EGJW v MGC, 2014 CanLII 49888 (ON HPARB)

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File # 12-CRV-0736

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

Grant Huscroft, Designated Vice-Chair, Presiding
Beth Downing, Board Member

Carol Wilton, Board Member*
* Ms. Wilton did not participate in the Board's final decision.

Review held on August 6, 2013 at Toronto, Ontario

IN THE MATTER OF A COMPLAINT REVIEW UNDER SECTION 29(1) of the *Health Professions Procedural Code*, Schedule 2 to the *Regulated Health Professions Act, 1991*, Statutes of Ontario, 1991, c.18, as amended

B E T W E E N:

E.G.J.W.

Applicant

and

M.G.C., MD AND D.J.L., MD

Respondents

Appearances:

The Applicant:	E.G.J.W., RN
For the Applicant:	Mercedes Perez
The Respondents:	M.G.C., MD (by teleconference) D.J.L., MD
For the Respondents:	Andrew McCutcheon, Counsel
For the College of Physicians and Surgeons of Ontario:	Anne Fitzgerald (by teleconference)

DECISION AND REASONS

I. DECISION

1. It is the decision of the Health Professions Appeal and Review Board to return this decision to the Inquiry, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario and to require it to reconsider the matter in light of the principles set out herein.

2. In addition, the Board recommends that the College review and revise its policies to ensure that they are in compliance with the requirements of the *Health Care Consent Act*.

INTRODUCTION

3. Decisions concerning medical care at the end of life are profoundly difficult for everyone involved and there will often be disagreement as how best to proceed. The difficulty is exacerbated when patients are unable to make decisions for themselves.

4. Ontario law provides that decisions concerning medical treatment for patients unable to make decisions for themselves are to be made by a Substitute Decision Maker (SDM) appointed pursuant to the *Health Care Consent Act* (the *HCCA*). The Consent and Capacity Board is responsible resolving any disputes that arise between doctors and SDMs in the best interests of the patients.

5. The complaint in this case arises out of exceptional circumstances in which it is alleged that the Respondent physicians countermanded "Full Code" instructions that had been left by the Applicant SDM and made a "Do Not Resuscitate" order (DNR) concerning the patient. The Applicant (the patient's daughter) was not informed that the DNR order had been made. Unfortunately, the patient's condition deteriorated rapidly and he died while the DNR order

was in place, before any dispute could be resolved. His death occurred in the presence of the Applicant, who had just arrived at the Sunnybrook Health Science Centre (SHSC), unaware that the "Full Code" instructions she had left were no longer in place.

6. The Inquiries, Complaints and Reports Committee (the Committee) of the College of Physicians and Surgeons of Ontario (the College) has considered this complaint on two occasions. The Board returned the Committee's first decision for further consideration because the Committee failed to consider the requirements of the *HCCA*, College policy, and the relevant policies at SHSC. The Committee considered these matters in its second decision and reiterated its decision to take no further action on the complaint. The Board has now been asked to review the Committee's second decision.

7. As explained below, the Board concludes that the Committee's decision to take no action on the Applicant's complaint is unreasonable. The Board returns the matter to the Committee and requires it to reconsider its decision in light of the requirements of the *HCCA*, which the Board sets out in its decision.

II. BACKGROUND

8. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by E.G.J.W. (the Applicant) to review a decision of the Committee on a complaint concerning the conduct and actions of M.G.C. MD and D.J.L., MD (the Respondents) in their care of the Applicant's late father, D.D. (the patient).

9. The patient signed a Power of Attorney for Personal Care on November 9, 2007, instructing that life-prolonging treatment be withheld or withdrawn in the event he suffered a terminal condition and that death was imminent.

10. The patient was admitted to Lakeridge Hospital on May 1, 2008 with a large pleural effusion, thought to be the result of congestive heart failure. He was 88 years of age and his medical history included end-stage kidney disease (vasculopathy), coronary artery disease, type 2 diabetes, hypertension, COPD, Dyslipidemia, cerebrovascular disease, chronic anemia, osteoarthritis, hernia, peripheral arterial disease, and bilateral toe gangrene.

11. The Applicant, a registered nurse, was the patient's SDM

12. The patient was transferred to SHSC on July 29, 2008. A DNR order was made on August 28, 2008, following a family meeting.

13. On September 17, 2008, the patient's legs were amputated above the knee. His status was changed to "Full Code" at the Applicant's request. The patient was transferred from ICU to C4 Medical on September 20, 2008.

