Consent and Capacity Board
Commission du consentement et de la capacité
Ontario

TO-13-0806
TO-13-0807

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

AND IN THE MATTER OF
JSR
A patient at
Sunnybrook Health Sciences Centre
TORONTO, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

A panel of the Board convened at Sunnybrook Health Sciences Centre at the request of RCR and MCR who brought a Form D Application to the Board under Section 35 (1) of the *Health Care Consent* Act for directions with respect to a whether a wish expressed by JSR is applicable in the circumstances.

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 JSR with respect to his capacity to consent to treatment 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 May 17, 2013, and June 11, 2013. The Form A-Treatment Decision was released on May 18, 2013 and the Form D-Direction Decision was released on June 25, 2013. Reasons were released on July 3, 2012.

LEGISLATION CONSIDERED

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

PARTIES

JSR's Deemed Form A – Treatment Application
JSR, the patient
Dr. A. Amaral, the health practitioner

RCR and MCR's Form D – Directions Application
Dr. A. Amaral, the health practitioner
JSR, the patient
RCR, JSR's son,
MCR, JSR's wife
Dr. Amaral, RCR and MCR attended the Hearing. Both Dr. Amaral and RCR gave evidence. MCR did not give evidence. JSR did not attend the Hearing.

PANEL MEMBERS

Michael Newman, presiding lawyer member
Sabita Maraj, public member
Jane Stone, public member

APPEARANCES

JSR was represented at the Hearing by counsel, Mr. J. Black
Dr. Amaral was represented at the Hearing by counsel, Mr. A. McCutcheon and Ms. E. Baron
RCR and MCR were represented at the Hearing by counsel, Mr. M. Handelman

PRELIMINARY MATTERS

The panel was advised that there had not been within the previous six months a determination by the Board of JSR's capacity to consent to any proposed treatment in this case. The panel was also advised that JSR did not have a Guardian of the Person. JSR had a Power of Attorney for Personal Care. However that document did not contain a provision waiving JSR's right to apply for the review of the health practitioner's finding(s) 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 four witnesses, Dr. A. Amaral, RCR, JA, RCR's friend and Dr. G. Rubenfeld and two Exhibits:

1. POA Personal Care dated October 21, 1999
2. Document Brief of Dr. Amaral (entitled Hospital Chart Excerpts, 3 Tabs)

INTRODUCTION

JSR was a 73 year old gentleman, married to his wife MCR. On October 21, 1999 JSR completed a Power of Attorney for Personal Care by which he appointed his wife, MCR as his attorney for personal care and his son RCR as his substitute attorney for personal care. MCR has deferred care decisions concerning JSR to her son RCR.

JSR suffered from what was medically described as advanced terminal stage progressive supernuclear palsy (PSP) and vascular dementia. PSP was a degenerative neurological disease or brain disorder characterized by increasing cognitive dysfunction, severe motor deficits related to balance, gait, gaze and movement all of

which complications JSR suffered from. JSR was admitted to hospital and been cared for in the critical care areas at Sunnybrook Health Sciences Centre since June 29, 2012.

On or about May 14, 2013 RCR and MCR brought the current Form D application before the Board, pursuant to S35 (1) of the *Health Care Consent Act*. By their application the applicants indicated (i) JSR has been found incapable with respect to the following kind of treatment "withholding of ventilator support"; (ii) they were the substitute decision makers for JSR and that; (iii) JSR has previously expressed a wish with respect to this matter but, "it is not clear if the wish is applicable in the circumstances". Finally, the application sought directions in this matter.

THE LAW

Capacity with Respect to Treatment

The Form D application for directions triggered a deemed Form A application by JSR pursuant to the *Health Care Consent Act* (S 37.1) with respect to his 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. Amaral, it must hear cogent and compelling evidence in support of the health practitioner's case. JSR as the patient appearing before the Board did not have to prove anything, the onus being entirely on the health practitioner, Dr. Amaral. 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 or 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, 32, 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

Application for review of finding of incapacity

32. (1) A person who is the subject of a treatment may apply to the Board for a review of a health practitioner's finding that he or she is incapable with respect to the treatment. 1996, c. 2, Sched. A, s. 32 (1).

