TO-12-0289
TO-12-0290

IN THE MATTER OF
the ***Health Care Consent Act***
S.O. 1996, chapter 2, schedule A,
as amended

AND IN THE MATTER OF
FF
A patient at
Baycrest Hospital-Complex Continuing Care
TORONTO, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

A panel of the Board convened at Baycrest Hospital-Complex Continuing Care at the request of Dr. Sheryl Korn, a health practitioner. Dr. Korn, who proposed a treatment for FF brought a Form D Application to the Board under Section 35 (1) of the *Health Care Consent* Act for directions with respect to a wish expressed in a Power of Attorney for Personal Care signed by FF on May 13, 2003.

An Application to the Board under Section 35 of the *Health Care Consent Act* is deemed, pursuant to subsection 37.1 of the *Health Care Consent Act* to include an application to the Board under Section 32 by FF with respect to her capacity to consent to treatment proposed by a health practitioner unless the person's capacity to consent to such treatment has been determined by the Board within the previous six months.

DATES OF THE HEARING, DECISIONS AND REASONS

The hearing took place on Wednesday, May 16, 2012, Wednesday, May 30, 2012 and Tuesday, June 5, 2012. Decisions were released on Wednesday, June 6, 2012. Reasons were released on Thursday, June 14, 2012.

LEGISLATION CONSIDERED

The *Health Care Consent Act*, including s. 1, 2, 4, 5, 10, 11, 21, 32, 35 and 37.1

PARTIES

FF's Deemed Form A – Treatment Application
FF, the patient
Dr. S. Korn, the health practitioner

Dr. S. Korn's Form D – Directions Application
Dr. S. Korn, the health practitioner
FF, the patient
AF, FF's son, SJ, FF's daughter and DB, FF's daughter

Dr. Korn attended a portion of the Hearing and gave evidence. AF and DB attended the Hearing and gave evidence. SJ attended the hearing by teleconference and gave evidence. FF did not attend the Hearing.

PANEL MEMBERS

Michael Newman, presiding lawyer member
Joseph Glaister, psychiatrist member
Earl Campbell, public member

APPEARANCES

FF was represented at the Hearing by counsel, Mr. E. Bundgard
Dr. Korn was represented at the Hearing by counsel, Mr. M. Handelman
AF, SJ and DB were represented at the Hearing by counsel, Ms. M. Perez

PRELIMINARY MATTERS

The panel was advised that there had not been within the previous six months a determination by the Board of FF's capacity to consent to any proposed treatment in this case. The panel was also advised that FF did not have a Guardian of the Person. FF had a Power of Attorney for Personal Care, but same did not contain a provision waiving FF's right to apply for the review of the health practitioner's findings in accordance with Section 32 of the *Health Care Consent Act*. We determined that the Board had jurisdiction to continue with the Hearing.

THE EVIDENCE

The evidence at the hearing consisted of the oral testimony of seven witnesses, Dr. S. Korn, AF, FF's son, SJ, FF's daughter, DB, FF's daughter, HH, FF's former lawyer, MO, FF's Rabbi, DC, a Rabbi consulted by AF and eight Exhibits:

1. Dr. Korn's Summary dated April 26, 2012
2. Selected List Patient Notes dated March 6, 2012 – April 9, 2012
3. FF's Power of Attorney for Personal Care dated May 13, 2003
4. Merrian-Webster Dictionary definition of "Artificial" (3 pages)
5. Document entitled Treatment Alternatives Proposed
6. Collection of Documents from HH's file
7. Rabbi DC's handwritten letter and transcribed version dated May 1, 2012
8. Ms. Neves' list patient note dated April 9, 2012 (8:24)

INTRODUCTION

FF was an 86 year old widow, with three children, seven grandchildren and 52 great grandchildren. Until January 24, 2012, FF had been living in the community with a full time caregiver. On January 24, 2012, FF's condition dramatically changed when she choked on food and suffered a cardiac arrest while in Florida. FF was resuscitated in a Florida hospital but had sustained anoxic brain injury leaving her in a vegetative state, her prognosis deemed grave. She was found incapable with respect to all treatments on January 24, 2012. FF was subsequently transferred to a Toronto hospital and then to Baycrest Hospital where she remained at the time of the Hearing. She currently has a feeding tube and tracheostomy, both installed in a Florida hospital prior to her transfer back to Toronto and admission to Baycrest Hospital. Dr. Korn became FF's most responsible health practitioner at Baycrest Hospital. FF's medical conditions included Alzheimer's dementia, hypertension and hyperthyroidism.