14. On September 22, 2008, Dr. C. recorded the following progress note in the patient's chart:

> Impression: this gentleman is in the final phase of his life and the time he has remaining would seem short.
> Further aggressive therapy, e.g. CPR, ICU care, would almost certainly not provide any lasting benefit to his health, only increased suffering…. (Therefore) this will not be offered as a therapeutic option. I have discussed this with Drs. L. & Sinuff who concur and this is the consensus of our medical opinion. Do not attempt resuscitation in event of cardiac arrest.

15. Dr. L. noted: "Agree — In this pt. resuscitation represents a futile therapy (without) demonstrable benefit." In addition, the Respondents co-signed the following orders in the patient's chart: "Do not attempt resuscitation in the event of cardiorespiratory event. No transfer to ICU."

16. The Respondents did not consult with the Applicant before making the DNR order despite the "Full Code" instructions she had left. Dr. C. made a telephone call to the Applicant on September 22 and left a message indicating that he wanted to speak with her. However, the message did not indicate that a DNR order had been made nor did it indicate urgency. Dr. C. stated that nothing had changed and asked that the Applicant call the ward or Dr. L. to be updated on the situation.

17. The Applicant came to SHSC later that same day (September 22) and found the patient in respiratory distress. She requested help from a variety of sources but no medical interventions were made to save the patient, who died from a cardiac arrest.

18. The Committee investigated the complaint and decided to take no further action. Following a request for review made by the Applicant, the Board concluded that the Committee's decision was unreasonable and returned it to the Committee for further consideration. The Board explained its decision as follows:

> The Committee had to address, and did not address, whether it was appropriate in the circumstances for Dr. C. to place a DNR order on the patient's chart and execute it in light of the fact that the SDM did not consent to it. The Board is of the opinion that the question before the Committee was not whether the patient's death was inevitable and whether the resuscitative measure would have been beneficial. The question before the Committee was whether it was within the standard of practice of the profession for such order to be made without consent from the SDM. In other words, who makes decisions relating to the patient's plan of treatment?
>
> The Board is of the view that, before the Committee could conclude that the DNR order was clinically and ethically appropriate, it had the obligation to explain and justify its decision more fully. In this particular case, the Board believes the Committee was obliged

to consider and address the statutory framework in Ontario (notably the Health Care Consent Act (*HCCA*)), the relevant sections of CPSO Policy #1-06 and the pertinent SHSC policies.

…

The scheme of the *HCCA* provides that a SDM could be appointed if a patient is incapable of providing consent to treatment. Section 37 of the *HCCA* states: "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 Consent and Capacity Board for a determination as to whether the substitute decision-maker complied with section 21." Section 21 of the *HCCA* deals with the principles for giving or refusing consent, as well as the best interests of the patient.

The Board observes that the Record before the Committee contained CPSO Policy #1-06 - Decision-making for the End of Life. Yet in reaching its decision, the Committee failed to indicate how this policy was applied to the particular circumstances of this matter. For example, the Board is unclear as to how the Committee reconciled its interpretation of subsections (a) to (g) of CPSO Policy #1-06 (set out below) with the conflict resolution provisions of the SHSC policy titled "Decision-making and Conflict Resolution Regarding Futility in the Use of Life Support."

> a) Principle 1. End-of-life care must strive to address the physical, psychological, social and spiritual need of patients, and where appropriate their families, with sensitivity to their personal, cultural and religious values, goals, beliefs and practices.
>
> b) Principle 3. The patient or substitute decision-maker ... should have the opportunity to participate in informed discussions about the care options that may optimize the quality of the patient's life while he or she is living with a life-threatening illness, and when dying.
>
> c) Quality Care at the End of Life: Many factors influence decision-making for people who face life-threatening illnesses ... Patient choices can change as the disease progresses and as the end of life approaches.
>
> d) Advance Care Planning: When patients become ill and as illness progresses, physicians should ensure that the patient's advance care instructions and wishes are reassessed with patients or substitute decision makers…
> ...
>
> e) When it is clear from available evidence that treatment will almost certainly not be of benefit or may be harmful to the patient, physicians should refrain from beginning or

> maintaining such treatment. Any recommendation not to initiate life support, or to withdraw life support should be discussed with the patient or substitute decision-maker ... If the patient or substitute decision-maker … specifically requests the physician to provide or continue the treatment notwithstanding the recommendations of the health care team, the physician should turn to the conflict resolution measures discussed in Part 4.1 of this policy in an effort to achieve consensus.
>
> f) Conflict Resolution: When it becomes evident in the course of making decisions for the end of life that there is disagreement over appropriate treatment between patients or substitute decision-makers ... and health care providers, physicians should ensure that appropriate conflict resolution processes are followed.
>
> g) Conflicts between health care providers and authorized substitute decision-makers arising from questions of whether the substitute decision maker has followed the principles set out in the *Heath Care Consent Act* can be addressed to the Office of the Public Guardian and Trustee.

