Court File No: 34362

IN THE SUPREME COURT OF CANADA
(ON APPEAL FROM THE COURT OF APPEAL FOR ONTARIO)

BETWEEN:

DR. BRIAN CUTHBERTSON AND DR. GORDON RUBENFELD

Appellants

and

HASSAN RASOULI BY HIS LITIGATION GUARDIAN AND SUBSTITUTE DECISION MAKER, PARICHEHR SALASEL

Respondent

and

THE CONSENT AND CAPACITY BOARD

Intervener

FACTUM OF THE INTERVENERS, MENTAL HEALTH LEGAL COMMITTEE and HIV & AIDS LEGAL CLINIC ONTARIO

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PART I – OVERVIEW

1. The appellants' position is that informed consent need not be sought where a physician determines that a treatment provides no medical benefit. Importing the concept of standard of care from the law of negligence, the appellants assert that a physician is not required to offer or discuss such treatments.

Factum of the Appellants, para. 1

2. The Court of Appeal for Ontario (OCA) accepted the proposition that consent need not be sought respecting treatments that a physician considers to be of no medical benefit but dismissed the appeal on the narrowest of grounds. Specifically, the OCA held that where the removal of ventilation will lead to imminent death such that end-of-life palliative care is offered, consent is required to this treatment package.

Rasouli v. Sunnybrook, et al., 2011 ONCA 482 at paras. 46 to 52, Tab 5, Vol. 1, Record of the Appellants

3. Central to this appeal is the interpretation of a provincial statute of general application. The appellants' position and the reasons of the OCA, if accepted, would undermine the requirement of informed consent to treatment generally and are not confined to Mr. Rasouli's case or end-of-life circumstances. Careful consideration of the history and purposes of the *Health Care Consent Act, 1996* (*HCCA*), the definition of treatment and the circumstances (if any) in which health practitioners may circumvent the doctrine of informed consent is required.

Health Care Consent Act, 1996, S.O. 1996, c.2, Sch. A (*HCCA*)

PART II – STATEMENT OF POSITION WITH RESPECT TO QUESTIONS IN ISSUE

4. These interveners would respond to the first three questions raised by the appellants in the affirmative and disagree with the mechanism they propose for resolving disputes. Health practitioners must provide patients and/or substitute decision-makers (SDMs) with the information that a reasonable person in the same circumstances would require to make a decision, including alternative courses of action. In addition, where the patient is unable to leave a place of care,[1] the health practitioner must either facilitate the resulting treatment decision or apply to resolve the dispute before the Consent and Capacity Board (the CCB).

Factum of the appellants, para. 2; *HCCA*, ss. 11(2) and 11(3)

[1] Confinement can include jails, locked psychiatric units and intensive care units. In these contexts, it may not be open to health practitioners to suggest to patients or SDMs that they seek information or treatment elsewhere.

PART III – STATEMENT OF ARGUMENT AND SUBMISSIONS

A. History of the law of consent to treatment in Ontario

5. It has long been recognized that informed, voluntary consent to treatment is required from capable individuals. The tort of battery protects a person's interest in bodily security from unwanted physical interference. This Court has accepted that "[n]o amount of professional skill can justify the substitution of the will of the surgeon for that of his patient".

> *Parmley v. Parmley*, [1945] S.C.R. 635 at paras. 23 to 31 (Westlaw); *Hopp v. Lepp*, [1980] 2 S.C.R. 192 at paras. 5 and 23 to 34 (Westlaw); *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.) at paras. 17 to 21

6. Consent to treatment legislation in Ontario originated in the mental health context as absolute deference to psychiatry gave way over time to the substantive and procedural protection of individual autonomy. In the 1930s, involuntary admission and treatment decisions were determined by physicians with no review mechanism other than *habeas corpus.* The 1967 *Mental Health Act* (*MHA*) introduced independent review of involuntary admission. Amendments to the *MHA* in 1978 codified the right of involuntary patients or their SDMs to refuse treatment, subject to the opinion of a review board. These amendments also defined mental competence and formalized a statutory process for substitute decision-making.

