Carter vs. Rasouli:
Why was one SCC decision right and the other wrong?

James Downar, MDCM, MHSc (Bioethics), FRCPC

Critical Care and Palliative Care, University Health Network and Sinai Health System

Associate Professor, Dept. of Medicine, University of Toronto

Disclosures

- Paid consultant to Joule, Inc. for CMA course on MAID
- Member and former chair of Physician Advisory Committee for Dying with Dignity Canada
- Chair, Ethics Committee, Canadian Critical Care Society
- Big Pharma- Boehringer-Ingelheim (Canada), Medtronic, Novartis

- MAID, Palliative Care, ICU, and (sometimes) futile care provider

Overview

- Key legal considerations in the Carter decision
- An explanation of the Rasouli decision
- The fallout of the Rasouli decision
- A comparison of Carter vs. Rasouli

Canadian Charter of Rights and Freedoms

1. The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Carter vs. Canada AG (2015)

- “Insofar as they prohibit physician-assisted dying for competent adults who seek such assistance as a result of a grievous and irremediable medical condition that causes enduring and intolerable suffering, ss. 241(b) and 14 of the Criminal Code deprive these adults of their right to life, liberty and security of the person under s. 7 of the Charter.”
- “An individual’s response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy. The prohibition denies people in this situation the right to make decisions concerning their bodily integrity and medical care and thus trenches on their liberty. And by leaving them to endure intolerable suffering, it impinges on their security of the person.”

Carter vs. Canada AG (2015)

- Violation of s.7 not saved by s. 1
  - Absolute prohibition on assisted death overbroad
  - Limitation of rights (to end own life) not always connected to the objective of protecting vulnerable in time of weakness
- “Nothing in this declaration would compel physicians to provide assistance in dying. The Charter rights of patients and physicians will need to be reconciled in any legislative and regulatory response to this judgment.”

The Case of Mr. Rasouli

- 62M- Meningioma
- Postoperative meningitis/encephalitis
- Minimally conscious state
- Dependent on mechanical ventilation, tube feeding and hydration
- MDs: No realistic hope for recovery
- Proposed to WDLS, provide palliative care

Rasouli, 2013 SCC 53

The courts…

- SDM applies to Ontario Superior Court to prevent WDLS
  - No injunction granted- consent required to WDLS
- MDs appeal to Ontario Court of Appeal
  - MDs- No consent required to stop treatments of no medical value
  - Judge ruled that WDLS linked to provision of palliative care- “treatment” package requires consent
  - Imminence of death, starting new therapies was key consideration

MDs appeal to Supreme Court

- Consent not required to WH or WD treatments outside the standard of care, regardless of other treatments
- Imminence of death should not determine the need for consent
- Requiring MDs to provide NBT forces them to breach legal and professional duties

Supreme Court Dismisses Appeal

- 5-2 Ruling
- Statutory interpretation of "treatment" in Ontario's Healthcare Consent Act
    - "… anything done for a therapeutic, preventive … or other health-related purpose … includ[ing] a plan of treatment … ".
    - "Plan of treatment" is "the administration … of various treatments … and may, in addition, provide for the withholding or withdrawal of treatment … "

Rasouli, 2013 SCC 53

Supreme Court Dismisses Appeal

- P4 “This case turns on statutory interpretation — what the HCCA provides. It is not a case about who, in the absence of a statute, should have the ultimate say in whether to withhold or withdraw life-sustaining treatment. Nor does the case require us to resolve the philosophical debate over whether a next-of-kin’s decision should trump the physicians’ interest in not being forced to provide non-beneficial treatment and the public interest in not funding treatment deemed of little or no value.”

Supreme Court Dismisses Appeal

- P70 “These considerations lead me to conclude that “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. This 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.”

Supreme Court Dismisses Appeal

- P103 “In some cases, the Board has upheld the decisions of substitute decision- makers to refuse withdrawal of life support as being in the best interests of the patient: D.W. (Re), 2011 CanLII 18217; S.S. (Re), 2011 CanLII 5000; P. (D.), Re. In others, it has reversed the decision of the substitute decision-maker and required consent to be given for the withdrawal of life support: A.K.; E.J.G.; N., (Re), 2009 CarswellOnt 4748. The particular facts of each case determine whether withdrawal of life support is in the best interests of the patient.”

So what did this mean?

CMAJ ANALYSIS

Withholding and withdrawing treatment in Canada: implications of the Supreme Court of Canada's decision in the Rasouli case

James Downar MDCM MHSc, Robert W. Sibbald MSc, Tracey M. Bailey BA LLB, Brian P. Kavanagh MB

A decision of the Supreme Court of Canada in 2013 has potential implications for situations when withholding

medical benefit. The imminence of death was a key distinction.

The physicians appealed to the Supreme

Competing interests: James Downar is a member of the Canadian Critical Care Society, which was an

So what does this mean?

- Withdrawal of life support in a *Rasouli*-like case would require consent
- Withdrawal of treatment "may sometimes, although not always, constitute treatment"
    - Administration of other treatment
    - Need for physical contact (which might constitute battery)
    - Likelihood of death shortly after withdrawal

Downar et al. *CMAJ 2014.*

The Consent and Capacity Board

- Parajudicial body, usually convened for mental health decisions
    - Decisions can be appealed to Ontario Superior Court
- For Rasouli-like cases, three possible roles
    - Consider whether a prior wish is applicable to the present circumstances (Form D)
    - Consider a request from SDM to depart from prior capable wishes (Form E)
    - Review SDM's compliance with rules of substitute decision-making (Form G)
- No role when…
    - …the patient is capable.
    - …there is a clear prior capable wish.