The Board recognizes that in the particular circumstances of this case, there was such a sudden and rapid decline in the respiratory condition of the patient that the Applicant and the Respondents did not realize that there was a conflict until what tragically turned out to be the final moments of the patient's life. Despite the presumably exceptional circumstances, the Board is of the view that, in determining whether the Respondents met the acceptable standards of their profession in insisting that the DNR decision of the physician trumped the wishes of the SDM, it was incumbent on the Committee to address explicitly the application of all the relevant policies and legislation. Accordingly, for these reasons, the Board finds that the Committee's decision with respect to [the Respondents] was unreasonable.

19. The Committee reconsidered the complaint and decided to take no further action. The Committee explained its decision as follows:

> •[The Board] has asked the Committee to deal specifically with the question as to whether [the Respondents] met the standard of the profession by placing the DNR order on the chart without [the Applicant's] consent.
>
> • The original panel of the Committee reviewing this matter in January 2010 noted that [the patient] had a prior advance directive in his POA signed November 2007 which stated that he gave authority to the treating physician to not administer resuscitative measures if the physician felt it would only prolong his dying.
>
> • The Committee acknowledges that an advance directive is to be interpreted by an individual's SDM, and is not to be treated by the physician as consent or refusal to consent to treatment. This fact is clearly set out in the College's policy regarding end of life

decisions.

• In the present case, [the Applicant] asserts that [the patient] later expressed wishes different from those set out in the advance directive, and requested full resuscitative measures. She therefore takes the position that the advance directive should not be given any weight in the circumstances.

• The Committee notes, however, that [the patient's] situation on September 22, 2008 was very different from previously, and he may well have not wanted extreme measures given his condition and prognosis at that time.

• Even ignoring the advance directive, the Committee is of the view that [the Respondents] acted reasonably in deciding that the situation warranted the placement of a DNR order on [the patient's] chart.

• As was noted by the original panel of the Committee in January 2010, Dr. C. used good clinical judgment in the situation in determining that extreme measures to preserve life should not be attempted, as they would only further exacerbate [the patient's] suffering. We concur with the original panel's conclusion that [the patient's] death was inevitable and that resuscitative measures would have been futile.

• In the Committee's opinion, [the Respondents] acted in compliance with the relevant policies of the College and SHSC in refusing to offer care that they deemed to be futile and in taking reasonable steps to try to communicate their decision in this regard in a timely manner to [the Applicant].

• While communication in this case could perhaps have been better, the Committee recognizes that Dr. C. did, to the best of his ability, try to speak with [the Applicant].

• The College policy states that physicians are not obliged to provide treatment that will almost certainly not be of benefit to the patient. When it is clear that there will be no benefit or the treatment may be harmful to the patient, a physician should refrain from beginning such treatment.

• The SHSC *No Cardiopulmonary Resuscitation (No CPR)* policy states under "General Principles" that interventions anticipated to be futile or non-beneficial lie outside the standard of care. It goes on to state that physicians are not obliged to propose or provide futile or non-beneficial interventions, but they should consider the patient or SDM's request and reason for wanting CPR.

• The "Communication" section of the SHSC policy states that patients for whom CPR will almost certainly not be beneficial should not have CPR presented as a treatment option.

• The College's policy states, "when it becomes evident in the course of making decisions for the end of life that there is a disagreement over appropriate treatment between patients and substitute decision-makers ... and health care providers, physicians should ensure that appropriate conflict resolution provisions are followed."

• The College policy is not clear whether a physician can make a DNR order first and then speak with family and follow conflict resolution, or whether the physician must go through the conflict resolution process before making the order.

• The College policy does not specifically state that a physician is required to provide CPR until a dispute/disagreement about a DNR order is resolved, and the Committee notes that it would be contrary to the principle of not providing futile treatment if a physician was required to do so.

• In the Committee's view, the SHSC policy is clear in stating that a physician can make a DNR order without consent, and then deal with disagreement on the part of the patient or SDM if it arises.

• As such, [the Respondents] were in compliance with the relevant SHSC policy, both in the view of [SHSC] and in the Committee's view.

• The SHSC policy contains three separate sections providing that physicians can place "No CPR" orders on the chart and then "inform" the patient or SDM that they have done so, suggesting that this decision may be made unilaterally by the physician.