Dr. Korn applied to the Board of directions, pursuant to section 35 of the Health Care Consent Act (HCCA). The doctor wanted the Board to determine whether FF had expressed a prior capable wish applicable to her current circumstances by a Power of Attorney for Personal Care signed May 13, 2003. On that date FF executed a Power of Attorney for Personal Care naming all three of her children, AF, SJ and DB as her Attorneys for Personal Care. FF's Power of Attorney for Personal Care contained the following provision:

"I hereby instruct that if there is no reasonable expectation of my recovery from physical or mental disability, I be allowed to die and not be kept alive by artificial or heroic measures. I do, however, instruct that medication be mercifully administered to me to alleviate suffering even though this may shorten my remaining life".

FF's Power of Attorney for Personal Care only recently came to the attention of FF's three children and then subsequently Dr. Korn.

THE LAW

Capacity with Respect to Treatment

Dr. Korn's Form D application for directions triggered a deemed Form A application by FF pursuant to the Health Care Consent Act (S 37.1) with respect to her own capacity to make proposed treatment decisions.

In considering the deemed capacity application, the onus is always on the health practitioner at a Board Hearing to prove his or her case. The case as with other matters before the Board must be proved on a civil

balance of probabilities. In order for the Board to find in favour of the health practitioner, here Dr. Korn, it must hear cogent and compelling evidence in support of the health practitioner's case. FF as the patient appearing before the Board did not have to prove anything; the onus being entirely on the health practitioner, Dr. Korn. The Board may consider both direct and hearsay evidence, although hearsay must be assigned only that weight which is appropriate to it in the circumstances.

The *Health Care Consent Act*, *1996* states that a health practitioner who proposes a treatment for a person shall ensure that it is not administered unless, he or she is of the opinion that the person has given consent; or he or she is of the opinion that the person is incapable with respect to the treatment, and another person has given consent in accordance with the *Health Care Consent Act*, *1996*.

The test for capacity is set out in Section 4(1) of the *Health Care Consent Act, 1996* which states that a person is capable with respect to treatment if the person is able to understand the information that is relevant to making a decision about the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. The section went on to set out that a person is presumed to be capable with respect to treatment and that a person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment.

Section 2 of the *Health Care Consent Act* in part reads as follows:

"**plan of treatment**" means a plan that,

(a) is developed by one or more health practitioners,

(b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and

(c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition; ("plan de traitement")

"**treatment**" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include,

(a) the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the *Substitute Decisions Act, 1992* of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,

(b) the assessment or examination of a person to determine the general nature of the person's condition,

(c) the taking of a person's health history,

(d) the communication of an assessment or diagnosis,

(e) the admission of a person to a hospital or other facility,

(f) a personal assistance service,

(g) a treatment that in the circumstances poses little or no risk of harm to the person,

(h) anything prescribed by the regulations as not constituting treatment. ("traitement") 1996, c. 2, Sched. A, s. 2 (1); 2000, c. 9, s. 31.

Section 5 of *Health Care Consent Act* reads as follows:

Wishes

5 (1) A person may, while capable, express wishes with respect to treatment, admission to a care facility or a personal assistance service. 1996, c. 2, Sched. A, s. 5 (1).

Manner of expression

(2) Wishes may be expressed in a power of attorney, in a form prescribed by the regulations, in any other written form, orally or in any other manner. 1996, c. 2, Sched. A, s. 5 (2).

Later wishes prevail

(3) Later wishes expressed while capable prevail over earlier wishes. 1996, c. 2, Sched. A, s. 5 (3).

Sections 10, 11, 12, and 13 of the *Health Care Consent Act* provide that:

No treatment without consent

10. (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

(a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or

(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).

Opinion of Board or court governs

(2) If the health practitioner is of the opinion that the person is incapable with respect to the treatment, but the person is found to be capable with respect to the treatment by the Board on an application for review of the health practitioner's finding, or by a court on an appeal of the Board's

decision, the health practitioner shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless the person has given consent. 1996, c. 2, Sched. A, s. 10 (2).

Elements of consent

11. (1) The following are the elements required for consent to treatment:

1. The consent must relate to the treatment.

2. The consent must be informed.

3. The consent must be given voluntarily.

4. The consent must not be obtained through misrepresentation or fraud. 1996, c. 2, Sched. A, s. 11 (1).

Informed consent

(2) A consent to treatment is informed if, before giving it,

(a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and

(b) the person received responses to his or her requests for additional information about those matters. 1996, c. 2, Sched. A, s. 11 (2).

Same

(3) The matters referred to in subsection (2) are:

1. The nature of the treatment.

2. The expected benefits of the treatment.

3. The material risks of the treatment.

4. The material side effects of the treatment.

5. Alternative courses of action.

6. The likely consequences of not having the treatment. 1996, c. 2, Sched. A, s. 11 (3).

Express or implied

(4) Consent to treatment may be express or implied. 1996, c. 2, Sched. A, s. 11 (4).

Included consent

12. Unless it is not reasonable to do so in the circumstances, a health practitioner is entitled to presume that consent to a treatment includes,

(a) consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different from the nature, expected benefits, material risks and material side effects of the original treatment; and

(b) consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered. 1996, c. 2, Sched. A, s. 12.