> *The Mental Hospitals Act*, R.S.O. 1937, c. 392, ss. 15, 20, 22, 24 and 42; *The Psychiatric Hospitals Act*, R.S.O. 1937, c. 393, ss. 9 and 15; *The Mental Health Act, 1967*, S.O. 1967, c. 51, ss. 8, 13 and 26 to 30; *Mental Health Act*, R.S.O. 1980, c. 261, ss. 1(g), 1(j), 9, 14, 28, 30 to 33 and 35; *Re Carnochan*, [1941] S.C.R. 470 (Westlaw)

7. Amendments in 1987, 1992 and 1996 continued the transition towards full promotion of individual autonomy, divorcing involuntary detention from treatment capacity and confining the authority to treat unilaterally to emergencies. In doing so, the Legislature was informed by the Ontario *Human Rights Code* (recognizing handicap as a prohibited ground of discrimination in 1981), the *Charter*, the findings of the 1990 Weisstub *Enquiry on Mental Competency* and the seminal OCA decision in *Fleming v. Reid*. The *Substitute Decisions Act, 1992* introduced partial guardianship, advanced directives and powers of attorney for personal care.

> *An Act to Amend the Mental Health Act, 1987*, S.O. c. 37, ss. 2, 6, 9, 11 and 12; *Consent to Treatment Act, 1992*, S.O. 1992, c. 31, ss. 1 ("treatment"), 4 to 6, 9 to 21, 28 to 33 and 35 to 45; *Substitute Decisions Act, 1992*, S.O. 1992, c. 30, Part II; *HCCA* generally and ss. 25 to 28 respecting emergencies; *Human Rights Code, 1981*, S.O. 1981, c. 53, ss. 1 to 4; *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, ss. 7 and 15; Prof. D. Weisstub, *Enquiry on Mental Competency: Final Report* (Toronto: Queen's Printer for Ontario; 1990) at pp. 292 to 323 and 405 to 429; *Fleming v. Reid*, (1991) 4 O.R. (3d) 74 (C.A.) at paras. 47 to 59 (Westlaw)

B: The purpose and scheme of the *HCCA*

8. The purposes section of the *HCCA* sets out the clear objectives of the *Act*. By its enactment, the legislature seeks to enhance personal autonomy and provide rules for obtaining informed consent that apply consistently in all settings. The *HCCA* is intended to promote communication and understanding between health practitioners and their patients.

HCCA, supra, s. 1; *Starson v. Swayze*, 2003 SCC 32 at paras. 6 to 11(Westlaw)

9. In the treatment context, the purposes of the *HCCA* are advanced through the scheme of the *Act* which:

- gives primacy to the principle of *no treatment without consent*
- includes a comprehensive definition of treatment
- requires that consent be informed and voluntary
- asserts the presumption of capacity
- provides rules for substitute decision-making that give primacy to prior capable wishes and enunciates a statutory test for best interests in their absence
- provides for expanded procedural protections such as notice and rights advice
- provides independent review by the CCB

HCCA, supra, ss. 4, 5, 10, 11, 13, 14, 15, 18, 20, 21, 32, 33 and 70

10. The *HCCA* carefully articulates and integrates individual rights and state interests. Both are required to comply with *Charter* obligations and the state's *parens patriae* role in the health care context. The *HCCA* advances individual autonomy by requiring health practitioners to secure informed consent from capable individuals. It meets the *parens patriae* obligations of the state by requiring that SDMs give informed consent for incapable individuals. It is also in the state's interest that all vulnerable individuals, capable and incapable, be treated only on the basis of informed consent.