• For example, the "General Principles" section recommends that in the case of nonbeneficial intervention, a "No CPR" order be written on the patient's order sheet, that the patient and/or SDM be informed, and that the perspective of the patient and/or the SDM be documented as well as their requests for assistance or comfort measures. It is noted that patients and SDMs may question physicians' decisions about CPR and that in such cases the Disagreement section of the policy is to be followed. The "Implementation" section of the SHSC policy indicates that the physician may place a "No CPR" order on the chart without the agreement of the patient or the SDM and then follow the process outlined in the Disagreement section.

• In the Committee's view, the above provisions in the "General Principles" and the "Implementation" sections indicate that the physician is not required to exhaust the conflict resolution/disagreement process prior to placing a "No CPR" order on the patient's chart.

• This is reasonable given the general principle (set out in both the College and SHSC policies) that a physician should not offer CPR to a patient if it has been determined that it is not beneficial or may be harmful. It would contravene this principle if the health care team

were faced with a situation where they were required to administer CPR considered to be futile because there was no DNR order on the chart pending completion of the disagreement process.

• The Disagreement section in the SHSC policy sets out steps to facilitate decisions made about CPR with consideration of all relevant factors. There is a statement in the section acknowledging that the patient's condition may not permit completion of the process.

• The first few steps outlined in the Disagreement section are "Interprofessional Team Consensus" and "Communication and Clarification". The final step is "Notice", and states that if the health care team intends to withhold CPR because the patient almost certainly will not benefit, the patient or SDM will be informed of the decision in a timely way.

• In the present case, [the Respondents] did discuss [the patient's] situation with the health care team to ensure consensus regarding the decision not to provide CPR, and there were reasonable attempts to contact [the Applicant] to communicate and discuss the decision in a timely manner.

• Unfortunately, [the patient's] condition deteriorated very rapidly to such a point that there was no time to engage in a detailed discussion with [the Applicant] prior to the situation unfolding in which CPR was withheld.

• The Committee can understand how devastating and traumatic the situation was for [the Applicant], and it is truly unfortunate that events occurred as they did in this case. However, we are satisfied that [the Respondents] at all times complied with the provisions of the relevant SHSC policy. As such, we are of the view that they acted reasonably and appropriately in the circumstances of this case in placing the DNR order on [the patient's] chart without the consent of [the Applicant].

• The Committee is of the opinion that a physician is entitled to rely on the relevant policy in place at his/her institution, and to assume that it is not in conflict with any relevant College policy, the relevant statutory scheme, and the common law.

• In the present case, the Committee is of the view that it was reasonable for [the Respondents] to look to the provisions of the relevant SHSC policy (with which they would have been very familiar), and to assume that if they followed these provisions, they were meeting their obligations and responsibilities in the circumstances.

• [The Applicant] takes the position that any time a health care practitioner disagrees with a decision of an SDM and it is not an emergency situation, the conflict resolution process outlined in the SHSC policy and/or the College's policy, including an application to the CCB for direction, must be exhausted before a No CPR order is placed.

> • This interpretation of the common law and the *HCCA* argued by [the Applicant] is in the process of being considered by the courts. However, it is contrary to the SHSC policy applicable at the time, contrary to an arguable interpretation of the College's policy at the time, and was not clearly the state of the statutory and common law at the time of the events in question (the common law being in flux and undecided).

Based on all of the above, the Committee has determined that the appropriate disposition is to confirm the previous panel's decision to take no further action on this complaint.

III. REQUEST FOR REVIEW

20. Counsel for the Applicant requested that the Board review the Committee's second decision in a letter dated December 19, 2012.

IV. POWERS OF THE BOARD

21. After conducting a review of a decision of the Committee, the Board may do one or more of the following:

> a) confirm all or part of the Committee's decision;
> b) make recommendations to the Committee;
> c) require the Committee to exercise any of its powers other than to request a Registrar's investigation.

22. The Board cannot recommend or require the Committee to do things outside its jurisdiction, such as make a finding of misconduct or incompetence against the member, or require the referral of allegations to a discipline hearing that would not, if proved, constitute either professional misconduct or incompetence.

V. ANALYSIS AND REASONS

23. Pursuant to section 33(1) of the *Health Professions Procedural Code* (the *Code*), being Schedule 2 to the *Regulated Health Professions Act, 1991*, the mandate of the Board in a complaint review is to consider either the adequacy of the Committee's investigation, the reasonableness of its decision, or both.

24. In its prior decision, the Board concluded that the Committee had conducted an adequate investigation into the complaint. Counsel for the Applicant stated at the Review that the only issue was the reasonableness of the Committee's decision.

