2011 CanLII 18217 (ON C.C.B.)

HA-10-4434
HA-10-4435

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

AND IN THE MATTER OF
DW
A PATIENT OF
HALTON HEALTHCARE SERVICES – OAKVILLE TRAFALGAR MEMORIAL SITE
OAKVILLE, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

A panel of the Board convened at the Halton Healthcare Services – Oakville Trafalgar Memorial Site ("Oakville Trafalgar") at the request of Dr. Kohli, a health practitioner. Dr. Kohli brought a Form G Application to the Board under Section 37 (1) of the *Health Care Consent Act* ("*HCCA*" or the "*Act*") for a determination as to whether or not the substitute decision-maker in this case had complied with Section 21 of the *HCCA*, the principles for substitute decision-making, when making a decision about proposed treatment for DW. Dr. McConachie, DW's current health practitioner, took over carriage of the Form G Application from Dr. Kohli.

An Application to the Board under Section 37 of the *HCCA* is deemed, pursuant to subsection 37.1 of the *Act* to include an application to the Board under Section 32 of the *HCCA* by DW with respect to his capacity to consent to the proposed treatment unless the person's capacity to consent to such treatment has been determined by the Board within the previous six months. As no such prior finding had been made, the Board also considered DW's deemed application.

DATES OF THE HEARING, DECISIONS AND REASONS

The hearing commenced on February 18, 2011 and continued on March 2nd, March 9th, March 14th and March 16th. On March 9th the panel released its Decision respecting the deemed Form A application, holding that DW did not have the capacity to consent to the proposed treatment. On March 17th the panel released its Decision about whether the substitute decision-maker was in compliance with the principles identified in the *HCCA*. We held that MW had complied with the *Act*. Reasons for these Decisions, contained in this document, were released on March 22, 2011.

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LEGISLATION CONSIDERED

The *Health Care Consent Act* ("*HCCA*"), including s. 1, 2, 4, 10, 11, 21, 32, 37 and 37.1.

PANEL MEMBERS

Lora Patton, lawyer and presiding member
Dr. Helen Meier, psychiatrist member
Linda Leong, public member

PARTIES & APPEARANCES

Deemed Form A Application

DW, the patient, was represented by Mr. McIver.
Dr. McConachie, the health practitioner, was represented by Ms Clarke.

Form G Application

DW, the patient, was represented by Mr. McIver.
MW, DW's substitute decision-maker, was represented by Mr. Handelman.
Dr. McConachie, the health practitioner, was represented by Ms Clarke.

PRELIMINARY MATTERS

On February 18th and March 2nd, MW sought adjournments to allow her to retain counsel. On both dates the Board agreed to the requests, noting that although the health practitioner had concerns about the urgency of the application, MW should be permitted an opportunity to retain counsel given the significance of the issues to be decided. By March 2nd, MW had retained counsel; however, her counsel of choice could not attend on that date. He was available to proceed within a reasonable timeframe and the panel agreed to adjourn.

THE EVIDENCE

The evidence at the hearing consisted of the oral testimony of six witnesses, Dr. McConachie, the attending physician and Chief of Medicine; Rebecca Franks, R.N.; Lynn Budgell, Acting Director for Quality, Risk Management and Ombuds Services; MW, the substitute decision-maker; SW, the daughter of DW and MW; and Richard Bishop, R.N. There were nine Exhibits taken into evidence:

1. The "Book of Documents of Dr. Kohli" which included:
    a. Form G under the *HCCA*, "Application to the Board to Determine Compliance," signed by Dr. Kohli, dated February 7, 2011;
    b. Consent and Capacity Board Summary, signed by Dr. Kohli, dated February 14, 2011; and
    c. Excerpts from the Clinical Notes of DW, various authors and dates.
2. Additional Excerpts from the Clinical Notes of DW, various authors and dates;
3. Power of Attorney for Personal Care of DW, dated March 8, 2001;
4. Multidisciplinary Progress Note, signed by Dr. McConachie, dated March 9, 2011;
5. Consultation Note, prepared by Dr. Abid, dated June 17, 2010;
6. Letter from Dr. Kohli to MW, dated February 7, 2011;
7. Consultation Note, prepared by Dr. Kirby, dated March 1, 2011;
8. Consultation Note, prepared by Dr. Kirby, dated January 13, 2010; and
9. Letter from John Oliver to MW, dated December 7, 2010.