Experience with the CCB and EOL Cases

- From 2009-2013, 23 Form G hearings involved MDs proposing DNR/withdrawal or “palliative” treatment plans
    - 16 ruled in favour of MD proposal
        - 9 appealed, none overturned
    - 7 ruled against MD proposal
        - 2 appealed, none overturned
- In 2014-6, 5 Form G hearings
    - 2 ruled for MD, 2 rules against MD, 1 identified new SDM

http://consentqi.ca/law/overview-2/end-of-life-cases/

Experience with the CCB and EOL Cases

- Qualitative study of 13 MDs who had applied for Form G hearings
    - 12/13 found the process helpful, but benefits often tempered by lengthy appeals
- Survey of Canadian ICU/GIM RNs and MDs
    - Ontario respondents more likely to believe that "our current means of resolving NBT are inadequate" (87% vs. 73%, $p<0.0005$)

Chidwick and Sibbald. Healthcare Q 2011;2:69-74.
Downar et al. *Crit Care Med 2014*.

Does *Rasouli* apply outside *Rasouli*?

- Nationwide survey of academic ICU MDs
- Series of 5 vignettes
    - Important differences in care (Kappa 0.67)
    - More aggressive (p=0.01)
    - Less likely to be "medically appropriate" (p=0.03), even in cases not analogous to Rasouli
    - Both Ontario and non-Ontario

Cape et al. *J Med Ethics*. 2015 doi:10.1136/medethics-2015-102856

Is consent required to withhold CPR?

- Default is to provide CPR
  - Hospital policy
  - Public aware and often trained to provide CPR
- "DNR" is a change in treatment plan, but…
  - …no new contact
  - …death not an immediate consequence
  - …no new therapies linked to DNR order

Downar et al. *CMAJ 2014.*

Revised CPSO Policy (Sept 2015)

- “A decision regarding a no-CPR order cannot be made unilaterally by the physician.”
- “If the patient or substitute decision-maker disagrees and insists that CPR be provided, physicians must engage in the conflict resolution process as outlined in Section 8 of this policy which may include an application to the Consent and Capacity Board.”

CPSO. *Planning for and Providing Quality EOL Care.*

New CPSO Policy (Sept 2015)

- "While the conflict resolution process is underway, if an event requiring CPR occurs, physicians must provide CPR. In so doing, physicians must act in good faith and use their professional judgment to determine how long to continue providing CPR."

CPSO. *Planning for and Providing Quality EOL Care.*

CMAJ COMMENTARY

Mandate to obtain consent for withholding nonbeneficial cardiopulmonary resuscitation is misguided

James Downar MDCM MHSc, Michael Warner MD MBA, Robert Sibbald MSc*

- Law is unclear
  - ON courts refused “FC” injunctions x2
- CPR is…
  - …not different from other treatments at EOL
  - …not a solution to grief or conflict
  - …not a value

CMAJ COMMENTARY

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- How long to perform futile CPR?
  - How to defend a duration of CPR?
  - Slow codes?
- Mandating consent doesn't encourage conflict resolution
- What about comfort care?

Problem

- 65M- Advanced cancer, bowel obstruction, multi-organ failure, requesting “everything”
    - Oncologist- Cannot offer chemotherapy
    - Surgeon- Cannot offer surgery
    - Intensivist- Cannot offer life support/CPR
- Only one MD will be disciplined by CPSO

Do the courts require CPR?

- Cefarelli v. Hamilton Health Sciences
  - A No-CPR order "… cannot be said to be a withdrawal of treatment..."
  - Reversing a No-CPR order is "… effectively a request to impose CPR treatment which… carries no possibility of medical benefit, but would only inflict harm."

Do the courts require CPR?

I therefore order that the DNR be suspended until such time as the CCB has rendered its decision. However, this is not a requirement or order that CPR be performed. Should a cardiac arrest occur, the Resps will have to assess the situation & take or not take such steps as they consider appropriate, taking into account all of the circumstances existing at the time.

Cheah et. a/. v. Sunnybrook Health Sciences Centre et. al. (22 October 2010), Toronto 03-102/10 (Ont. S.C.J.), Endorsement of Conway, J.

Differences in the SCC Rulings

- Carter- Charter challenge (s. 7)
  - Liberty- the freedom to make choices about bodily integrity
  - Security of the person- Avoid enduring suffering
  - Not saved by s. 1- overbreadth of blanket ban
- Rasouli- statutory interpretation of Healthcare Consent Act
  - What requires consent?
  - Liberty- SDM making choices
  - Security of the person- suffering vs. imminent loss of life

Overbreadth of Requirement for Consent

- Desire to emphasize communication, consensus approach
- Medical choices affect liberty/security of person (loss of life)
  - Not offering cardiac surgery
  - Delisting for organ transplantation
  - Isolation for MRSA
  - Transferring a patient to the medical ward
- Should consensus be the goal?
- Why is “correctness” only relevant after the fact?

Standard of care

"Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise reasonable care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing."

- Crits v. Sylvester

- Balancing benefits vs. harms
- Guidelines
- Expert opinion

Standard of Care vs. Need for Consent

- Would it be justifiable to eliminate the need for consent for some decisions?
  - Does consent always protect liberty or security of the person?
  - What if the need for consent forces you away from the standard of care?