HCCA, supra, ss. 20, 21, 25 and 26; *Fleming v. Reid, supra*, at para. 47; *Re Eve*, [1986] 2 S.C.R. 388 at paras. 72 to 81; *Manitoba (Director of Child & Family Services) v. C. (A.)*, 2009 SCC 30 at paras. 39 to 45

11. Section 11 of the *HCCA* provides that informed consent requires a discussion of "alternative courses of action". This is a statutory recognition that without choice, the ability to control the course of one's medical care is meaningless. In *Arndt v. Smith*, this Court rejected "the paternalistic approach to determining how much information should be given to patients". The requirement of informed consent mandates a discussion of known alternatives, regardless of

whether these are recommended or offered by the treating physician.[2] Where a person is detained or otherwise prevented from seeking treatment elsewhere, the obligation of the physician to engage in a fulsome discussion of known options is crucial.

> Factum of the Appellants, paras. 45, 50, 51, 63, 64 and 70; Factum of the Respondent, paras. 39 to 55; *HCCA, supra*, at s. 11; *Malette v. Shulman, supra*, at paras. 18 and 19; *Arndt v. Smith*, [1997] 2 S.C.R. 539 (Westlaw) at paras. 15 and 16 (*Arndt*); *Zimmer v. Ringrose*, [1981] 124 D.L.R. (3d) 215 (Alt. C.A.) (Westlaw) at paras. 10 to 16; *Haughian v. Paine*, [1987] 37 D.L.R. (4th) 624 (SK CA) (Westlaw) at paras. 38 to 44; *Dickson v. Pinder*, 2010 ABQB 269 (Westlaw) at paras. 67 to 81 and 103 to 107; *Gallant v. Brake-Patten*, 2010 NLTD 1 (Westlaw) at paras. 14, 55 to 58; College of Physicians and Surgeons of Ontario, Policy Statement # 3-11, "Complementary/Alternative Medicine" (updated November 2011); College of Physicians and Surgeons of Ontario, Policy Statement # 4-05, "Consent to Medical Treatment" (updated September 2005); *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119 at para. 40 to 43

12. Section 21 of the *HCCA* conforms to the requirements of section 7 of the *Charter* as described in *Fleming v. Reid* by assuring the primacy of prior capable wishes[3] and, hence, of individual liberty and autonomy. As the respondent notes, in the absence of prior capable wishes, section 21 requires consideration of medical and non-medical factors, underlining that treatment decision-making properly incorporates values and beliefs.

> *Consent to Treatment Act, 1992, supra*, s. 13; *HCCA, supra*, s. 21; *Fleming v. Reid, supra*, at paras. 33 to 38; *Conway v. Jacques* (2002), 59 O.R. (3d) 737 (ON CA) at paras. 27 to 32; Factum of the Respondent, paras. 91 to 94

13. Where a health practitioner is of the opinion that an SDM has failed to comply with the principles of substitute decision-making in section 21, the practitioner may apply to the CCB. The CCB may substitute its opinion for that of the SDM and provide directions. In practice, the CCB regularly orders SDMs to consent to proposed treatments and to withhold or withdraw treatments by specified deadlines, failing which SDMs lose their decision-making authority.

> *HCCA, supra*, ss. 21, 36 and 37; Factum of the Appellants, paras. 93 to 95; *SL (Re)*, 2012 CanLII 35952 (ON CCB) (CanLII); *TM (Re)*, 2012 CanLII 19274 (ON CCB) (CanLII); *G (Re)*, 2011 CanLII 63117 (ON CCB) (CanLII); *BS (Re)*, 2011 CanLII 26315 (ON CCB) (CanLII); *EB, Re*, 2005 CanLII 48157 (ON CCB) (CanLII); *AW (Re)*, 2004 CanLII 48655 (ON CCB) (CanLII); *P (Re)*, 2005 CanLII 56634 (ON CCB) (CanLII); *EJG (Re)*, 2007 CanLII 44704 (ON CCB) (CanLII); *E (Re)*, 2009 CanLII 28625 (ON CCB) (CanLII); *B (Re)*, 2009 CanLII 50838 (ON CCB); *AK (Re)*, 2011 CanLII 82907 (ON CCB) (CanLII); *G (Re)*, 2009 CanLII 25289 (ON CCB) (CanLII); *JM (Re)*, 2011 CanLII 7955 (ON CCB) (CanLII)