INTRODUCTION

At the time of the hearing DW was an eighty-seven year old man. Born in Trinidad, he immigrated to Canada with his family in 1963. He had five adult children, one of whom lived in the Oakville area and the rest in other parts of Canada, the United States and England. DW had attended school and obtained a business degree. Until his retirement, he had worked in the business field.

MW was DW's wife of sixty-nine years. DW had executed a Power of Attorney for Personal Care in 2001 naming MW as his substitute decision-maker. There was no dispute that MW continued, at the time of the hearing, to be DW's substitute decision-maker.

DW had been diagnosed with dementia several years before the hearing. He had continued to live at home in an Oakville area apartment with his wife until he was first admitted to Oakville Trafalgar in January 2010. He had remained a patient at the hospital since that time, with the exception of a very short discharge to long-term care in January 2011 that lasted approximately three days. DW's advanced dementia was complicated by a number of additional health problems. His treatment team believed that there was no hope for "meaningful recovery."

DW's treatment team had proposed treatment plan to MW and she had refused to consent. Dr. Kohli believed that MW's refusal of the proposed treatment plan was inconsistent with the requirements of substitute decision-making as outlined in the *HCCA*. As such, he applied to the Board for a determination of that issue.

THE LAW

When the Board is considering capacity with respect to a treatment application, the onus is always on the health practitioner at a Board hearing to prove his or her case. The standard of proof on any application under the *HCCA* is proof on a balance of probabilities. The Board must consider all evidence properly before it. Hearsay evidence may be accepted and considered, but it must be carefully weighed. In order for the Board to find in favour of the health practitioner, it must hear clear, cogent and compelling evidence in support of the case. The patient does not have to prove anything.

Capacity to Consent to Proposed Treatment

Under the *HCCA*, a person is presumed to be capable to consent to treatment (Section 4(2)) and the onus to establish otherwise, in this case, rested with Dr. McConachie.

The test for capacity to consent to treatment and admission to a care facility is set forth in s. 4(1) of the *HCCA*, which states:

> 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.

Obligations of Substitute Decision-Making

The *HCCA* identifies the principles that a substitute decision-maker must apply when making a decision about a proposed treatment. Those principles are outlined 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.
>
> 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.

In the event that a health practitioner believes that a substitute decision-maker did not comply with Section 21, he or she may apply to the Board for a determination. Section 37 addresses issues related to such an application:

> 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.
>
> **Parties**
> (2) The parties to the application are:
>
> 1. The health practitioner who proposed the treatment.
> 2. The incapable person.
> 3. The substitute decision-maker.
> 4. Any other person whom the Board specifies.
>
> **Power of Board**
> (3) In determining whether the substitute decision-maker complied with section 21, the Board may substitute its opinion for that of the substitute decision-maker.
>
> **Directions**
> (4) If the Board determines that the substitute decision-maker did not comply with section 21, it may give him or her direction and, in doing so, shall apply section 21.

Time for compliance
(5) The Board shall specify the time within which its directions must be complied with.

Deemed not authorized
(6) If the substitute decision-maker does not comply with the Board's directions within the time specified by the Board, he or she shall be deemed not to meet the requirements of subsection 20 (2).

Subsequent substitute decision-maker
(6.1) If, under subsection (6), the substitute decision-maker is deemed not to meet the requirements of subsection 20 (2), any subsequent substitute decision-maker shall, subject to subsections (6.2) and (6.3), comply with the directions given by the Board on the application within the time specified by the Board.

Application for directions
(6.2) If a subsequent substitute decision-maker knows of a wish expressed by the incapable person with respect to the treatment, the substitute decision-maker may, with leave of the Board, apply to the Board for directions under section 35.

Inconsistent directions
(6.3) Directions given by the Board under section 35 on a subsequent substitute decision-maker's application brought with leave under subsection (6.2) prevail over inconsistent directions given under subsection (4) to the extent of the inconsistency.

P.G.T.
(7) If the substitute decision-maker who is given directions is the Public Guardian and Trustee, he or she is required to comply with the directions, and subsection (6) does not apply to him or her.

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 person's capacity to capacity 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.