25. Accordingly, the focus of the Board's second review is on the reasonableness of the decision reached by the Committee. In considering this issue, the Board has considered the submissions of the parties, examined the Record of Investigation (the Record), and reviewed the Committee's decision in this matter. Following release of the decision of the Supreme Court of

Canada in *Cuthbertson v. Rasouli*, 2013 SCC 53 (CanLII), [2013] 3 SCR 341, 2013 SCC 53 (CanLII), the Board invited counsel for the parties to make submissions concerning the possible relevance of the case. Submissions were received from both parties and have been considered by the Board.

Reasonableness of the Decision

26. In considering the reasonableness of the Committee's decision, the question for the Board is not whether it would arrive at the same decision as the Committee, but whether the Committee's decision can reasonably be supported by the information before it and can withstand a somewhat probing examination. In doing so, the Board considers whether the decision falls within a range of possible, acceptable outcomes that are defensible in respect of the facts and the law.

27. The Committee concurred with the first panel of the Committee that considered the complaint in concluding that the Respondents exercised good clinical judgment in determining that extreme measures to preserve life should not be attempted because they would only further exacerbate the patient's suffering. The Committee also agreed with the first panel that the patient's death was inevitable and that resuscitative measures would have been futile.

28. However, this does not resolve the issue before the Board. As the Board noted in its first decision, "the question before the Committee was not whether the patient's death was inevitable and whether the resuscitative measure would have been beneficial." The Board remitted the Committee's first decision in this matter for reconsideration because the Committee failed to address the issue surrounding decision-making authority for the patient's care. As the Board explained, **"**before the Committee could conclude that the DNR order was clinically and ethically appropriate, it had the obligation to explain and justify its decision more fully. … [T]he Committee was obliged to consider and address the statutory framework in Ontario (notably the Health Care Consent Act (*HCCA*)), the relevant sections of CPSO Policy #1-06 and the pertinent SHSC [Sunnybrook Hospital] policies."

29. In its second decision, the Committee concluded that the Respondents acted in accordance with SHSC policy, which it considered clearly permitted the making of a DNR order without consent, and arguably with College policy, which the Committee considered unclear. The Committee emphasized that physicians are entitled to rely on hospital policy on the assumption that it is not in conflict with College policy or the law. As to the law, the Committee considered that it was not clear and that the common law was "in flux" at the relevant time.

Submissions of the parties

30. At the Review, Counsel for the Applicant argued that the Respondents failed to follow the requirements of the *HCCA* in making the DNR order and that this constituted a breach of the standard of practice *per se*, even assuming that SHSC and College policies were followed.

However, Counsel argued that the Respondents failed to comply with College and SHSC policy in any event. She submitted that the Committee had now erred twice and that the Board should refer the matter to the Discipline Committee.

31. Counsel for the Respondents submitted that the Committee had complied with the specific requirements the Board set out in its previous decision and had addressed College policy, SHSC policy, and the *HCCA* in its second decision. Counsel submitted, further, that the interpretation of the *HCCA* was not settled law in 2008 and remained unsettled in 2012 when the Committee made its decision. He stated that it would be unfair to require doctors to guess correctly as to the requirements of the law rather than follow College and SHSC policy. He noted that the College prescribes policy for its members and had not provided definitive guidance concerning the *HCCA* requirements. All that was required in his view was compliance with College and SHSC policies given good faith disagreement as to the requirements of the *HCCA*. Counsel submitted that the breach of the legislation was not a breach of the standard of practice and that there was no obligation on the Board to determine the requirements of the *HCCA*.

32. In reply submissions, Counsel for the Applicant argued that the law was not in flux and that there was no cause for following SHSC or College policy rather than the *HCCA*. She submitted that the "treatment" under the *HCCA* includes withholding of treatment and that consent is required.

33. As noted above, the parties were offered the opportunity to make written submissions following release of the Supreme Court of Canada's decision in *Rasouli*.

34. In her letter dated February 28, 2014, Counsel for the Applicant stated as follows:

> Informed consent to the withdrawal of treatment has always been mandated by the *HCCA*. Physicians cannot act unilaterally in this respect. This applies in the context of the withholding and withdrawal of end of life treatments. If physicians disagree with the decision of a substitute decision-maker, the dispute must be resolved by the CCB [Consent and Capacity Board]. The Form G process has never been optional for physicians who do not agree with the end of life treatment decision of a substitute decision-maker. There is nothing in the *HCCA* that permits a physician to unilaterally withhold or withdraw life support measures especially those that have already been offered to the patient and/or substitute decision-maker.
>
> In this case, the respondent physicians have unilaterally sought to exclude certain types of treatment from the *HCCA* (as did the physicians in the *Rasouli* case). The Supreme Court in *Rasouli* unequivocally rejected this approach. The respondent physicians attempt to exclude certain treatments from the ambit of the *HCCA* does not signal vagueness or ambiguity in the legislation but simply an attempt to sidestep the clear requirement of informed consent and the jurisdiction of the CCB.