Exception

(2) Subsection (1) does not apply to,

(a) a person who has a guardian of the person, if the guardian has authority to give or refuse consent to the treatment;

(b) a person who has an attorney for personal care, if the power of attorney contains a provision waiving the person's right to apply for the review and the provision is effective under subsection 50 (1) of the *Substitute Decisions Act, 1992*. 1996, c. 2, Sched. A, s. 32 (2).

Parties

(3) The parties to the application are:

1. The person applying for the review.

2. The health practitioner.

3. Any other person whom the Board specifies. 1996, c. 2, Sched. A, s. 32 (3).

Powers of Board

(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. 1996, c. 2, Sched. A, s. 32 (4).

Restriction on repeated applications

(5) If a health practitioner's finding that a person is incapable with respect to a treatment is confirmed on the final disposition of an application under this section, the person shall not make a new application for a review of a finding of incapacity with respect to the same or similar treatment within six months after the final disposition of the earlier application, unless the Board gives leave in advance. 1996, c. 2, Sched. A, s. 32 (5).

Same

(6) The Board may give leave for the new application to be made if it is satisfied that there has been a material change in circumstances that justifies reconsideration of the person's capacity. 1996, c. 2, Sched. A, s. 32 (6).

Decision effective while application for leave pending

(7) The Board's decision under subsection (5) remains in effect pending an application for leave under subsection (6). 2000, c. 9, s. 32.

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 the Form D brought by MCR and RCR pursuant to the *Health Care Consent Act* for directions with respect to what are described as JSR's wishes. The evidence clearly disclosed JSR expressed no wishes in his Power of Attorney for Personal Care dated October 21, 1999. As noted earlier, a Form D application triggered a statutory application by JSR with respect to his 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.

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.

JSR's Capacity with Respect to Treatment

Did the evidence establish that JSR was unable to understand the information relevant to making a decision about the treatment in question? Did the evidence establish that JSR 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, Dr. Amaral, a staff physician and intensive care specialist at Sunnybrook Health Sciences Centre and JSR. There were no additional parties. Dr. Amaral's evidence described JSR's condition. Neurologically, Dr. Amaral said JSR did not follow commands. He did not follow with his eyes, cough, or move his extremities including in response to deep painful stimulus. He has severe fixed muscle contractures such that his legs cannot be straightened even by his caregivers. He was also unable to communicate in any fashion. The doctor's evidence included that JSR's neurological condition has progressively deteriorated since his admission to the hospital in June 2012.

(Exhibit 2, Note of Dr. Guest dated May 7, 2013, pages 524-525, Evidence of Dr. Amaral, Evidence of Dr. Rubenfeld).

Dr. Amaral said that from a respiratory perspective, JSR has experienced a number of episodes of respiratory failure due to muscle weakness causing aspiration, atelectasis (the collapse or closure of the lung) and pneumonia since his admission on June 29, 2012. He has been offered mechanical ventilation on four occasions since August 2012, and has often been unable to breathe on his own. A tracheotomy was performed in October 2012. When not ventilated, JSR required frequent suctioning to prevent mucus plugging and aspiration pneumonia. Notwithstanding these treatments, he has suffered from these symptoms at various times since admission, which have on occasion led to serious desaturation and mild cardiac events. Dr. Amaral's evidence included that JSR will continue to experience these respiratory difficulties. (Evidence of Dr. Amaral Exhibit 2, Consult Note – Dr. Guest, May 7, 2013 (page 524-5).

From a clinical perspective, according to Dr. Amaral, JSR has a number of bed sores on his feet. He also has a large sacral ulcer that has persisted since prior to his admission to the hospital, for which he has received continuous wound care and antibiotic treatment since his admission to limit further infection and sepsis. JSR required assistance with all activities of daily living, and was reliant on a catheter for urination and a PEG tube for feeding. (Dr. Amaral and RCR's evidence)

Dr. Amaral noted that JSR was in the terminal stages of PSP. He was confined to a bed in the Intensive Care Unit and was unable to move. The doctor further noted the opinion of the medical staff that JSR's underlying disease was not reversible, and indeed was progressive, and there was no cure, that JSR would continue to experience acute and worsening symptoms stemming from the disease. In the doctor's opinion the critical care therapies being used currently were aggressive and invasive. The medical team's opinion was that given the progressive nature of JSR's condition he will not experience neurologic improvement (to the contrary, he will continue to decline) and it was extremely unlikely that he would be able to engage or interact with the world around him or leave the hospital.