DW'S CAPACITY TO CONSENT TO THE PROPOSED TREATMENT

Dr. McConachie, an internist and Chief of Medicine at Oakville Trafalgar, testified that he had first met DW in January 2010 when DW was admitted to the hospital. He advised that over the period of time that DW had been a patient in the intensive care unit, he had been DW's attending physician on a rotating basis, one week out of every five. Since DW was readmitted to hospital in January 2011, Dr. McConachie had resumed his role as attending physician on a rotating basis. As such, he had been DW's attending physician for approximately three non-consecutive weeks.

It was Dr. McConachie's evidence that the health care team had proposed a plan of treatment that included ending mechanical respiratory support by removing the endotracheal tube and discontinuing ventilation. Palliative care measures would be maintained. Dr. McConachie stated that DW had not had the capacity to make decisions about his own treatment at least since the January 2010 admission, largely due to advanced dementia.

Dr. McConachie stated that he had assessed DW's capacity to consent to the proposed treatment the morning of the hearing, on March 9th. He found that DW did not respond to simple commands to open or close his eyes or to blink. While DW would spontaneously open his eyes, he could either not comprehend the oral commands or could not respond. Dr. McConachie stated that his March 9th assessment confirmed his on-going, informal findings of DW's incapacity. Since DW's admission in January 2010, MW had made treatment decisions on DW's behalf as his substitute decision-maker.

Dr. McConachie noted that DW's mental state did not appear to change throughout the course of the day. He did not believe that DW was able to respond non-verbally, for example by purposefully looking in a particular direction, moving toward or away from an object or person or making any noise to indicate pleasure or displeasure. It was his opinion that DW's acute illness, the pneumonia, and his current treatment for that illness, did not impact DW's mental state. It was also his opinion that DW's mental state and his capacity to make this treatment decision would not improve, regardless of whether the acute illness were to pass. He noted that capacity was assessed when DW was at a low level of sedation or when he was not sedated.

Dr. McConachie stated that DW could not comprehend information that was related to him about his condition or the proposed treatments. He believed that DW could neither understand information relevant to the treatment decision nor understand the reasonably foreseeable consequences of accepting or refusing the proposed treatment plan.

In submissions, Mr. McIver did not take issue with Dr. McConachie's evidence about DW's factual incapacity but he argued that, prior to the morning of the hearing, no formal finding of incapacity had been made. While he acknowledged that Dr. McConachie had provided a clinical note related to his March 9th assessment and finding, he argued that the assessment was belated and that the clinical note provided no information beyond the conclusion that DW was incapable (Exhibit 4). He urged the panel to reject the March 9th assessment and finding as insufficient. Without a finding of incapacity to review, the panel had no authority to proceed. Mr. McIver submitted the case of *Daugherty v. Stall* (2002 Canlii 2657 (On.S.C.)), arguing that the failure to make a formal finding respecting DW's capacity was a violation of DW's rights and should result in the application being dismissed.

The *HCCA* requires a health practitioner to conduct an assessment and make a finding of incapacity if they have decided to rely on a substitute decision-maker for consent to treatments. Where such a finding is not reflected in a patient's chart, the Board may draw an inference that no such finding was made. DW had been a patient at Oakville Trafalgar almost continuously for fourteen months. He was admitted with pre-existing advanced dementia in January 2010 and no clinical note, or indeed any evidence, was provided that indicated a finding of incapacity had occurred. Although Dr. Kohli's Summary for the Consent and Capacity Board indicated that DW was found incapable on January 10, 2010, no supporting clinical note was provided and there was no information about who had made such a finding, or the treatment(s) for which the finding was made (Exhibit 1b, page 3). It may well be that the health care practitioners, given the setting and DW's urgent health needs, did not conduct a formal capacity assessment. Regardless of the circumstances, the *HCCA* requires that such be done.

Nonetheless, Dr. McConachie had formally assessed DW on March 9th and recorded his assessment in the chart (Exhibit 4). The panel was satisfied that this finding (including both the clinical note and Dr. McConachie's oral evidence which expanded on the nature of his assessment) was that which we should review. Combined with the on-going informal assessments of DW's mental state and condition as inferred from the clinical notes (Exhibits 1 and 2), Dr. McConachie provided clear and compelling evidence to support the finding of incapacity. We held that DW was both unable to understand the information relevant to his treatment and the reasonably foreseeable consequences of accepting or refusing the treatment.