Plan of treatment

13. If a plan of treatment is to be proposed for a person, one health practitioner may, on behalf of all the health practitioners involved in the plan of treatment,

(a) propose the plan of treatment;

(b) determine the person's capacity with respect to the treatments referred to in the plan of treatment; and

(c) obtain a consent or refusal of consent in accordance with this Act,

(i) from the person, concerning the treatments with respect to which the person is found to be capable, and

(ii) from the person's substitute decision-maker, concerning the treatments with respect to which the person is found to be incapable. 1996, c. 2, Sched. A, s. 13.

Sections 21, 35 and 37.1 of the *Health Care Consent* Act read as follows:

21. (1) A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles:

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.

2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.

21.(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;

(b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1) ; and

(c) the following factors:

1. Whether the treatment is likely to,
   i. improve the incapable person's condition or well-being,
   ii. prevent the incapable person's condition or well-being from deteriorating, or
   iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

35. (1) A substitute decision-maker or a health practitioner who proposed a treatment may apply to the Board for directions if the incapable person expressed a wish with respect to the treatment, but,

(a) the wish is not clear;

(b) it is not clear whether the wish is applicable to the circumstances;

(c) it is not clear whether the wish was expressed while the incapable person was capable; or

(d) it is not clear whether the wish was expressed after the incapable person attained 16 years of age.

Notice to substitute decision-maker

(1.1) A health practitioner who intends to apply for directions shall inform the substitute decision-maker of his or her intention before doing so.

Parties

(2) The parties to the application are:

1. The substitute decision-maker.

2. The incapable person.

3. The health practitioner who proposed the treatment.

4. Any other person whom the Board specifies.

Directions

(3) The Board may give directions and, in doing so, shall apply section 21

Deemed Application Concerning Capacity

37.1 – An application to the Board under section 33, 34, 35, 36 or 37 shall be deemed to include an application to the Board under section 32 with respect to the persons capacity to consent to treatment proposed by a health practitioner unless the person's capacity to consent to such treatment has been determined by the board within the previous six months. 2000, c.9, s.36.

ANALYSIS

The main application before the Board was Dr. Korn's Form D brought pursuant to the *Health Care Consent Act* for directions with respect to FF's wishes set out in her May 13, 2003 Power of Attorney for Personal Care(sometimes referred to as FF's POA). As noted earlier, a Form D application triggered a statutory application by FF with respect to her own capacity to consent to the proposed treatment unless that capacity had been determined by the Board within the previous six months. There was no evidence of any such prior determination. We found the Board had jurisdiction in this matter.

The general law relating to capacity to consent to treatment is set out in the *Health Care Consent Act* (at times referred to as the HCCA). That legislation also sets out a scheme for identifying substitute decision makers (SDM's) for incapable persons. It also described how SDM's should make decisions and the available options should SDM's not be making proper decisions.

The Purposes of the HCCA are set out at its very beginning. These include providing rules with respect to consenting to treatment, facilitating treatment for incapable persons, enhancing the autonomy of persons for whom treatment is proposed and promoting communication and understanding between health practitioners and their patients.

Furthermore, the HCCA in Section 2 requires that a health practitioner must (emphasis mine) determine whether a person is capable to consent to treatment. The HCCA also provided that all health practitioners must be members of their respective professional colleges in Ontario. Physicians are included as health practitioners.

As noted earlier the test for capacity is set out in Section 4(1) of the HCCA as follows:

> 4. (1) Capacity – a person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.
> (2) Presumption of capacity – a person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services.
> (3) Exception – a person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission or the personal assistance service, as the case may be.

There is a presumption of treatment capacity on which a person is entitled to rely unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment.

By Section 15(1) and (2) capacity can fluctuate and capacity also can vary over time and in relation to the type of treatment. The determination of capacity is therefore issue and time specific. The health practitioner must look at the specific treatment or plan and determine whether the person is capable for the particular treatment.

In the event that a person has been found incapable, a substitute decision maker may give consent to treatment on behalf of the incapable person. Section 16 of the HCCA provides that if the incapable person becomes capable, the person's own decision to give or refuse consent to treatment prevails.

FF's Capacity with Respect to Treatment

Did the evidence establish that FF was unable to understand the information relevant to making a decision about the treatment in question? Did the evidence establish that FF was unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision about the treatment in question?

There were two statutory parties to the deemed treatment application. The parties were Dr. Korn, a staff physician at Baycrest Hospital (and FF's most responsible physician) and FF. There were no additional parties. In her evidence, Dr. Korn stated that as a result of the choking accident in January, 2012, FF sustained anoxic brain injury resulting from a lack of oxygen to her brain, leaving FF in a persistent vegetative state. The doctor said FF had no sense of awareness of herself and was unable to respond to conversation. The doctor said FF was unable to take in information as a result of the brain damage she suffered. Dr. Korn noted that FF was able to breath on her own. In Dr. Korn's opinion, FF failed both branches of the test for capacity and was therefore unable to both (i) understand any information relevant to her condition or proposed treatments or (ii) appreciate the reasonable foreseeable consequences of a decision or lack of decision as a result of the damage caused to her brain.

