CITATION: Ackie et al. v. Manocha, 2014 ONSC 669
COURT FILE NO.: CV-13-003121
DATE: 20140131

2014 ONSC 669 (CanLII)

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

MERLE ACKIE AND CLESCELIA EARLINE ACKIE-FRIDAY — *Theodore Nemetz, amicus curiae*

Appellant

– and –

DR. SANJAY MANOCHA — *Andrew McCutcheon,* for the Respondent

Respondent

HEARD: January 15, 2014

HIMEL J.

REASONS FOR JUDGMENT

[1] This appeal concerns an end of life decision where a patient's doctors and her family do not agree on whether long-standing life support treatments should be withdrawn. Because of the difficulties inherent to these decisions, the legislature of Ontario has created a statutory process for ensuring an incapable patient's prior capable wishes are respected and, failing any, the best interests of the person are considered by the substitute decision-maker. In short, the process places the focus squarely on the patient – both her physical reality and her dignity. The Supreme Court of Canada has endorsed this process in *Cuthbertson v. Rasouli*, 2013 SCC 53. While the legislative scheme can never eliminate the difficulties inherent to end of life decisions, it reflects our society's attempt at addressing this conundrum. In this case, it is encouraging that all parties engaged in the process. The issue before me is whether it was done in a reasonable manner in accordance with the relevant statutory framework.

[2] Merle Ackie ("Merle") appeals the decision of the Consent and Capacity Board (the "Board") dated September 28, 2013 regarding her daughter Clescelia E. Ackie-Friday ("Clescelia"). The Board held that continuing full supportive care in the Intensive Care Unit ("ICU") at Humber River Regional Hospital (the "Hospital") was not in Clescelia's best interests and directed Merle to consent to the palliative care treatment plan proposed by Dr. Sanjay Manocha ("Manocha"). On November 7, 2013, Whitaker J. ordered that *amicus curiae* be appointed to assist in preparing a factum and presenting the issues on this appeal on behalf of the appellant who is unrepresented. Through the Ministry of the Attorney General and Legal Aid

Ontario, Mr. Nemetz was appointed to act as *amicus curiae*. The appellant resides in St. Vincent and is currently in England with another daughter. She was unable to obtain a visa in order to return to Canada at this time. However, through Mr. Nemetz she has advised that she does not oppose the appeal proceeding before me and no adjournment was sought.

Factual background

[3] Clescelia is a 46 year old woman who suffers from myasthenia gravis. She has a history of episodes of respiratory failure. Myasthenia gravis is an immune condition that can cause muscle weakness, including weakness in the muscles that control the lungs and can result in cardiorespiratory arrest. Merle is Clescelia's mother and substitute decision-maker under the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sch. A ("*HCCA*") (the "*Act*"). Clescelia suffered a cardiorespiratory arrest in July 2011, while travelling in the United States. This caused extensive brain damage leaving her in a persistent vegetative state. She was unable to breathe regularly without the assistance of a mechanical ventilator.

[4] In September 2011, Clescelia was ultimately transferred to the Hospital and has been unconscious and unable to communicate or interact with her surroundings since that date. According to the neurological assessments performed, she is still able to experience pain and discomfort, such as is caused by certain treatments and the complications of her disease. For example, she has had numerous infections and pressure sores, and has required a tracheostomy and a permanent feeding tube. The physicians have attempted unsuccessfully to wean her from the ventilator.

[5] Dr. Manocha is one of several intensive care specialists in the Hospital's ICU. He is a specialist in respirology, internal medicine and critical care medicine, and is the Director of the Critical Care Unit at the Hospital. He has been responsible for Clescelia's care since September 2011, and is aware of her current condition. Dr. Manocha is of the opinion that Clescelia has no meaningful chance of improvement and her prognosis is that she will remain in this state until she deteriorates from a complication associated with being critically ill in an ICU. He is supported in this opinion by his colleagues, including Dr. David R. Morgenthau, a neurologist.

[6] Dr. Manocha approached Clescelia's family to discuss her values and beliefs regarding treatment. He proposed a palliative care plan to them which would focus on keeping Clescelia comfortable, withdrawing mechanical ventilation and not performing Cardiopulmonary Resuscitation (CPR) in the event of a further cardiac arrest. He explained that while the plan may hasten her death, it will respect her dignity and ensure she is comfortable and not suffering from the complications associated with aggressive care.