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[2] For example, the College of Physicians and Surgeons of Ontario (CPSO) policy respecting complementary medicines requires that physicians canvass alternative known courses of action regardless of whether they can offer or would recommend them. The policy recognizes that patients have a right to make health care decisions that accord with their own values and preferences, including pursuing non-conventional medicines. Where the physician cannot provide the services, referrals to other care providers are encouraged to support the patient's informed decision-making. In addition, the CPSO Consent to Treatment Policy advises "physicians to obtain consent for all physician-patient interactions", including those that fall outside of the *HCCA* definition of "treatment".

[3] The *HCCA* provides mechanisms for determining the existence and applicability of prior capable wishes (s. 35) and, where outcomes have improved since the expression of a capable wish, to depart from capable wishes (s. 36).

C: Consequences of eroding the statutory definition of treatment

14. The *HCCA* defines treatment as "anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan...". By using the disjunctive "or", the Legislature contemplated that interventions need not provide a therapeutic benefit if one of the other purposes of treatment is present. Treatment also includes a "plan of treatment" which itself is defined broadly and may provide "for the withholding or withdrawal of treatment in light of the person's current health condition". Even legislated exceptions are deemed treatment if a health practitioner considers them as such for the purpose of the *HCCA*.[4]

> *HCCA, supra*, ss. 2 ("plan of treatment", "treatment"), 3 and 10 to 13; *Scardoni v. Hawryluck* (2004), 69 O.R. (3d) 700 (ON SC) (Westlaw) at paras. 21, 39, 40 and 42 to 44

15. While certain events under the *HCCA* only arise when a treatment is proposed by a health practitioner,[5] obtaining informed consent is not limited to the discussion of medical interventions that are proposed but to withholding a medical intervention. It is in this sense that the withholding or withdrawal of a treatment is itself defined as treatment in the context of a plan of treatment.

> *Ibid.*

16. The broad definition of treatment and the doctrine of informed consent are required to protect against non-consensual interference with bodily integrity.[6] The appellants seek to narrow the definition of treatment by excluding interventions variously described as futile, non-therapeutic or non-indicated. There is no medical futility exception in the *HCCA*. This distinction has simply been proposed by the appellants and read into the legislation by the OCA.

> Factum of the Appellants, paras. 64, 70 and 74, Factum of the Respondent, paras. 51 to 62; *Golubchuk v. Salvation Army Grace General Hospital*, 2008 MBQB 49 (Westlaw) at para. 16; *HCCA, supra*, ss. 2 ("plan of treatment", "treatment"), 3 and 10 to 13

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[4] Of note, the appellants initially sought the respondent's consent for the removal of mechanical ventilation. Only when she refused did the appellants take the position that they did not require her consent. Affidavit of Parichehr Salasel sworn February 10, 2011 at paras. 66 to 70, Record of the Appellants, Vol. 3, Tab 16.

[5] For example, a finding of incapacity may only occur in the context of a treatment being proposed.

[6] While conceding that "plan of treatment" is statutorily defined to include the "withdrawal and withholding of treatment", the appellants narrowly interpret this definition to apply to drug trials or drug holidays. There is nothing in the *HCCA* that supports this interpretation.

17. As noted by the respondent at paragraph 59, there can be no objective definition of a value-laden term such as medical futility and none has been offered by the appellants. Nor is an after-the-fact examination of whether medical treatment met an applicable standard of care or of professional conduct of any benefit to a patient facing the risk of irreparable harm in the interim. None of these concepts find support in the *HCCA*.