35. In his letter dated February 28, 2014, Counsel for the Respondents stated as follows:

> *Rasouli* was irrelevant to the ICRC's decision and is similarly irrelevant to the Board's decision. Any guidance offered by *Rasouli* decision was not available to the physicians while [the patient] was under their care, nor was it available to the ICRC when it rendered either of its decisions in this matter.
>
> Even if *Rasouli* had been available at the time the physicians were involved with [the patient's] care, the Supreme Court's decision suggests that the DNR order that is in issue in this proceeding is not a 'treatment' as that term is defined in the *Health Care Consent Act, 1996* (the "*HCCA*"). Accordingly, neither [of the Respondents] were under an obligation to obtain [the Applicant's] consent before writing that order.

Analysis

36. For the reasons that follow, the Board concludes that the Committee's decision to take no further action on the complaint is unreasonable.

37. It appears from the Record that the Respondents made a DNR order on September 22, 2008 because their clinical judgment, which the Committee endorsed, was not only that further treatment of the patient would be futile but also that it would also exacerbate the patient's suffering. This order was made without consent of the Applicant as SDM, even though it countermanded instructions for "Full Code" that she had given. "Full Code" instructions are apparent at numerous points in the patient's chart, as recent as September 21, 2008, the day before the DNR order was made. The progress notes made on that date by Dr. Aoun, a resident member of the team, states clearly: "CODE STATUS: Daughter wants FULL CODE" (emphasis in original).

38. The Committee considered that the Respondents acted in accordance with SHSC policy and arguably with College policy in making the DNR order. The Committee acknowledged the Applicant's argument concerning the requirements of the *HCCA*, as this passage from its decision makes clear:

> • [the Applicant] takes the position that any time a health care practitioner disagrees with a decision of an SDM and it is not an emergency situation, the conflict resolution process outlined in the SHSC policy and/or the College's policy, including an application to the CCB for direction, must be exhausted before a No CPR order is placed.

39. However, the Committee rejected this argument in brief reasons set out in this passage:

> • This interpretation of the common law and the *HCCA* argued by [the Applicant] is in the process of being considered by the courts. However, it is contrary to the SHSC policy

> applicable at the time, contrary to an arguable interpretation of the College's policy at the time, and was not clearly the state of the statutory and common law at the time of the events in question (the common law being in flux and undecided).

As this passage indicates, the Committee emphasized SHSC and, to a lesser extent, College policy and failed to ascertain and accord priority to the requirements of the *HCCA*. The Committee considered that SHSC policy clearly stated that a DNR order may be made without consent, subject to dispute resolution procedures if necessary. The Committee concluded that College policy was unclear on this point, but that it would be contrary to the policy against providing futile treatment if the Respondents were required to provide CPR until dispute resolution procedures were exhausted.

40. The Committee's analysis mischaracterizes what is alleged to have occurred in this case. The complaint in this case is not simply that a DNR order was made by the Respondents. The complaint is that a DNR order was made by the Respondents despite "Full Code" instructions the Applicant had given as SDM. The Applicant's instructions were changed without prior discussion with or the consent of the Applicant, and as a result the Applicant could not object in a timely way.

41. It is important to emphasize that the *HCCA* puts the onus on *doctors* to object if they consider that the decisions of the SDM are not in the best interests of the patient. College and hospital policies are supposed to give effect to the law. If hospital and/or College policies authorize the Respondents' actions, then these policies are, to that extent, inconsistent with the law.

42. It is fundamental that law takes precedence over policy in the event of any inconsistency. However, in taking the view that the Respondents acted in compliance with SHSC policy and arguably with College policy, the Committee gave scant consideration to the requirements of the *HCCA* and the consent to treatment requirements it establishes.

43. Although the Board gives respectful consideration to the views of the Committee, it is incumbent on the Board to ensure that the Committee's decisions are made in accordance with any relevant legal requirements.

44. This is especially important in the case of end of life decisions. The *HCCA* governs consent to medical treatment and establishes a dispute resolution mechanism that must be used for patients who lack capacity to make their own decisions. The Applicant was the patient's SDM and had the right to make decisions on his behalf, subject only to the requirements of the *HCCA* and the dispute resolution procedure it establishes.