[7] Clescelia was a spiritual person. She was a member of an independent church that had separated from the Seventh Day Adventist Church but that held many of the same beliefs. Pastor Nelson had provided spiritual guidance to Clescelia during the years 2009 to 2011. He had a conversation with Clescelia following a previous medical problem during which she had expressed that she would prefer to die rather than be bedridden. The Pastor confirmed that the

religious beliefs of the Seventh Day Adventist Church permit the withdrawal of life support. The "Statement of Consensus on Care for the Dying" published by the Seventh Day Adventist Church states:

> Christian love is practical and responsible (Romans 13:8-10; Corinthians 13; James 1:27' 2:14-17). Such love does not deny faith nor obligate us to accept medical interventions whose burdens outweigh the probable benefits. For example, when medical care merely preserves bodily functions, without hope of returning a patient to mental awareness, it is futile and may, in good conscience, be withheld or withdrawn…

[8] When the palliative care plan was proposed to Merle, she refused to consent to it. She said she believed it is contrary to the medical evidence and that while the doctor is with Clescelia for short periods of time, the family has spent substantial time with her and has observed her respond to them. They believe that a miracle will occur, that Clescelia believed in miracles and that she will recover. The family said that she had been a vegan and that prior to her admission to Hospital she managed certain health problems with natural remedies. They requested that the physicians attempt to treat her with these remedies. The physicians brought the matter before the Consent and Capacity Board for a hearing.

The Decision of the Board

[9] The hearing was held on September 27, 2013. Merle, as substitute decision-maker for Clescelia, was present at the hearing and was represented by another daughter. Dr. Manocha was represented and gave evidence at the hearing. Clescelia was represented by counsel. The Board heard from six witnesses including the patient's sister, two brothers her mother Merle, her pastor (who participated by teleconference), and Dr. Manocha. For part of the proceeding, the hearing was held at Clescelia's bedside.

[10] In its reasons, the Board reviewed the relevant legislation and noted that, in any case of review of incapacity to consent to treatment under the *Act* and any application under the *Act* to determine whether the substitute decision-maker has complied with the principles of substitute decision-making, the onus is on the physician to prove the case on a balance of probabilities. The Board found that the evidence established that Clescelia was unable to understand the information relevant to making a decision about the treatment proposed and that she was unable to appreciate the reasonably foreseeable consequences of the current and proposed treatment. The evidence was that she had been incapable since her admission to hospital and had been in a persistent vegetative state since September 2011. The patient's counsel could not communicate with her so she was not able to make submissions on the issue of capacity to consent to treatment. The Board found that the patient was unable to understand the information relevant to making a decision about treatment, and unable to appreciate the foreseeable consequences of the current and proposed treatment. She was therefore, not capable of consenting to treatment. The Board's finding concerning incapacity to consent to treatment was not appealed.

[11] In the decision that is under appeal, the Board reviewed the medical evidence which explained that the patient was in a persistent vegetative state for more than two years with no prospect of recovery. It outlined the proposed treatment plan of palliative care which had been discussed with the substitute decision-maker who refused to consent as the family believed that Clescelia would recover. According to the evidence, the physician had met with the family to discuss the plan on September 11, 13, and 25, 2013. Family members consistently said that they had very strong religious faith and believed that God would intervene to assist Clescelia in recovering from her brain injury. They would not consent to removing the life support treatment she was being given. The family told the Board that Clescelia had been a religious person but that they had had no discussions with her about prior wishes she may have had concerning life support. They said that she believed in natural remedies and they asked that more time be given for the natural remedies to be administered. They also said that they knew of family members who woke from comas after doctors said there was no hope of recovery.

[12] Materials were filed with the Board from the Seventh Day Adventist Church concerning its position on life support. Clescelia's Pastor testified by teleconference from the United States and said that Clescelia had been a very religious person, that she had expressed concern about becoming bedridden from the myasthenia gravis condition and that if she became bedridden, she preferred that the Lord "let her sleep until he comes again." He explained this meant "to die and reawaken later on." He also said that Clescelia believed in miracles and had faith in natural remedies.

[13] The Board found that the evidence did not establish that there was a prior capable wish concerning what should happen in a life support situation. There was no power of attorney or living will to provide evidence of prior capable wishes. There had been no discussions with family regarding her wishes.