APPLICATION TO DETERMINE COMPLIANCE WITH THE *HCCA*

1. DW's Medical Condition

It was Dr. McConachie's evidence that DW was "diagnosed with dementia six years ago [and he was] in the terminal state of his illness" (Exhibit 1b, page 1). DW was "chronically bedridden, non-communicative, [had] advanced Parkinsonism [and] Type 2 diabetes" (Exhibit 1b, page 1). DW had initially been hospitalized in January 2010 with pneumonia requiring ventilatory support and tracheotomy and his hospitalization continued until January 17, 2011. DW was re-admitted three days after his discharge with pneumonia and again required ventilatory support. Since January 2010 DW had required treatment for "hemodynamic instability, recurrent sepsis, PICC line infection, UTI [urinary tract infection], sacral and right ankle decubitous ulcers [bed sores] unlikely to heal, hypercalcemia and hyperparathyroidism secondary to immobility and pain management" (Exhibit 1b, page 1). Dr. Kohli, who had written the Consent and Capacity Board summary, stated that DW's prognosis was "grim as per the clinical assessments of several and various specialists including intensivists, respirologists, infectious disease specialists, geriatricians and hospitalists...with no chance of meaningful recovery" (Exhibit 1b, page 1). Dr. Kohli also stated that "there is no further treatment that will improve or change the outcome for [DW]" (Exhibit 1b, page 3).

Dr. McConachie stated that DW was able to open his eyes spontaneously but did not do so on command. There was no variation noticed in DW's consciousness throughout the day. Dr. McConachie stated that DW was mostly unable to move due to the contractures throughout his body, a process that occurs when a person is bedbound and the tendons shorten, curling the limbs and neck inward. DW received nutrition through a gastrointestinal tube and had both a urinary catheter and fecal management system in place. On his second day of testimony, March 14th, Dr. McConachie advised that DW had been weaned off the ventilator successfully and that he was breathing independently. However, he stated that DW's underlying conditions remained unchanged and it was Dr. McConachie's opinion that there was no hope for a "meaningful recovery." He stated that DW's mental status would continue to decline as a result of the dementia and that he would remain bedbound and dependent on others for aspects of activities of daily living; DW would suffer periodic bouts of opportunistic infections and would be uncomfortable at least and perhaps in pain as a result of the necessary, intrusive medical interventions that took place to manage his feeding, incontinence, airway suctioning, repositioning and daily care.

Rebecca Franks, R.N. also gave evidence. She was the clinical resource nurse in the intensive care unit and was aware of DW's condition, treatment and prognosis since the January 2010 admission. Ms Franks was not typically directly involved in patient care but was in communication with the staff who worked in the intensive care unit. She confirmed DW's condition as described by Dr. McConachie. Further, she advised DW had declined over the course of his fourteen months in hospital: in January 2010 DW was able to track movements and people throughout the room with his eyes and he had lost that ability before January 2011. She indicated that DW would not respond to voices or commands and that his only apparent response was withdrawal from pain – for example when he was being suctioned, having his wounds dressed or was being repositioned.

MW, DW's wife and substitute decision-maker, described being at DW's bedside in the hospital most of the time over the last fourteen months. She would briefly return home for a shower and change clothes but otherwise she ate and slept at DW's bedside. She said that DW was doing better (she gave evidence on March 16th). At that time, he had been off the ventilator for one week. His bedsores were improving and she had been told by the wound specialist that his sores were "good." She stated that she knew that DW had dementia and that this condition would not improve; however, she noted that his other illnesses had improved. MW said that DW would open his eyes and would listen to her, though she acknowledged that he was "not what he used to be eight months ago." Earlier he would speak in short sentences, saying "yes" in response to questions. She stated that he would open his eyes when he heard her voice and would move his shoulders, arms, head and legs at times. She believed that DW was "afraid" when nurses would suddenly reposition him and that he would "shake in fear" if he happened to be asleep when nurses moved him. She would comfort him at these times.

SW, DW's daughter gave evidence. She said that she was aware that DW's dementia would not improve but stated that DW was able to track a person with his eyes and was able to nod in answer to questions, would respond to requests from family members to move his limbs and would move his lips when she would say the rosary. She said that she had witnessed a miracle on the previous Sunday when her father lifted his legs when asked and would nod his head. She said she was "shocked and in awe" and that DW was "a miracle."