45. Counsel for the Respondents argued that the *HCCA* does not apply in this case because the Respondents *withheld* treatment rather than provided it. This argument cannot be accepted. The *HCCA* extends specifically to cases involving the withholding of treatment. This follows from the definitions of "plan of treatment" and "treatment" in section 2(1) of the *Act*:

> "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*; (emphasis added)
>
> "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 … (emphasis added)

46. The Board's interpretation of the *HCCA* is supported by a legal opinion the Applicant commissioned from Mr. Mark Handelman, former Vice-Chair and Senior Lawyer member of the Consent and Capacity Board, dated September 28, 2009. In his opinion, Mr. Handelman stated as follows:

> In every case except emergency treatment, the law requires that consent to a treatment or plan of treatment be obtained. Consent only comes from a capable patient or the lawful SDM of an incapable patient.
>
> As well and different than in other provinces, the *HCCA* is clear that withdrawing or withholding a treatment is also a treatment. That is set out in s. 2 *HCCA*, which contains definitions of the terms used in the Act. The definition of "plan of treatment" includes in part,
>
> (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.
>
> The definition of "treatment" in s. 2 *HCCA* includes "plan of treatment." It also contains a list of things that are not treatments, such as assessment of a person's capacity, taking of a person's health history and treatments "that in the circumstances poses little or no risk of harm to the person." Withholding and withdrawing treatment is not included in the list of exceptions to the definition of "treatment."
>
> The argument that withholding or withdrawing a treatment is not "treatment" has never been successfully made in the Courts or tribunals of Ontario, at least since the *HCCA* was enacted over a decade ago. I am not aware of any cases in which that argument was even

made.

…

Additionally, even if consent *was* not required for a particular procedure or the withholding of a procedure, once consent is sought for that procedure or withholding, the treatment team is bound by the consent or refusal of consent obtained, subject only to the right (if not the obligation) to challenge it by application to the CCB. I point this out because of the Resident's chart entry indicating that you, as SDM, wanted "full code." In other words, once you and the resident discussed the matter and he made that chart entry, the argument that no consent was needed for a DNR because it is not a "treatment" is no longer viable in law even if it was appropriate absent that discussion.

In summary, in my opinion it was illegal for anyone but you, as lawful SDM, to decide that your father should become the subject of a "Do Not Resuscitate" Order. The physicians' only legal recourse was to apply to The Consent and Capacity Board if they could not persuade you otherwise.

Mr. Handelman summarized his conclusions as follows:

1. [The patient] was made the subject of a "DNR" Order, which is a direction to withhold a treatment, at a time when he faced no medical emergency. That Order required the consent of his lawful SDM, which the treatment team did not obtain. Rather, the attending physicians made the treatment decision. That is unlawful.

2. Aware that you disagreed with the DNR Order, [SHSC] policy required the physicians to enter a conflict resolution process culminating with the requirement that they consult hospital lawyers to determine if the disagreement was appropriately resolved by application to the Consent and Capacity Board. The attending physicians did not follow that policy.

3. The [College] policy mirrors the law and the [SHSC] policy. [The Respondents] did not follow it.

4. Whether they are right or wrong, doctors who unilaterally override the treatment decisions of lawful substitute decision-makers instead of lawfully resolving the dispute contravene the ethical principle of respecting a patient's dignity and autonomy even though the treatment decision is in respect of an incapable patient and even when they disagree with it.

47. The Board's interpretation of the *HCCA* is also supported by dicta in the decision of the Supreme Court in *Rasouli*. Although the decision of the majority of the Court in that case concerns withdrawal rather than withholding of treatment, the Court addressed three arguments

relevant to this case: "(1) life support that is not "medically indicated" is not "treatment" under the *HCCA*; (2) in any case, withdrawal of treatment does not itself constitute "treatment" under the *HCCA*; and (3) requiring consent for withdrawal of life support will place them [doctors] in an untenable ethical position" (para. 33).

48. In responding to these arguments the Court made the following points. First, the *HCCA* governs the question of consent regardless of physicians' assessments of the benefits that medical procedures may provide. As the Court noted, "treatment" means anything done for a "health related purpose" regardless of the medical benefit it may provide:

> The wording of the *HCCA* does not limit "health-related purpose" to what the attending physician considers to medically benefit the patient. The *HCCA* does not use the terms "medical benefit" or "medically indicated". The legislature could easily have taken this approach but instead chose to define "treatment" more broadly with a wide-ranging and non-exhaustive list of health-related purposes (at para. 39).

In other words, the Respondents' clinical judgment is not determinative of the application of the *HCCA* and the requirements it establishes.