Factum of the Respondent, paras. 53 to 54 and 59; *HCCA*, *supra*

18. By reading in exceptions to the definition of treatment, the appellants seek to confine the information shared and the range of alternative treatment options discussed to treatments that are "indicated" or which meet the standard of care. Taken to its logical conclusion, this would represent the resurgence of deference to medical opinion over the regime of informed consent contemplated by the *HCCA.*

19. Narrowing the definition of treatment has the consequence of undermining the requirement that consent be "informed" and "voluntary" such that the protection of individual autonomy that permits the *HCCA* to withstand *Charter* scrutiny is lost. It further defeats the state's *parens patriae* interest in ensuring that incapable persons are treated based on the informed consent of SDMs.

HCCA, *supra*, ss. 20, 21, 25 and 26; *Fleming v. Reid*, *supra*, at paras. 47 to 59

20. The decision of the OCA and the positions advanced by the appellants are not confined to Mr. Rasouli's specific circumstances. An enumerated purpose of the *HCCA* is to provide rules with respect to consent to treatment that apply consistently in all settings. If the OCA's reasoning in exempting interventions that a physician considers futile from the definition of treatment is permitted to stand, it would be open for health practitioners to seek exceptions in other contexts. Before this Court, for example, the appellants go beyond even the concept of futility, instead framing the questions in the appeal as relating to all treatment not required by the applicable standard of care, which they define as "non-indicated treatment".

HCCA, *supra*, s. 1(a); Factum of the appellants, para. 2

21. Justice Himel would have overcome the appellants' spectral vision of patients picking and choosing their own treatments by limiting the definition of treatment to interventions proposed by a health practitioner. For some purposes under the *HCCA* (i.e. incapacity findings and applications to determine compliance with section 21), a treatment must first be proposed.

Restricting the definition of treatment to those proposed by a health practitioner for all purposes is circular and not contemplated in the *HCCA*. Moreover, there is no need to impose this limit in the absence of evidence of doctors being held captive by patients' or SDMs' irrational requests.

> *Rasouli v. Sunnybrook et al.* 2011 ONSC 1500, at paras. 42 to 46, Record of the Appellants, Vol. 1, Tab 2; *HCCA, supra,* ss. 32 to 37

D: The mental health and HIV treatment contexts

22. Findings of incapacity under the *HCCA* leading to substitute decision-making occur most frequently in the psychiatric context. The Mental Health Legal Committee's client constituency is particularly vulnerable to unilateral decisions by physicians respecting the utility of certain treatments, particularly where a diagnosis includes psychosis. Similar to Mr. Rasouli's circumstances, involuntary psychiatric patients may be unable to withdraw from care and lack choice in treatment providers. Disagreements over available treatment options can contribute to findings of treatment incapacity, upholding the historical tendency to conflate the refusal of treatment and even mental illness itself with incapacity and undermining the autonomy interests of an already marginalized community.

> *Starson v. Swayze*, *supra*, at para. 75, *M.N. v. Klukach*, 2004 CarswellOnt 546 (Westlaw) at paras. 31, 34, 42 to 43, 47 and 51; *M. (Re),* 2009 CanLII 73244 (ON CCB) (CanLII), *CW (Re),* 2012 CanLII 14826 (ON CCB) (CanLII), *MS (Re)* 2011 CanLII 58930 (ON CCB) (CanLII); *I (Re),* 2009 CarswellOnt 6585 (ON SC) (Westlaw) at paras. 66 to 68, 75, 79 and 83; *Fleming v. Reid*, *supra,* at paras. 1, 25 to 29 and 34 to 37

23. Individuals who access the HIV & AIDS Legal Clinic's (HALCO) services are also in regular contact with the health care system. Given the stigma, ignorance and discrimination that continue to accompany an HIV diagnosis, HALCO's constituency is particularly vulnerable to unilateral decisions by physicians that affect the availability of certain treatments. Although HIV is a chronic, manageable illness for those receiving HIV treatment, value-laden assumptions about quality of life are pervasive and influence medical decision-making respecting which treatments should be withheld or withdrawn. For example, for many years infection with HIV was accepted as an absolute contraindication for solid organ transplantation despite the absence of medical evidence supporting this assumption. Other treatments susceptible to improper value judgments can include dental care and access to obstetrician services.[7]

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[7] The study conducted by UCLA found that of 102 Los Angeles County obstetricians surveyed, 55 percent would not provide any services to an asymptomatic patient with HIV. The study of physician preferences published in the *Yale Journal on Regulation* found that 80 percent would personally choose not to be resuscitated if they had AIDS.