The evidence of the parties was consistent on a number of points. Everyone agreed that DW was experiencing a form of dementia or brain disease that impaired his mental functioning and that would not improve. The disease had slowly caused him to lose awareness of his surroundings and he was no longer able to independently attend to any self-care activities. All agreed that DW was bedridden and dependent on others for all activities of daily living and that he would continue to be fed through a gastrointestinal tube and would receive incontinence management. In general, the parties agreed that there had been an improvement in some aspects of DW's condition: specifically, his pneumonia had resolved, he was no longer dependent on mechanical ventilation and there was some improvement in his bed sores. Different values were placed on DW's recent improvements as the family was focused on the small gains while the treatment team considered these to be temporary improvements that would be lost when new, inevitable infections took hold.

The parties disagreed about DW's mental functioning and whether he was able to track movement with his eyes, respond to basic questions and purposefully move; however, the panel did not find that this disagreement was fundamental to our decision. To the extent that the evidence varied on this point, we preferred the evidence of the treatment team. Although MW and SW were present in the room more often than the various health care workers that cared for DW and had a greater opportunity to observe him, we believed that their observations were influenced by what MW later said was her preference to see the positive in her husband's condition. None of the health care workers had directly observed DW moving his eyes or body with purpose, none had seen him respond and the evidence about DW's physical state supported his inability to do either.

The panel found that DW had advanced dementia and that he would be bedbound with serious contractures and dependent on others for all aspects of activities of daily living for the balance of his life. His overall condition had declined since January 2010. We acknowledged that the pneumonia and breathing difficulties had improved but we also found that similar infections and complications were likely to resurface due to DW's compromised physical state and his prolonged hospitalization.

2. The Proposed Treatment Plan

Dr. McConachie testified on March 9th that the proposed treatment included discontinuation of ventilation with palliative care. He stated that as a result of that plan, DW may die very quickly and that he should be permitted to do so. Alternately, DW may be able to breathe independently for a period of time, and on-going palliative care would then be provided; however, when DW's breathing ultimately failed, no further resuscitation including ventilation would be initiated. This was the proposed plan of treatment indicated in the Form G application (Exhibit 1a, page 1: "proposed palliative care including withdrawal of ventilator and provision of comfort measures") and the Summary for the Consent and Capacity Board (Exhibit 1b, page 2: "extubation and palliative comfort care").

Dr. McConachie's testimony continued on March 14th. By that date, DW's condition had changed in that he was able to breathe independently and was no longer dependent on mechanical ventilation. In light of these changed circumstances, the proposed treatment plan had evolved. Dr. McConachie described the new proposed treatment plan as the removal of the endotracheal tube (which provided supplemental oxygen to DW) when medically indicated, and to decline ventilatory support or other resuscitation measures when DW's breathing failed or when he encountered other crises, such as further infections.

While there were a number of concerns raised about how MW was advised of the proposed treatment plan, when she was advised and how changes to the plan were communicated to her, there was no disagreement about the ultimate contents of that plan. The panel considered the amended plan, as presented by Dr. McConachie on March 14th, as the basis for the application.

3. Did MW apply DW's known capable wishes about his treatment when making decisions about the proposed plan of treatment?

None of the parties asserted that DW had made a prior capable wish applicable to the proposed treatment plan or about end of life decision-making. The panel reviewed DW's Power of Attorney for Personal Care and no such prior capable wish was contained in that document (Exhibit 3). We held that DW had made no known prior capable wish and, as a result, MW was required to apply Section 21(2) of the *HCCA* when making decisions about his treatment.

4. Did MW consider DW's values and beliefs that she knew he held when capable and believed he would still act upon if capable (s.21(2)(a)) and DW's wishes that he had expressed about treatment that were not prior capable wishes (s.21(2)(b))?

Dr. McConachie stated that he did not know DW's wishes, values or beliefs because DW had been non-verbal since his admission in January 2010. He said that any information that he had was from the family and that he could not be certain that this information was accurate without hearing directly from DW and he provided no specifics. The panel inferred from the whole of Dr. McConachie's testimony that he was sceptical that MW's position with regard to the proposed treatment plan was consistent with DW's wishes, values or beliefs.

MW stated that she had known DW since she was nine or ten years old. They were married when she was nearly seventeen and the seventieth anniversary of their wedding would occur in June 2011. MW said that no one knew DW better than her, that over the course of their marriage they had become one person.