49. Second, the Court noted that the concept of "treatment" is designed to have a "very broad meaning" (para. 47) and the Court refers to the concepts of withdrawal and withholding of treatment interchangeably:

> The scheme of the *HCCA* suggests that the legislature contemplated that withdrawal of treatment requires consent in some cases. One form of treatment identified under the *HCCA* is a "plan of treatment", which is a defined term under the statute: s. 2(1). A physician may obtain consent for a plan of treatment that provides for various treatments and may provide for the *withholding or withdrawal* of treatment: ss. 2(1) and 13. Section 29(3) then states that if a treatment is withheld or withdrawn in accordance with a plan of treatment that the physician believes reasonably and in good faith was consented to, the physician is not liable for withholding or withdrawing the treatment. This provision would serve no purpose if consent were not required for the withholding or withdrawal of treatment in some circumstances (para 50).

50. Third, the Court acknowledged that end of life decisions may clash with physicians' ethical imperatives, but emphasized that the clash must be resolved under the dispute resolution mechanism of the *HCCA*.

51. In the Board's view, the Court's remarks apply equally in the case of the withholding of treatment and a withdrawal of treatment. But as noted above, the complaint in this case is not simply that the Respondents declined to provide treatment to the patient. The complaint is that a plan of treatment calling for "Full Code" was changed unilaterally by the Respondents. The

Respondents were required to obtain consent from the Applicant as SDM before replacing the "Full Code" order with the DNR order regardless of their view as to the futility of treatment, and in the absence of consent were required to invoke the dispute resolution procedure under the *HCCA*.

52. The Committee's statement that the patient "may well have not wanted extreme measures given his condition and prognosis at that time" is irrelevant given there appears to be no doubt that the Applicant had the right to make decisions on his behalf as SDM at the relevant time. In short, the treatment decisions were for the Applicant to determine, subject only to the requirements of the *HCCA*. The Respondents were entitled to contest any decisions she made pursuant to the procedure set out in the *HCCA* in the event they disagreed with her instructions.

53. The Committee's assertion that the requirements of the law were in flux at the time the Respondents made the DNR order misunderstands the nature of the duty to observe the requirements of the law. The law of the *HCCA* applied at all times regardless of any uncertainty surrounding its operation. The decision of the Supreme Court of Canada in *Rasouli* clarified the operation of the law but did not change it either retrospectively or prospectively. Although a good faith misunderstanding as to the nature of a legal duty may be relevant to Committee's determination as to the nature of remedial action that may be required in these circumstances, it does not excuse a failure to comply with the law per se.

54. For all of these reasons, the Board concludes that the Committee's decision to take no further action on the complaint based on its conclusion that the Respondents acted in accordance with Hospital and arguably College policy is unreasonable.

Remission to the Committee

55. Although the passage of time since this complaint was filed is significant, the Board returns the decision to the Committee and requires it to reconsider its decision.

56. The Board notes that the Committee has a number of options at its disposal in dealing with complaints against physicians. It can provide advice, caution them in writing or in person, or require them to complete education or remediation programs. It can also refer complaints against its regulated members as specified allegations of misconduct to the Discipline Committee for a hearing.

57. Although the circumstances in this case are exceptional, the misconduct alleged is serious. Counsel for the Applicant referred the Board to a prior decision of the Discipline Committee, *Re Findlay* (November 4, 2002), which concerned an allegation that a doctor had made a DNR order without discussing the matter with the patient or her family. The circumstances of that case were quite different from this one, but the Discipline Committee's comment is apt: "Making a "do not resuscitate ("DNR"") order without proper authorization is a very serious issue."

58. It does not necessarily follow from the seriousness of a complaint that it must be referred to Discipline Committee. However, the Committee must consider whether this is a proper case for referral to the Discipline Committee or whether, in the circumstances of the matter, some form of remediation is required.

59. The Board emphasizes that the importance of this complaint transcends the conduct of the Respondents. It is incumbent on the College to ensure that doctors understand their legal obligations under the *HCCA*. The public must have confidence that substitute decision making processes required by Ontario law are understood and respected.

60. College policies must conform to the requirements of the *HCCA* and ensure the primacy of the *HCCA*. College policy should be shared with hospitals in order that they can review and revise their policies as required.

VI. DECISION

61. Pursuant to section 35(1) of the *Code*, the Board returns the matter to the Committee and requires it to reconsider its decision in light of the principles set out in this decision.

VII. GENERAL RECOMMENDATION

62. The Board recommends that the College review and revise its policies to ensure that they are in compliance with the requirements of the *HCCA*.

ISSUED August 28, 2014

*Grant Huscroft*_____
Grant Huscroft

*Beth Downing*_____
Beth Downing