The doctor said JSR had no sense of awareness of himself and was unable to respond to conversation. Dr. Amaral further said JSR was unable to take in information including due to his increasing and severe cognitive dysfunction and deficits, his vascular dementia and the progressive nature of several of his conditions. While Dr. Amaral said he was unable to assess JSR's ability to understand relevant information

(and therefore his capacity concerning the first branch of the test for capacity) in Dr. Amaral's opinion, JSR clearly failed the test for capacity on the basis of the second branch of the test, being unable to appreciate the reasonable foreseeable consequences of a decision or lack of decision as a result of his severe cognitive deficits and dysfunction and other conditions. In short, Dr. Amaral said JSR was incapable with respect to all medical treatments.

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 JSR did not have to agree with any particular diagnosis, he 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 JSR must have an ability to appreciate the relevant information as it related to him.

The panel found that Dr. Amaral's evidence was clear, cogent and compelling. That evidence was also unchallenged and uncontradicted in terms of JSR's treatment capacity. We found that as a result of JSR's medical conditions including his vascular dementia, severe cognitive dysfunction and deficits, and PSP and their progressive nature, he 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 because of his very serious medical conditions, JSR lacked the ability to appreciate the reasonably foreseeable consequences of making or not making a decision. We found JSR incapable with respect to all medical treatments.

The Application for Directions

The Form D application by the substitute decision makers placed the burden on them to establish that JSR, the incapable person had a wish with respect to this matter but "it is not clear if the wish is applicable in the circumstances".

The Board had earlier determined that JSR was incapable with respect to all medical treatments. Part II of the HCCA dealt with the law concerning Treatment. Treatment was a statutorily defined term. Section 2(1) of the HCCA set out on page 5 of these Reasons defined Treatment. The Board found that only health practitioners (also a defined term) could propose Treatment, although patients or their substitute decision makers could suggest or request treatments. RCR acknowledged that in his oral testimony, and added that he could only consent or refuse to consent to treatment if the doctor proposed treatment.

As Section 32 (1) of the HCCA noted, a person who is the subject of a treatment may apply to the Board for a review of a health practitioner's finding that he or she is incapable with respect to the treatment. There was no legal authority put to the Board which required health practitioners to propose treatments suggested or requested by a patient or substitute decision makers.

The Board noted the evidence that on two occasions during JSR's admission to the intensive care unit he received ventilator support. On both those occasions, he was weaned from that ventilator support. At the start of the Hearing JSR was not receiving ventilator support, nor was it offered as a treatment. The issue before the Board dealt with what was described in the Form D application as treatment by way of "withholding of ventilator support". Throughout the Hearing, Dr. Amaral's evidence was that ventilator support was not being offered, as he was of the view that it would not provide medical benefit to JSR, not being in JSR's best interests. He testified that should JSR suffer respiratory distress, the plan of treatment contemplated that other treatments and measures were required to allow JSR to die without pain or discomfort.

The panel reviewed Section 35 of the HCCA which sets out:

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. 1996, c. 2, Sched. A, s. 35 (1); 2000, c. 9, s. 33 (1).

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. 2000, c. 9, s. 33 (2).

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. 1996, c. 2, Sched. A, s. 35 (2).

Directions

(3) The Board may give directions and, in doing so, shall apply section 21. 2000, c. 9, s. 33 (3).

There was no statutory provision or authority put to the Board dealing with a situation where treatment was not proposed or offered, and which required that health practitioners offer such a treatment as requested by a patient or substitute decision maker.