S. Burris, "Dental Discrimination Against the HIV-Infected: Empirical Data, Law and Public Policy" (1996) 13 *Yale Journal on Regulation* 1; P.E. Marik et al., "Physicians' own preferences to the limitation and withdrawal of life-sustaining therapy" (1999) 42 *Resuscitation* 197; Minister of Health and Long-Term Care Advisory Committee on HIV/AIDS (OACHA) Working Group on HIV and Transplantation, Report, "HIV and Solid Organ Transplantation: A review of the literature with recommendations for action" (November 2003); UCLA School of Law, The Williams Institute on Sexual Orientation Law and Public Policy, *HIV Discrimination in Health Care Services in Los Angeles County: The Results of Three Testing Studies*, December 2006

E: The forum for the resolution of disputes and access to justice

24. The appellants assert that physicians serve as the gatekeepers in delineating which treatments need be the subject of consent. Those dissatisfied with the health practitioner's opinion may secure a second opinion and/or bring injunction proceedings in the Superior Court of Justice (SCJ).[8] The appellants' position is alarming not merely from a procedural rights perspective, but also from an access to justice perspective. The core client communities served by both the HALCO and MHLC are largely impoverished, stigmatized and marginalized. It is unreasonable to expect that patients or SDMs will have the financial and emotional resources necessary to obtain a second expert opinion or to mount complicated, time-consuming, and expensive litigation in the SCJ.

Factum of the Appellants, paras. 104 to 108

25. The legislature addressed the issue of access through provisions in the *HCCA* that place the onus on health practitioners to apply to the CCB when they believe that an SDM has failed to comply with section 21 of the *HCCA*. The CCB process is designed to offer an expeditious and cost-effective mechanism to resolve disputes. Importantly, the *HCCA* provides authority for the CCB to direct Legal Aid Ontario to appoint counsel for the alleged incapable person, a crucial step where the interests of the alleged incapable person may not align with those of an SDM.

HCCA, *supra*, ss. 37 and 81

26. The appellants argue that the CCB is not an "expert" tribunal except in the psychiatric context and that the composition of the CCB reflects cases over which it has jurisdiction. However, it is clear that the CCB has decided more end-of-life cases and other cases involving disputes between physicians and SDMs than any Canadian court. Further, the *HCCA* does not

[8] The appellants suggest that their position is drawn from the Sunnybrook Health Science Centre Policy: "Decisions about Life Support Interventions", Record of the Appellants, Vol. 3, Tab 11. Significantly, the policy makes no mention of an expectation that patients or SDM's will make application to the SCJ to resolve disputes. On the contrary, it stresses the need to maintain dialogue and sustain respectful and effective communications and suggests that the options for unresolved conflicts include applications to the CCB.

specify the types of medical professionals the government may appoint. A tribunal's expertise is determined by the scope and purpose of its enabling legislation as well as its experience with the issues that are routinely adjudicated under its enabling legislation.[9] Courts have found that the CCB is an expert tribunal even when the panel consisted of a single lawyer member. This Court has cited the advantages of delegation of rights-based decisions to administrative tribunals.

