 825.

and knowable.<sup>185</sup> It also, however, provides a role for clinical judgment. It acknowledges that patient autonomy is not the only relevant consideration and that requested treatment should sometimes be denied – whether for the patient’s own good, for resource allocation considerations, or, more rarely, for public health reasons. The proposed approach also allows for adjudication where a physician’s clinical judgment may be affected by improper considerations or where the physician may be mistaken about the medical situation in terms of diagnosis, prognosis, etc.

None of this would detract from physicians’ existing duties to provide information and to discuss treatment options with patients. Where doctors and patients disagree as to whether treatment should be provided, reasonable efforts should be made to arrive at a consensus. Nor would this affect patients’ rights to a second opinion or to have their care transferred to another physician who is willing to provide the requested treatment.

One potential problem with the proposed approach is that it gives considerable discretion to judges to decide particular cases based on what they consider to be reasonable. Given the value judgments involved, this approach arguably substitutes the judge’s judgment for that of the physician. And yet courts are accustomed to balancing different interests (in determining best interests, for example) and to determining what is reasonable (in determining the negligence standard of care, for example). That is, by their very role, courts are better equipped to answer such questions than medical professionals.

Another potential problem is that a reasonableness approach is less certain than an approach that simply allows physicians to deny treatment according to their clinical judgment (as in England) or that allows patients to have certain treatments regardless of clinical judgment (as in Ontario). As in negligence law, however, the value of a reasonableness analysis is that it allows for a fact-specific, contextual approach to a complex situation.

In Canada, it should be exceedingly rare for courts to order physicians to treat contrary to their clinical judgment, but it should be possible if providing the requested treatment is not unreasonable in the circumstances.

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<sup>185</sup> The rule of law has been noted as an important Canadian value when it comes to making laws governing the withholding and withdrawal of potentially life-sustaining treatment (*ibid* at 813).

## CONCLUSION

Nearly two decades ago, Justice Beard stated the following in *Sawatzky*:

I think that many Canadians have been surprised to learn that a doctor can make a “do not resuscitate” order without the consent of a patient or his or her family, yet that appears to be the current state of the law in Canada, Britain and the United States. 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 Freedoms*, it may be for the government to resolve any moral or ethical questions that remain at the end of the day. The government can ensure a much wider debate including all interested sectors of society, while a court proceeding is, by necessity, relatively narrow and limited even if some interventions are allowed. Regardless of the outcome of this hearing, these issues require full public discussion.<sup>186</sup>

So far, this call for legislation and full public discussion has gone unheeded. There is little political upside to legislating on this matter: some individuals and groups are bound to be unhappy with any statute. And yet the complexity of the issue and the difficult ethical questions involved are such that the legislatures are better suited to setting standards than the courts.

In *Rasouli*, the Supreme Court interpreted an Ontario statute so as to create a de facto entitlement to life-sustaining treatment contrary to physicians’ clinical judgment. This approach may be adopted by other Canadian jurisdictions with similar legislation. This is in stark contrast to the law in England, where courts have consistently affirmed that while patients may refuse treatment, they have no positive right to treatment contrary to clinical judgment – even where withholding the treatment would result in the patient’s death.

I have argued that the law in Ontario took a misstep in *Rasouli*. The law is now unprincipled and is often unclear, in that the scope of the *Rasouli* decision is uncertain. Further, the law of informed consent should not dictate the outcome of disputes between physicians and patients or SDMs about whether certain treatment should be provided.

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<sup>186</sup> *Sawatzky*, *supra* note 71 at para 5.

That does not mean, however, that England's approach of deference to clinical judgment is unproblematic. In light of the discussion above, it is clear that treatment decisions are not purely medical matters for physicians alone to decide.

Claims to be entitled to treatment contrary to clinical judgment will continue to arise in Canada. There should be limits on what patients can demand and these limits should go beyond considerations of resource allocation or objective ineffectiveness. After all, giving a person with an addiction a prescription for large quantities of opioids is not ineffective, nor does it engage resource considerations. Nevertheless, physicians should be able to resist such demands. One approach – that favoured by the Supreme Court in *Rasouli* – is to have a separate rule for life-sustaining treatment. Such a distinction, however, is not principled. Finally, it will not always be appropriate to limit treatment to what is clinically indicated.

Perhaps we can do no better, given the wide range of interests involved and fact scenarios that will arise, than for courts or tribunals, guided by the legislature, to assess what is reasonable when families and physicians cannot agree as to how to proceed.