[14] The Board then embarked upon the best interests analysis in accordance with section 21(1)2 of the *HCCA*. It considered Clescelia's values and beliefs but did not accept that her strong religious beliefs meant that she would choose to live in her present condition waiting for a miracle to occur. It accepted the Pastor's evidence that strong religious beliefs would not preclude the adoption of the proposed treatment plan. It accepted the evidence that natural remedies would not have any effect at this late stage in her condition. The Board considered the components of "well-being" and accepted that Clescelia had no chance of making a truly meaningful recovery. The Board looked at the expected benefits to treatment and found that they outweighed risk of harm because the treatment plan would allow the patient to not suffer pain and to die with dignity. The Board found that there was no less restrictive and less intrusive treatment that could be beneficial.

[15] The Board concluded that Clescelia was not capable to consent to treatment and that the treatment plan proposed was in her best interests. The Board held that the substitute decision-maker did not comply with the principles for substitute decision-making set out in section 37(1) of the *Act* and directed her to consent to the treatment plan proposed by the physician.

Supplementary evidence

[16] Section 80 of the *HCCA* provides as follows:

> (1) A party to a proceeding before the Board may appeal the Board's decision to the Superior Court of Justice on a question of law or fact or both.
>
> …
>
> (9) The court shall hear the appeal on the record, including the transcript, but may receive new or additional evidence as it considers just.

[17] At this hearing, further affidavit evidence was filed to provide an update on Clescelia's condition since the hearing. This evidence was not opposed or disputed. There has not been any significant change in her condition and she remains in a persistent vegetative state and is fully dependent on mechanical ventilation. Her prognosis has not changed. At the request of family members, the Hospital staff have provided some natural remedies to her (liquid chlorophyll and citicoline) but there is no evidence of benefit. The Hospital has not provided lecithin granules as that might obstruct her feeding tube resulting in a need for further interventions.

The Nature of the Appeal and the Position of the Parties

[18] Merle appeals the decision of the Board on the grounds that the Board erred in fact and law in finding that she had not complied with the principles for substitute decision-making and by ordering that she consent to the treatment plan proposed by Dr. Manocha. The appellant takes the position that the decision is unreasonable. The appellant submits that the Board did not consider all the evidence before it concerning the values and beliefs of Clescelia and that it placed too much emphasis on the evidence received containing the writings of the Church.

[19] The respondent takes the position that the standard of review on an appeal from a decision of the Board on the principles of substitute decision-making is one of reasonableness. Counsel argues that the Board's decision was reasonable and correct based upon the evidence before it and the applicable law.

The Law

[20] The *HCCA* provides the statutory scheme for decision-making involving medical treatment. It sets out who can act as a substitute decision-maker for a mentally incapable person and how the substitute is to make decisions regarding consent to treatment.

[21] Section 1 of the *HCCA* outlines the purposes of the *Act*:

> 1. The purposes of this *Act* are,

> (a) to provide rules with respect to consent to treatment that apply consistently in all settings;
>
> (b) to facilitate treatment, admission to care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters;
>
> (c) to enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed and persons who are to receive personal assistance services by,
>
> > (i) allowing those who have been found to be incapable to apply to a tribunal for a review of the finding,
> >
> > (ii) allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on their behalf concerning treatment, admission to a care facility or personal assistance services, and
> >
> > (iii) requiring that wishes with respect to treatment, admission to a care facility or personal assistance services, expressed by persons while capable and after attaining 16 years of age, be adhered to;
>
> (d) to promote communication and understanding between health practitioners and their patients or clients;
>
> (e) to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment, admission to a care facility or a personal assistance service; and
>
> (f) to permit intervention by the Public Guardian and Trustee only as a last resort in decisions on behalf of incapable persons concerning treatment, admission to a care facility or personal assistance services.

[22] The test for capacity is set out in section 4(1):

> 4. (1) 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.

[23] Section 10(1) outlines when a health practitioner must obtain consent:

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> 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).

[24] The *HCCA* defines treatment as follows, in s. 2(1):

> "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.

[25] A treatment plan is defined 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.

[26] The scheme of the *HCCA* is to facilitate treatment on the behalf of an incapable person through the requirements of consent under s. 10(1) and the appointment of a substitute decision-maker under s. 20(1). The legislature has created a process that facilitates treatment through the delegation of decisions to specific individuals – those eligible to be substitute decision-makers, or, in the event no person listed under s. 20(1) is available, the Public Guardian and Trustee: see s. 20(5). Facilitating the treatment of incapacitated individuals receiving life support, including the treatment of withdrawing life support, by applying this established statutory process is consistent with the scheme of the *HCCA*. The Supreme Court of Canada has clarified that the withdrawal or removal of life support services falls within treatment as defined by the *HCCA* and that health practitioners are required to obtain consent from a patient or their substitute decision-maker before withdrawing or ending life support: see *Cuthbertson v. Rasouli*, 2013 SCC 53.