> Factum of the Appellants, para. 100; See para. 13, above, for a partial list of cases; *HCCA, supra*, ss. 1, 37.1, 70 and 73; *Mental Health Act*, R.S.O. 1990, c. M.7, s. 39; *Personal Health Information Protection Act, 2004*, S.O. 2004, C.3, Sch. A, ss. 2, 22 and 24*; Substitute Decisions Act, 1992, supra; Mandatory Blood Testing Act, 2006*, S.O. 2006, c. 26*; T. I. v. L. L.* (1999), 46 O.R. (3d) 284 (ON CA) (Westlaw) at paras. 16 and 19 to 21; *Daugherty v. Stall*, 2002 CarswellOnt 4163 (ON SC) (Westlaw) at paras. 12 to 19; *Starson v. Swayze*, *supra*, at para. 86; *M. (A.) v. Benes* (1999), 46 O.R. (3d) 271 (ON CA) (Westlaw) at paras. 35 and 45 to 47; *Scardoni v. Hawryluck*, *supra*, at paras. 34 to 35 and 60 to 62; *Conway v. Jacques*, *supra*, at para. 34; *Dunsmuir v. New Brunswick*, 2008 SCC 9 (Westlaw) at paras. 49, 54 and 55; *Pushpanathan v. Canada (Minister of Citizenship and Immigration)*, [1998] 1 S.C.R. 982, paras. 32 to 34; *Barbulov v. Cirone*, 2009 CarswellOnt 1877 (ON SC) at paras. 25 and 26; *R. v. Conway*, 2010 SCC 22 (Westlaw) at para. 79; *Martin v. Nova Scotia (Workers' Compensation Board)* [2003] 2 S.C.R. 504 (Westlaw) at para. 2

27. The appellants argue that injunction proceedings in the SCJ are faster than applications to the CCB. While the respondent in the present case commenced this application on January 27, 2011 and was able to secure the ruling of Himel J. on March 9, 2011, the process before the CCB would have proceeded even more quickly. The CCB must convene a hearing within seven days and render a decision within 24 hours. Uniquely, hearings before the CCB are held where the incapable person resides (including hospitals, nursing homes and even private homes), further enhancing access to justice. The *HCCA* also includes an expedited appeal process.[10] While the appellants complain that an appeal from the CCB acts as a stay of the Board's decision, a stay sought pending appeal from the SCJ is likely to be granted in circumstances where not granting the stay will render the appeal moot.

> Factum of the Appellants para. 101; *HCCA, supra*, ss. 75 and 80; *Rules of Civil Procedure*, Rules 61.04, 61.09, 61.12 and 63; *Courts of Justice Act*, R.S.O. 1990, C.43, ss. 6, 106 and 132; *Warren Woods Land Corp. v. 1636891 Ontario Inc.* 2012 ONCA 12 at para. 1

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[9] The CCB derives jurisdiction from enabling legislation, which includes the *MHA*, the *HCCA*, the *Personal Health Information Protection Act, 2004*, the *Substitute Decisions Act, 1992* and the *Mandatory Blood Testing Act, 2006.*

[10] Section 80 of the *HCCA* provides that appeals are to be perfected within 14 days of the delivery of the record and transcript by the CCB, while the corresponding period for perfection of appeals from the SCJ is 30 days or 60 days where a transcript is required.

F: Conclusion

28. While the facts of the case before the Court involve end-of-life decision-making, it has implications for the health care decision-making process in all settings. In addition, the circumstances in which Mr. Rasouli is unable to leave to seek treatment elsewhere are akin to those faced by patients who are confined in settings such as psychiatric hospitals and jails. In making the decision in the present case these interveners ask that the Court be mindful of the implications upon other treatment settings.

29. The appellants cite a perceived risk of patients requesting absurd treatments in support of their position in the absence of any evidence and ask on this basis that the Court read exceptions into the *HCCA* definition of treatment. Giving heed to their arguments would effect a return to the paternalistic regime of physician-directed decision-making and defeat the clear intention of the Legislature to reflect *Charter* interests and protect vulnerable persons. As such the appeal should be dismissed and the OCA's reasoning should be rejected.

PART IV – RELIEF SOUGHT

30. These interveners request an opportunity to present oral argument at the hearing of the appeal not exceeding 20 minutes.