MW described DW's religious beliefs, indicating that he was a "religious Catholic." She would never serve meat on a Friday because it was against his beliefs. DW would attend church regularly, more than once a week at times, and he would walk to church in the winter if the car was broken. DW would pray every night, kneeling beside the bed, and MW would often fall asleep before he was finished. He would pray again in the morning after he woke. MW stated that DW was more religious than she. She noted that at one point several months earlier DW was very ill with a blood infection and that she had called for a priest to perform last rites. Priests had also attended the hospital on other occasions.

More specifically, MW testified that DW had many discussions with her about end of life over the years in a number of different contexts. She stated that DW did not believe, because of his own interpretation of his religion and because of his general values, in artificially ending a life and that termination of life support or not doing the utmost to remain alive was the equivalent of suicide. She stated that it would be his wish, if he were able to express it, to continue with aggressive treatment. MW said that Dr. McConachie was correct that DW needed many tubes and she understood that the treatment team thought that these were uncomfortable for DW. However, she stated that DW would prefer to be uncomfortable, even in the face of the dementia and his dependence, that he would choose discomfort over a decision to stop taking all possible steps to maintain his life. On cross-examination, MW readily conceded that neither she nor DW had anticipated his current condition, specifically that he would be so dependent because of dementia that he would have to remain in care. Nonetheless, she felt that his decision to pursue life in every way would remain the same because that was consistent with his personal religious beliefs and values.

SW, a daughter of DW and MW, testified. She stated that she attended the hospital “almost daily.” She stated that she was “very certain” that MW’s position about the proposed treatment plan reflected DW’s wishes, values and beliefs. She related a story about a family friend “Suzanne” who had multiple sclerosis. She said that her father would have lengthy conversations with Suzanne about her medical choices in light of her deteriorating condition. DW always said that she should “keep fighting, keep holding on and pray.” She said that this was reflective of DW’s values and beliefs and that he would “prefer to suffer” than to end his life by not pursuing all possible options.

SW stated that she knew that DW was suffering but that despite that, it would be his wish to continue. To DW, to induce death in any manner or to forego treatment was “mercy killing.” Later, SW stated that DW would have wanted resuscitation, regardless of any pain, because to not take that step would be a sin for which one would go to Hell. She said that she was aware that DW’s dementia and other conditions would not improve regardless of any medical intervention but that situation would not have affected his values and beliefs about end of life decisions.

Dr. McConachie and the treatment team had largely relied on the objective medical findings to define what was in DW’s best interests. While those findings were relevant to MW’s decisions about the proposed treatment plan, they did not form the entirety of her obligatory considerations under s. 21(2) of the *HCCA*.

The panel had no reason to believe that MW’s evidence was anything but sincere. There were occasions in which her evidence appeared to be more optimistic than objective, for example when she described her belief that DW was able to respond to her voice by opening his eyes or following her direction to move his limbs. Ms Clarke urged us to prefer the treatment team’s evidence in this regard and, presumably, to consider that MW description of DW’s values and beliefs were strongly influenced by her own wishes. We disagreed.

When testifying about DW’s wishes, values and beliefs, MW was steadfast. Her description of DW’s religious beliefs were supported by specific examples of his devotion to the church and strengthened by spontaneous examples that rang true; for example, when describing her husband's prayers into the night and the fact that she would often fall asleep before he had finished. MW was also clear that DW had specifically addressed his own personal interpretation of his religion when it came to end of life decision-making: it was because of his personal religious values, not the general position of the church, that DW was opposed to anything less than aggressive, life-saving measures. MW openly acknowledged that DW had not expressly addressed his own end of life decision-making and stated that he had not anticipated that he would find himself in the present circumstances. She did not hesitate when making these statements and did not try to embellish her discussions with DW to support her position. Instead, she was clear that she was inferring DW's values and beliefs about the present proposed treatment plan from a lifetime of general discussions and his specific religious beliefs about end of life decision which she had come to know during their time together.

We did not find all of MW's evidence compelling. The story of Suzanne, as related by SW, was argued to be a specific example of DW's position about end of life treatment. While the panel believed that the story had particular meaning for the family, we were unable to ascertain any helpful information from the evidence provided to us as it was vague and out of context. We did not know Suzanne's condition at the time of DW's alleged statements that she "keep fighting" but it seemed clear that she continued to reside in the community and was not in any way terminal. We were unable to determine DW's intent in making the attributed statements – whether he was speaking about Suzanne's ongoing battle with her condition or whether he was speaking of future medical choices.