[27] Section 21(1) of the *HCCA* outlines the principles that are to be applied by the substitute decision-maker for giving or refusing consent. As the court said in *Cuthbertson v. Rasouli*, at para. 79:

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

[28] The two situations described by the court are codified in section 21:

> 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.

[29] Section 37(1) gives authority to a health practitioner to apply to the Board for a determination where the consent is given or not given by the substitute decision-maker and the health practitioner is of the opinion that the substitute decision-maker did not comply with the principles in section 21. It provides as follows:

> 37. (1) If consent to a treatment is given or refused on an incapable person's behalf by his or her substitute decision-maker, and if the health practitioner who proposed the treatment is of the opinion that the substitute decision-maker did not comply with section 21, the health practitioner may apply to the Board for a determination as to whether the substitute decision-maker complied with section 21.

[30] Section 32(4) provides:

> (4) The Board may confirm the health practitioner's finding or may determine that the person is capable with respect to the treatment, and in doing so may substitute its opinion for that of the health practitioner.

Jurisdiction of the court

[31] Under s. 80(1) of the *Act* a party to a proceeding before the Board may appeal the Board's decision to the Superior Court of Justice on a question of law or fact or both. The court on appeal has a broad remedial jurisdiction. The court may: exercise all the powers of the Board; substitute its opinion for that of a health practitioner, substitute decision-maker, or the Board; or refer the matter back to the Board with directions for rehearing in whole or in part: see s. 80(10).

Standard of Review

[32] There is a presumption that tribunals interpreting or applying their home statutes are to be reviewed on a reasonableness standard: see *Alberta (Information and Privacy Commissioner) v. Alberta Teachers' Association*, 2011 SCC 61, [2011] 3 S.C.R. 654. In *McLean v. British Columbia (Securities Commission),* 2013 SCC 67, the Supreme Court reaffirmed the presumption that the reasonableness standard will apply when a tribunal is applying or interpreting its home statute or statutes closely connected with its function: see paras. 19-33. In the past, the existence of a broad statutory right of appeal has often been said to indicate a more stringent standard of review. The more recent trend in administrative law however, is to view such an appeal right as, at best, an indirect indication of the legislature's intent and not determinative of the analysis: see *Halliburton Group Canada Inc. v. Alberta*, 2009 ABQB 420, at para. 51; generally, D.J.M. Brown and J.M. Evans, *Judicial Review of Administrative Action in Canada*, loose-leaf (Toronto: Canvasback Publishing, 1998), at 14:2522. Such a right cannot on its own rebut the presumption of reasonableness review for a tribunal's application and interpretation of its home statute.

[33] In *Dunsmuir v. New Brunswick*, 2008 SCC 9, [2008] 1 S.C.R. 190, the Supreme Court held, at para. 57, that where existing jurisprudence has already determined the proper standard of

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review, the full standard of review analysis need not be repeated. The standard of review for the Board's findings about whether a person had expressed an applicable prior capable wish and whether the person's best interests require a particular treatment has been previously determined as reasonableness: see *Barbulov v. Cirone*, 2009 CanLII 15889 (Ont. S.C.), at para. 25, citing *T.(I.) v. L.(L.) (*1999), 46 O.R. (3d) 284 (C.A.); *Conway v. Jacques* (2002), 59 O.R. (3d) 737 (C.A.), at para. 34. The Board's inquiry on these issues requires an application of the law to the facts and the Supreme Court of Canada has held that reasonableness applies to such applications: *Starson v. Swayze*, 2003 SCC 32, [2003] 1 S.C.R. 722, at para. 5. In *T.(I.) v. L.(L.)* the Court of Appeal outlined, at para. 21, why reasonableness is the appropriate standard:

> In our view, this reasonableness standard is the appropriate standard for reviewing the findings of the Consent and Capacity Board that are in issue on the appeal: whether T.C. had expressed an applicable prior capable wish and, if not, whether T.C.'s best interests required the prescribed medication, and thus whether in refusing her consent, L.L. did not comply with s. 21(2). The reasonableness standard is appropriate for reviewing the Board's findings for the following reasons:
>
> > (a) Whether T.C. expressed an applicable prior capable wish is a question of fact. The Board, which heard the evidence on this question, is in the best position to assess credibility and make a finding on whether there was a prior capable wish. Thus, deference is called for.
> >
> > (b) The best interests test in part requires a factual finding, in part requires medical expertise because medical outcomes are included in the test, and in part requires a weighing of relevant factors. All of these considerations argue for deference, and we observe in particular that the SDM has no medical expertise, an expertise that is needed to weigh the factors under s.21(2)(c). Although an SDM may have greater knowledge of an incapable person's values and beliefs under s. 21(2)(a) of the *Act*, that consideration alone does not undermine the need for deference to the Board's determination of an incapable person's best interests.
> >
> > (c) The importance of expeditious decision making under the *Act* is another reason for according deference to the Board's findings. Delay resulting from an appeal is not ordinarily likely to be in an incapable person's best interests. Only where a Board's finding can be shown to be unreasonable should it be set aside on appeal.
> >
> > (d) Moreover, the Board itself must hear and decide applications promptly. Under s. 75, the Board must begin a hearing within seven days of receiving an application and must decide the

> application by the day after the hearing ends. If reasons are requested, they must be provided within two business days. In the light of this short time frame, the Board is entitled to some leeway, and indeed it is hard to think that the Legislature could have intended otherwise. A correctness standard would put an unfair burden on the Board. In our view, provided the Board's findings are reasonable, an appellate court should not interfere. We note that Gans J. in Jacques v. Conway, [1998] O.J. No. 3743 (Gen. Div.) also concluded that the Board's findings were entitled to deference on appeal.

[34] The reasonableness standard was outlined by the Supreme Court in *Dunsmuir*, at para. 47:

> A court conducting a review for reasonableness inquires into the qualities that make a decision reasonable, referring both to the process of articulating the reasons and to outcomes. In judicial review, reasonableness is concerned mostly with the existence of justification, transparency and intelligibility within the decision-making process. But it is also concerned with whether the decision falls within a range of possible, acceptable outcomes which are defensible in respect of the facts and law.

[35] Accordingly, the Board is entitled to deference in its findings of fact and weighing of evidence. It is for the appellant to show positively that the decision is unreasonable: see *Law Society of New Brunswick v. Ryan*, 2003 SCC 20, [2003] 1 S.C.R. 247, at para. 48.

Decision

[36] In the case before me, the Board found that the substitute decision-maker did not apply the principles set out in s. 21 of the *HCCA*. The Board is not required to show deference to the findings of the substitute decision-maker and is entitled to draw its own conclusions. The Board found that, while there was an expression of wishes by Clescelia to the Pastor that she did not want to be bedridden, this comment was made in different circumstances than the current situation where she is in a persistent vegetative state and has no hope of recovery. Accordingly, the Board found that this did not constitute a prior expressed wish made when she had capacity to consent or refuse to consent to treatment. As a result, the Board then went on to conduct the best interests analysis as set out in s. 21(2).

[37] In determining the best interests of Clescelia, the Board looked at the provisions in subsection 2, paragraphs (a) and (b), and considered the issue of values or beliefs that the incapable person held when capable. Here, the Board took into account Clescelia's religious beliefs, her belief in miracles, her commitment to natural remedies and the beliefs of her faith. It then considered any wishes expressed by her with respect to the treatment noting that she did not express any to her family but did express wishes to the Pastor. The Board then considered the factors in paragraph (c) and determined that: the proposed treatment of palliative care would not

prolong her life but would reduce her pain and suffering; her condition will never improve without the treatment and she will inevitably die in the intensive care unit; the benefit of removing intrusive and aggressive treatments now will reduce the infections and complications that cause her pain and suffering; and there are no less restrictive or less intrusive treatments that would be as beneficial as the proposed treatment.

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[38] The Board's conclusion that the substitute decision-maker did not apply the principles set out in the statute under s. 21 of the *HCCA* was a reasonable one. The Board reasonably concluded that the substitute did not consider the statutory test for making a decision for an incapable person but, rather, considered what she deemed was in the best interests of the patient. The Board applied the appropriate tests consistent with past decisions to the evidence led before it. The Board's decision is not outside the range of possible acceptable outcomes which are defensible in respect of the facts and law: see *Dunsmuir*, at para. 47.

[39] The appellant bears the onus of demonstrating how the decision is unreasonable but has failed to do so. Accordingly, the appeal is dismissed.

[40] As agreed, the parties will provide submissions to me on the issue of costs if they are being sought or will advise whether there shall be no order as to costs. The respondent shall provide written submissions by February 15, 2014 and the appellant by February 23, 2014.

Himel J.

Released: January 31, 2014

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