The Supreme Court of Canada in the Starson decision, (2003 SCC 32), examined and analyzed the treatment capacity provisions of Ontario's Health Care Consent Act. In Starson the Supreme Court directed that while FF did not have to agree with any particular diagnosis, she had to be able to understand information relevant to making a decision about the treatment and be able to appreciate the reasonably foreseeable consequences of a decision or lack of decision about the treatment, as set out in section 2 of the HCCA.

In Neto v. Klukach, (2004) O.J. No. 394 Justice Day of the Superior Count noted that the second branch of the test for capacity assesses the ability to evaluate, not just understand information. Here FF must have an ability to appreciate the relevant information as it related to her.

The panel found that Dr. Korn's evidence was clear, cogent and compelling. That evidence was also unchallenged and uncontradicted in terms of FF's treatment capacity. We found that as a result of FF's brain damage, she lacked the ability to cognitively understand any of the information that was relevant to her condition. In addition, we found that FF also failed the second branch of the test for treatment capacity. She was unable to appreciate the reasonably foreseeable consequences of making a treatment decision or not making such a decision. On a balance of probabilities the evidence was clear, cogent and compelling that in her unconscious, unresponsive condition, FF lacked both the ability to understand information that was relevant to making a treatment decision and the ability to appreciate the reasonably foreseeable consequences of making or not making a decision.

Dr. Korn's Application for Directions

Dr. Korn testified that FF's current condition medically described as a persistent vegetative state could not be improved, that FF would not recover from the severe anoxic brain damage she suffered as a result of the lack of oxygen to her brain. Dr. Korn said that in FF's current condition she showed no evidence of any awareness and required total nursing care. The doctor said that she had no expectation FF would get better, that her brain damage was severe. The doctor also said that FF required suctioning without which she would die, because the brain injury FF suffered prevented her from clearing secretions. The doctor said that the tracheostomy tube allowed staff to suction and clear FF's airwaves, which was required 3-4 times each 8 hour shift. The tube allowed FF to breathe more easily. Dr. Korn also testified that FF's feeding tube, through her stomach, provided FF with hydration and nutrition. The doctor said that the feeding tube and tracheostomy were both procedures performed while FF was admitted to hospital in Florida, prior to FF's admission to Baycrest Hospital on February 29, 2012. The doctor noted that sometime after FF's transfer to Baycrest Hospital, FF's three children became aware of FF's Power of Attorney for Personal Care and she was subsequently made aware of the document and FF's wishes.

Dr. Korn's position was that a feeding tube and tracheostomy in this case were both artificial and heroic measures and supports. The doctor said that in her medical opinion FF had no reasonable expectation of recovery from physical or mental disability. The doctor testified that if she had known in the beginning about the wishes expressed by FF in her Power of Attorney for Personal Care, she would have considered the current treatments as contrary to FF's wishes. Dr. Korn acknowledged there was no standard medical

definition for "heroic". The doctor said that at times feeding tubes were routinely used and were not always considered heroic measures. However, that was not the case here. The doctor's position was that she required direction from the Board in light of FF's wish in her Power of Attorney and the family's belief that based on FF's religious beliefs as a devout Orthodox Jew that maybe FF's wishes as set out in the Power of Attorney were not her wishes.

Dr. Korn's opinion was that if the tracheostomy tube was removed, FF would die within the day, because her airwave could not be maintained without the artificial support of the tube. However, given that the tracheostomy and feeding tube were currently in place, Dr. Korn would leave them and treat FF palliatively. The doctor noted that the feeding tube was an artificial measure, without which FF would starve to death. Dr. Korn said she would not feel comfortable removing the feeding tube. Dr. Korn said that in her medical opinion FF was suffering from both a physical and mental disability and had no reasonable expectation of recovery. The doctor said that although FF was currently stable, if not maintained as she was, she would die.

HH was a lawyer and specialist in Trusts and Estates. She had drawn up FF's and FF's late husband's Powers of Attorney (POA) and Wills originally on December 19, 2001 and then FF's POA of May 13, 2003 following the death of FF's husband. HH said she has drafted hundreds if not thousands of POA's. However HH testified that she had no specific recollection of discussions with FF and her late husband about the POA's. HH was able to speak about her usual practice and was able to pull copies of documents from FF's file. HH testified as to her practice of going through a process to finalize POA's and ensure that they contained the provisions clients wanted. HH said that she advised clients to speak with their doctors about "extreme measures". HH said it was not her common practice to discuss religion and she would have noted any discussions about religion. There were no such notes about religion. She noted that the particular wish provision in FF's May 13, 2003 POA was the exact same provision as set out in the December, 2001 POA's for both FF and her late husband.