ALL OF WHICH IS RESPECTFULLY SUBMITTED.

Marshall A. Swadron	Ryan Peck
Mercedes Perez	Amy Wah
Of counsel to the intervener Mental Health Legal Committee	Of counsel to the intervener HIV & AIDS Legal Clinic Ontario

PART V – TABLE OF AUTHORITIES

Tab	Authority
1.	*Parmley v. Parmley*, [1945] S.C.R. 635 (Westlaw)
2.	*Hopp v. Lepp*, [1980] 2 S.C.R. 192 (Westlaw)
3.	*Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.) (Westlaw)
4.	*Re Carnochan*, [1941] S.C.R. 470 (Westlaw)
5.	Prof. D. Weisstub, *Enquiry on Mental Competency: Final Report* (Toronto: Queen's Printer for Ontario; 1990)
6.	*Fleming v. Reid*, (1991) 4 O.R. (3d) 74 (C.A.) (Westlaw)
7.	*Starson v. Swayze*, 2003 SCC 32 (Westlaw)
8.	*Re Eve*, [1986] 2 S.C.R. 388 (Westlaw)
9.	*Manitoba (Director of Child & Family Services) v. C. (A.)*, 2009 SCC 30 (Westlaw)
10.	*Arndt v. Smith*, [1997] 2 S.C.R. 539 (Westlaw)
11.	*Zimmer v. Ringrose*, [1981] 124 D.L.R. (3d) 215 (Alt. C.A.) (Westlaw)
12.	*Haughian v. Paine*, [1987] 37 D.L.R. (4th) 624 (SK CA) (Westlaw)
13.	*Dickson v. Pinder*, 2010 ABQB 269 (Westlaw)
14.	*Gallant v. Brake-Patten*, 2010 NLTD 1 (S.C. N.L.) (CanLII)
15.	College of Physicians and Surgeons of Ontario, Policy Statement # 3-11, "Complementary/Alternative Medicine" (updated November 2011)
16.	College of Physicians and Surgeons of Ontario, Policy Statement # 4-05, "Consent to Medical Treatment" (updated September 2005)
17.	*Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119 (Westlaw)
18.	*Conway v. Jacques* (2002), 59 O.R. (3d) 737 (ON CA)
19.	*SL (Re)*, 2012 CanLII 35952 (ON CCB) (CanLII)

Tab	**Authority**
20.	*TM (Re)*, 2012 CanLII 19274 (ON CCB) (CanLII)
21.	*G (Re)*, 2011 CanLII 63117 (ON CCB) (CanLII)
22.	*BS (Re)*, 2011 CanLII 26315 (ON CCB) (CanLII)
23.	*E.B. (Re)*, 2005 CanLII 48157 (ON CCB) (CanLII)
24.	*A.W. (Re)*, 2004 CanLII 48655 (ON CCB) (CanLII)
25.	*P. (Re)*, 2005 CanLII 56634 (ON CCB) (CanLII)
26.	*E.J.G. (Re)*, 2007 CanLII 44704 (ON CCB) (CanLII)
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PART VI – STATUTES CITED

TAB	STATUTE
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2.	*The Mental Hospitals Act*, R.S.O. 1937, c.392, ss. 15, 20, 22, 24 and 42
3.	*The Psychiatric Hospitals Act*, R.S.O. 1937, c. 393, ss. 9 and 15
4.	*The Mental Health Act, 1967*, S.O. 1967, c. 51, ss. 8, 13 and 26 to 30
5.	*Mental Health Act*, R.S.O. 1980, c. 262, ss. 1(g), 1(j), 9, 14, 28, 30 to 33 and 35
6.	*An Act to Amend the Mental Health Act*, S.O. 1987, c. 37, ss. 2, 6, 9, 11 and 12
7.	*Consent to Treatment Act, 1992*, S.O. 1992, c. 31, ss. 1 ("treatment"), 4 to 6, 9 to 21, 28 to 33 and 35 to 45
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