The Ontario Court of Appeal has interpreted various provisions of the HCCA in Rasouli v Sunnybrook Health Sciences, 2011 ONCA 482 and in so doing the Court wrote the following:

> [41] For reasons that follow, we find it unnecessary to finally decide whether the appellants (physicians) are correct in their submission that treatment under the Act necessarily involves treatment that, in the opinion of the treating physician, has some medical value – although we hasten to add that we think there is much to be said for the appellants' position. Much as we accept that the Act is to be construed in a fair, large and liberal manner and that the dignity and autonomy of patients must be respected, especially in end-of-life decisions involving patients who are totally vulnerable, **we have difficulty accepting that the legislature intended to include within the definition of treatment measures that attending physicians consider to be of no medical value and therefore worthless. More to the point, if the legislature intended that consent was required to the withholding or withdrawal of life support measures that are considered to be medically ineffective or inappropriate, we would have expected clearer language to that effect**. [emphasis added]

The Court of Appeal has subsequently cited Rasouli for the proposition that there is reluctance in law to compel a medical practitioner to administer treatment. In *Centre for Addiction and Mental Health v. Ontario*, 2012 ONCA 342, the Court of Appeal held:

> [51] **First, there is a general reluctance in law to compel a medical practitioner or hospital authorities to administer treatment**. [emphasis added]This approach is evident in such decisions as *Re J (a minor) (wardship: medical treatment)*, [1992] 4 All E.R. 614 (C.A.); *Rotaru v. Vancouver General*

> *Hospital Intensive Care Unit*, 2008 BCSC 318 (CanLII), 2008 BCSC 318 ; *Rasouli (Litigation guardian of) v. Sunnybrook Health Sciences Centre*, 2011 ONSC 1500 (CanLII), 2011 ONSC 1500, 105 O.R. (3d) 761, aff'd 2011 ONCA 482 (CanLII), 2011 ONCA 482, 107 O.R. (3d) 9, leave to appeal to S.C.C. granted, *Cuthbertson v. Rasouli (Litigation Guardian)*, [2011] S.C.C.A. No. 329. The consent requirement of s. 672.62 respects that important societal notion. [emphasis added]

The Board accepted and agreed with the Court of Appeal's reasoning and comments and agreed with another panel of this Board in S (Re) 2011 Canli 32-775 where Hubbard, H.A. Presiding Member wrote at page 11:

> "The purpose of an application for directions under s. 35 is not to determine whether the treatment provided by the attending physician is sound, with a view to instructing him or her as to what to do if it is not. Rather, it has to do with the relationship between the treatment in question(emphasis ours) and the incapable person's expressed wish in circumstances in which that wish is unclear as to its meaning, or its applicability or, having regard to competence and maturity at the time it was made, its validity."

However, here by the second day of the Hearing, the "withholding of ventilator support" was no longer a concern as ventilator support was being provided to JSR, through a legal agreement between the parties. The Board was not advised in submissions that ventilator support had been withdrawn. Although JSR was in fact receiving ventilator support through agreement between the parties, Dr. Amaral's Counsel submitted that Dr. Amaral's position remained that mechanical ventilation support was not an appropriate treatment to offer JSR. The doctor's submission was that a Form D application could not be used as a mechanism to compel a health practitioner to provide a treatment that a health practitioner believed was not indicated and that the health practitioner was not prepared to offer. Ultimately, we did not need to consider that issue here. The Board found that ventilator support was not being withheld, but was in fact being offered and provided, as a result of the agreement between the parties.

Society holds health practitioners in high esteem. They receive years of medical and specialized training. Health practitioners were relied upon for that training and for their skill, judgement and high ethical standards. In addition, they have been provided with very specific legal rights, the ability to propose treatment and the ability to challenge decision making by substitute decision makers. In short, only health practitioners as a result of their professional status could propose a treatment because of their unique training,

knowledge, skill, judgement, professionalism and ethical standards. Treatment, subject to emergency provisions could only be provided as a result of being proposed by a health practitioner.

After considering the evidence, submissions and the law, the panel found that by the end of the Hearing and with ventilator support in place for JSR, Dr. Amaral in his unique position as JSR's health practitioner was prepared to offer ventilator support as a treatment as part of a legal agreement between the parties. The Board found that the "withholding of ventilator support" was no longer an issue for the Board to deal with in this matter. In the Board's view there was no longer any dispute between the parties with respect to the "withholding of ventilator support", as that support was no longer being withheld and accordingly we declined to give any directions.

RESULT

We found JSR not capable with respect to all treatment. We also declined to give any directions in this matter.

Dated: July 3, 2013

Michael Newman, Vice-Chair, Presiding Lawyer Member