HH testified that besides sending draft POA's to FF and her late husband she would have met FF prior to FF signing her May 13, 2003 POA and similarly would have met FF and her late husband in December, 2001 prior to their signing of POA's at that time. HH said that when meeting for signing, she would have gone through the POA in detail, as she put it "clause by clause", to ensure FF understood what was in the document (and similarly in December, 2001 with FF and her late husband). HH said that by sending a draft

POA to FF in advance of meeting in May, 2003 (and earlier to FF and her late husband in December, 2001), FF would have had plenty of time to look over and review the draft POA in her own home.

HH said that her practice, particularly with older clients was to assess them to ensure they understood what they were signing. HH said if she had any concerns they would have been noted. In this case, none were noted. If HH had not been satisfied a client could understand the explanation, HH said she would have taken steps to obtain an independent interpreter for assistance. HH had no doubt in her mind that she always went through the POA's with FF in English. HH said that technically FF did not require a new POA in 2003 as the only change from the December, 2001 POA was removal of FF's then recently deceased husband, with FF's three children moving up from alternate attorneys. HH was certain that before FF executed either POA, she would have gone through them with FF. As to what HH would have said about an end of life provision in the POA, HH said she would tell a client that it was an expression of your wishes and that the attorneys would have to apply the wish to a particular circumstance(s). HH said that in her opinion, she was satisfied that FF understood what the POA set out and had the capacity to execute the document at the time of signing.

AF, FF's son and SJ and DB, FF's daughters each gave evidence. The children spoke of their parents difficult life in Europe prior to World War II, their mother being forced to leave Austria when Germany invaded, their mother's parents being taken to a labour camp, and then later a concentration camp where they perished. All three children spoke of their parents' moves from Europe to South America and eventually to Canada. The children acknowledged FF could understand and participate in day to day routine English conversations, that she could read the newspaper. Each of the children were clear about their parents and their own Orthodox Jewish beliefs and traditions. AF, SJ and DB said their father was better educated than their mother and that their mother followed their father's lead, that whatever he said she would follow. In other words, FF tended to defer to her husband for business, religion and legal matters. All the children described their father as a very successful businessman and that he dealt on many occasions with lawyers for legal matters. AF referred to his father as a "careful and attentive businessman" and that his father's English was better than his mother's.

DB said her husband introduced HH to her parents when her father was looking for a lawyer for estate planning purposes. DB said that she was shocked that her father had the same wish in his POA for Personal Care. DB said her father was definitely a careful man and would have read something before he signed it.

All of FF's children acknowledged that during the time period of 2001 – 2003 their mother remained a bright woman and independent. She did her own shopping, made her own phone calls, and wrote her own cheques. AF said that in 2003, FF was living alone, driving her own car but that she also had a driver. AF said his mother's best friends were Orthodox Jews but she also had non Orthodox acquaintances. AF said he initially noticed some dementia in his mother around 2007-2008.

The children noted that they were not consulted, nor did they know in advance of their parents POA's and in particular the wishes set out in both their parents' POA's for Personal Care and currently in dispute before the Board. The children expressed their common view that the POA provisions before the Board should be interpreted generally such that they would be permitted as attorneys to decide on their mother's end of life care, and any cessation or continuation of treatment. The children said they had consulted their Rabbi and believed that full treatment should be continued for their mother who they saw as stable and not in the final stages of life. AF said his mother never verbalized or spoke about being in the situation she currently was in. AF said his mother was afraid of old age and was always a very young woman at heart. AF noted that RR was a colleague and friend of his. AF said RR was his father's accountant and was also Jewish and Orthodox. AF said RR knew his parents for many years and was a trusted advisor to his father. RR was also one of the witnesses to FF's signature on the Power of Attorney for Personal Care dated May 13, 2003. The children agreed with Dr. Korn that their mother was currently in a coma, not conscious, non responsive and not appearing in pain.

MO was FF's Rabbi and an adherent of Orthodox Judaism. According to MO, Orthodox Judaism was more adherent to traditions. MO said he knew FF since she and her husband joined his synagogue many years ago. He said FF's English was "pretty good". He noted that FF's late husband was a very successful businessman. MO described FF, her late husband and family as very complete and devoted Jews, totally observant in synagogue and ethics. He said he knew their practice. MO said it would be against "the grain" for FF to contravene the tenets of her faith, a faith which believed that every moment of life was precious. He said Orthodox Judaism did not use the word heroic. MO acknowledged that he was never consulted by FF or her late husband concerning end of life decision making.

MO said that from an Orthodox Jewish perspective there was no obligation to prolong life. However, MO also said that there was nothing undignified about FF's current state. MO said that a person's quality of life was not up to the individual, "it was God given". He said that the Orthodox Jewish view was that science

was in the service of humanity that "pulling the plug" was tantamount to taking life, which was not permitted. He acknowledged that there were contrary more lenient views in Orthodox Judaism, but that his view was the same as the overwhelming opinion of superior Orthodox Jewish scholars that removing a tracheostomy was akin to taking life. He acknowledged that individuals could write in their POA's that decisions were to be made in accordance with Jewish law or to consult a person's Rabbi. MO said in his view a provision in a POA such as the one in FF's would leave him questioning if she knew what she was writing, and whether those were her wishes.

DC was an Orthodox Jewish Rabbi from New York. He did not know FF personally, but has advised AF that according to Orthodox Jewish law, a person's body was God given, that a person was not considered the owner of his body and soul, so it must be preserved. DC said that according to Orthodox Jewish law, people were obligated to prolonging life, and failing to keep FF alive in her current condition would be tantamount to murder. According to DC, an Orthodox Jew would want to live as long as possible. .

The panel was referred to the Superior Court decision in Barbulov v. Cirone 2009 Canlii 15889(On SC). There Justice Brown analyzed the requirements for a valid Power of Attorney. At paragraphs 42-47, Justice Brown wrote:

[42] The *Substitute Decisions Act*, 1992, S.O. 1992, c. 30, contains the requirements for a valid power of attorney for personal care. Section 46 (1) provides that a person may give a written power of attorney for personal care, authorizing the person, or persons, named as attorneys to make, on the grantor's behalf, decisions concerning the grantor's personal care. The power of attorney may contain instructions with respect to the decisions the attorney is authorized to make: *SDA*, s. 46(7).

[43] Such a power of attorney need not be in any particular form: *SDA*, s. 46(8). The Act provides that a power of attorney for personal care is valid if, at the time it was executed, the grantor was capable of giving it, even if the grantor was incapable of personal care: *SDA*, 47(2).[1] The Act also imposes a requirement that the power of attorney for personal care be executed in the presence of, and signed by, two witnesses, although a court may declare effective a power of attorney that has not met this formality, if the court is satisfied that it is in the grantor's interest to do so: *SDA*, s. 48(1) and (4).

[44] In the present case there is no doubt that the 1995 POA met the requirements of the *SDA*, with respect to the capacity of Mr. Barbulov to give a power of attorney for personal care and the formalities of the creation of the document. However, the inquiry into whether a power of attorney expresses a person's wishes with respect to treatment, within the meaning of s. 5 of the *HCCA*, is not limited to questions of capacity and formalities. The intended effect or scope of a wish must be determined: *Fleming v. Reid* 1991 CanLII 2728 (ON CA), (1991), 4 O.R. (3d) 74 (C.A.), at p. 94; *Conway v. Jacques* 2002 CanLII 41558 (ON CA), (2002), 59 O.R. (3d) 737 (C.A.), at para. 31. To do so the CCB must determine whether the contents of a power of attorney for personal care express the wishes of the incapable person. Fundamental to this inquiry is the need for the Board to satisfy itself, on all the evidence, that the person who made the power of attorney

for personal care understood and approved of the contents of the document he or she was signing so that it can be said the document expresses the wishes of that person with respect to treatment.

[45] Counsel for the respondent referred me to the decision of the CCB in *Re G.A.*, 2007 CanLII 32891 (ON CCB), 2007 CanLII 32891 (ON C.C.B.) in which the Board held that if a party wanted to assert that the person who signed a power of attorney for personal care did not know its contents, that party would have to adduce evidence to establish that point. I would not put the matter quite that way. I think the proper approach should draw upon principles applicable to the proof of wills: *Feeney's Canadian Law of Wills, Fourth Edition*, at §3.1. Where a person seeks to rely upon a power of attorney for personal care as the expression of a prior capable wish of an incapable person, that person must demonstrate that the grantor not only possessed the requisite capacity to make the power of attorney, but also knew and approved of the contents of the document. As in the case of wills, a presumption operates that the contents of a power of attorney were known and approved if the document had been read over to the grantor, or if the contents were otherwise brought to his or her attention. This presumption, of course, can be overborne by evidence of circumstances that the grantor did not know or approve of the contents, with the result that the person advancing the power of attorney would need to satisfy the tribunal or court of the grantor's knowledge and approval of contents.

[46] In *Re G.A.* the Board went on to state, at page 14 of its reasons:

> While, in law, it is occasionally possible for a person to escape contractual responsibility on the basis that he or she did not know what they were signing, courts have always been cautious about letting that happen. People are presumed to be responsible for their actions and know to what they've agreed.

In my respectful view, that puts the matter too high, and conflates powers of attorney for personal care with commercial contracts when, in fact, they are different types of documents. By signing a commercial contract one person makes promises to another, which the latter can call the other to perform. Courts, indeed, are reluctant to release a person from such written promises simply on the person's assertion that he did not really understand the bargain he was making.

[47] Powers of attorney for personal care are a different creature. The grantor is not making a bargain with the grantee. Rather, the grantor is selecting a person to act in his stead and is expressing, through the document, the nature of the care he wishes to receive in the event that certain circumstances arise. Under a power of attorney for personal care the grantee does not receive any benefit enforceable against the grantor, as does the promisee under a commercial contract. Instead, the grantee is requested to perform a duty for the grantor and, if he accepts the grant, the grantee must comply with the expressed wishes of the grantor.

At paragraph 48, Justice Brown wrote about the circumstances where this Board was faced with a Power of Attorney for Personal Care and how the Board should approach the inquiry under section 21(1) of the HCCA.

[48] So, where the CCB is faced with a power of attorney for personal care, it should not approach the inquiry under section 21(1)1 of the *HCCA* on the basis of whether the grantor is trying to "escape contractual responsibility"; to do so would be an error. Instead, the inquiry must always remain focused on the task mandated by the statute – does this document express the capable wishes of the person with respect to treatment in particular circumstances? To conclude that the document does, the CCB must be satisfied on the

evidence that the grantor understood what he was doing through the document – i.e. he knew and approved of its contents and effects. If he or she did not, then I do not see how one could say that the power of attorney for personal care expressed the wishes of the person with respect to treatment, as required by section 5 of the *HCCA*.

In her submissions Counsel for FF's three children questioned the validity of FF's wish on the basis that the wish as expressed in FF's Power of Attorney for Personal Care dated May 13, 2003, went against the teachings of Orthodox Judaism. Counsel for both Dr. Korn and FF submitted that FF's Power of Attorney for Personal Care signed May 13, 2003 contained FF's prior capable wishes and was applicable to FF's current circumstances.

In the panel's view it was critical for us to determine first off whether FF's wishes as expressed in the POA for Personal Care were her wishes. If we found they were her wishes, we would then need to determine if the wishes were applicable to FF's current circumstances. In order to determine that issue examination of evidence in the light of Justice Brown's analysis in Barbulov was critical. Evidence received supported the position that (i) FF was a devout, Orthodox Jewish woman and (ii) that mainstream Orthodox Judaism put life above all else. However, in terms of considering her end of life decisions making, FF and her late husband, as with any capable individuals were at liberty to make choices for themselves. What also was clear was the FF was a private person and did not discuss with her children a number of topics including her wartime experiences and her POA. We found that both FF and her late husband made choices that conflicted with traditional Orthodox Jewish beliefs. Those were choices as capable individuals they were entitled to make.

Our inquiry had to remain focused on determining whether FF's POA of May 13, 2003 expressed the capable wishes of FF with respect to treatment in particular circumstances. (paragraph 48, Barbulov). In our view, we were satisfied on the evidence including HH's and that of FF's children that FF understood what she was doing through her POA, that she knew and approved of its contents and effects as we were directed to determine by Justice Brown in Barbulov. We therefore found that by her POA FF expressed wishes with respect to treatment, as required by section 5 of the HCCA. We found there was no evidence that FF was incapable of executing a Power of Attorney for Personal Care or making a wish therein. There was no evidence FF did not know of or approve of the contents of her May 13, 2003 Power of Attorney for Personal Care (or for that the matter the earlier December, 2001 Power of Attorney). We noted that besides acting as

FF's lawyer in terms of drawing up the POA HH was also a witness to FF signing her POA together with a close and trusted business advisor and family friend RR.

The evidence before us was clear, cogent and compelling that FF remained capable with respect to her decision making when her POA for Personal Care as drawn up and signed on May 13, 2003. We accepted HH's evidence as clear, cogent and compelling that FF knew of and approved of the contents of her POA. In weighing the evidence as a whole we found that the evidence of FF's children did not dispute their mother's capacity at the time she signed her Power of Attorney for Personal Care.

With our finding that FF's POA expressed her capable wishes the panel then proceeded to determine whether the wishes were applicable to FF's current circumstances. In our view, the medical evidence of Dr. Korn was clear, cogent and compelling that the wishes in the POA were applicable to FF's current circumstances.

In her POA for Personal Care, FF used the phrase "artificial or heroic measures". Artificial was defined in the evidence (Merrian Webster dictionary) to mean produced by humans, rather than naturally occurring. That was the medical evidence. We found there was no evidence to the contrary. We accepted the medical evidence. We found, therefore, that the tracheostomy and the feeding tube were both "artificial measures". Dr. Korn testified that without the tracheostomy, FF would choke within a short time and die, that her current medical condition was grave. We agreed with that clear, uncontradicted medical evidence.

As Cullity, J. noted in Scardoni V. Hawryluck, 2004 Canlii 34326 (Ontario S.C) at paragraph 54, "The relevance of an incapable person's wishes was explained by Sharpe JA in the Ontario Court of Appeal decision of Conway, V. Jacques, 2002, Canlii, 41558 at paragraph applies 30-31.

30. [30] Ontario's *Health Care Consent Act, 1996* is the legislature's response to the successful *Charter* challenge in *Fleming*. The Act requires close attention to the patient's wishes by those who make treatment decisions on the patient's behalf. The wishes of the patient are to be considered by the substitute decision-maker at two stages under the Act: 1) in acting in accordance with a prior capable wish applicable to the circumstances pursuant to s. 21(1)1; and 2) in determining the incapable person's best interests pursuant to s. 21(2) where there is no prior capable wish applicable to the circumstances.

31. [31] At the first stage, the substitute decision-maker must act in accordance with a wish expressed while capable that is applicable to the circumstances. However, I agree with the appeal judge that prior capable wishes are not to be applied mechanically or literally without regard to relevant changes in

circumstances. Even wishes expressed in categorical or absolute terms must be interpreted in light of the circumstances prevailing at the time the wish was expressed. As Robins J.A. held in *Fleming* at p. 94:

In my view, no objection can be taken to procedural requirements designed to determine more accurately the intended effect or scope of an incompetent patient's prior competent wishes or instructions. As the Act now stands, the substitute consent-giver's decision must be governed by wishes which may range from an isolated or casual statement of refusal to reliable and informed instructions based on the patient's knowledge of the effect of the drug on him or her. Furthermore, there may be questions as to the clarity or currency of the wishes, their applicability to the patient's present circumstances, and whether they have been revoked or revised by subsequent wishes or a subsequently accepted treatment program.

Prior capable wishes are not to be applied mechanically or literally without regard to relevant changes in circumstances. As Cullity, J. noted at paragraph 73 in Scardoni "In determining whether a patient's expressed wishes are applicable to the circumstances, they must be considered in their context". In her Power of Attorney for Personal Care, (signed May 13, 2003) FF instructed her attorneys and expressed her wishes as follows: "I hereby instruct that if there is no reasonable expectation of my recovery from physical or mental disability, I be allowed to die and not be kept alive by artificial or heroic measures. I do, however, instruct that medication be mercifully administered to me to alleviate suffering even though this may shorten my remaining life".

Were FF's instructions and wishes applicable to her circumstances as of the Hearing? The panel found FF's instructions and wishes were clear and unambiguous. In addition, there was no evidence of any other specific capable wish to the contrary. Evidence put forth by FF's children, including from both Rabbis expressed general Orthodox Jewish views of end of life care. However, these general views did not, in the panel's view, prevail over FF's express wishes in her Power of Attorney. Specific wishes expressed in a document such as FF's Power of Attorney for Personal Care written in part to address end of life decision making prevailed over a general philosophy or general religious beliefs.

FF did not set out specific illnesses in her Power of Attorney, but rather set out the words, "physical or mental disability". At the time the Power of Attorney was drafted, FF could not have known how she was going to die. She defined a condition – "no reasonable expectation of my recovery.." in which the instructions and wishes were to apply, rather than any specific illness. In the panel's view, FF clearly defined the circumstances when her wish applied. As of the Hearing, FF had been in a persistent vegetative state, for some time, having suffered anoxic brain injury, her prognosis medically deemed grave. She was being maintained on a feeding tube and a tracheostomy. She was incapable of making her own treatment decisions,

and was unable to feed herself. Dr. Korn's evidence was that there was no reasonable expectation of FF's recovering from what the doctor testified was physical or mental disability. The doctor's further evidence was that FF was being kept alive by artificial measures. There was no medical or other evidence to the contrary. We found the doctor's evidence including concerning FF's condition and prognosis as clear, cogent and compelling.

In her current state FF was, as Dr. Korn testified and we accepted, in a condition in which FF, through her POA directed that she be allowed to die and not be kept alive by artificial or heroic measures. Clearly FF wanted her three children to be her attorneys. They could decline. However FF provided her clear directions and wishes and they ought to be followed in this case. It being the panel's finding that FF expressed capable wishes applicable to her current circumstances, the panel did not consider section 21 (2) of the HCCA when determining what directions, if any, to provide.

RESULT

We found FF not capable with respect to all treatment. We also determined that (i) FF expressed a clear prior capable wish in her Power of Attorney for Personal Care dated May 13, 2003 as follows "I hereby instruct that if there is no reasonable expectation of my recovery from physical or mental disability, I be allowed to die and not be kept alive by artificial or heroic measures. I do, however, instruct that medication be mercifully administered to me to alleviate suffering even though this may shorten my remaining life" (ii) the wish is applicable to FF's current circumstances.

Dated: June 14, 2012

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Michael Newman
Vice-Chair, Presiding Lawyer Member