We were urged to find that the proposed treatment plan was consistent with DW's values and beliefs in that it was not ceasing life support or taking other steps to shorten his life. However, all of the evidence about DW's personal religious beliefs and values indicated that not only would he not have supported active steps to end his life but he would also have wanted on-going, aggressive treatment to prolong his life.

Overall, we determined that DW's own interpretation of his religion and his values related to end of life decision-making were such that he would seek aggressive treatment, even in the face of pain and prolongation of suffering. Although DW had not specifically addressed his own end of life treatment or his specific condition at the time of the hearing, he had made his personal beliefs about end of life treatment clear. In other words, although DW had not contemplated his current condition, his position that all steps be taken to maintain life and that to do otherwise would be sinful, would have remained the same in his present situation.

5. ***Did MW consider whether the proposed treatment plan was likely to improve DW's condition or well-being, prevent it from deteriorating or reduce the rate at which it was likely to deteriorate (s.21(2)(c)(1)(i-iii))? And did MW consider whether DW's condition was likely to improve, remain the same or deteriorate without the treatment; whether the benefit outweighed the risk of harm; and whether a less restrictive or less intrusive treatment would be as beneficial (s.21(2)(2-4))?***

Dr. McConachie stated that there was a difference between prolonging life and "living" and, at this point, aggressive medical intervention was only prolonging DW's life and increasing his suffering. He noted that DW was required to undergo invasive medical procedures including regular suctioning of his airway, wound dressing for the ulcers and maintenance of the feeding, urinary and fecal tubes. It was his opinion that no one would want to continue life in that manner given that "this was not a pleasant way to exist" and that there was no chance of "meaningful recovery." Dr. McConachie stated that if a full resuscitation code was necessary, DW could suffer fractures because he had developed serious contractures, making it more difficult to resuscitate around his limbs and to accommodate his body position. He stated that even if DW was able to breathe independently of mechanical ventilation, there would be "no meaningful long-term recovery of [DW's] other health issues." Dr. McConachie stated that the best possible outcome of any medical intervention was a return to the status quo: advanced dementia, contractures, being bedridden and wholly dependent on others or mechanical mechanisms for activities of daily living.

It was MW's evidence, as outlined above, that DW would want to continue to authorize all possible medical interventions to maintain his life, regardless of his circumstances.

The panel accepted the medical testimony provided by Dr. McConachie and others from the treatment team. We agreed that the Section 21(2)(c) factors that form part of the definition of DW's "best interests" required MW to consider "well-being" in a broad manner that included issues of his dignity and his quality of life (as defined by *Scardoni v. Hawryluck* (2004), CanLII 34326 (ON S.C.) and further interpreted by this Board in, for example *EJG* (2007 CanLII 44704 (ON C.C.B.)). Dr. McConachie's evidence was quite clear that DW was in the terminal phase of advanced dementia, that he would continue to be bedbound and fully dependent and that he would suffer indignities and possible discomfort or pain from the on-going medical interventions and treatment for opportunistic infections. It was his position that DW's dignity and quality of life required that MW consent to the proposed plan of treatment. Had those issues been the only elements of DW's "best interests," we would have agreed.

However, the *HCCA* also required the panel to consider DW's wishes, values and beliefs. Indeed, the court has noted the "value to be attributed to personal autonomy by allowing the Board to look at the question of a patient's best interests from the viewpoint of the patient" (*Scardoni*, at paragraph 83). In considering DW's best interests from his point of view, the panel agreed with MW that DW's personal religious beliefs and values, particularly those that specifically addressed end of life treatment would have caused him to seek out aggressive treatment, regardless of his current circumstance and the medical reality. For DW, not continue with aggressive treatment to maintain life was a sin.

It was the obligation of the panel to determine whether or not MW had arrived at the correct conclusion with respect to DW's best interests (see *M.(A.) v. Benes* (1999) 46 O.R. (3d) 271 at page 271, cited in *Scardoni* at paragraph 36). We found that, for all of the reasons stated above, she had. We held that MW had complied with the *Act*.

Additional Issues Raised by the Parties

An additional matter was raised by counsel for MW that, although it did not form the basis of our decision, bears discussion. Both Mr. Handelman and Mr. McIver raised issues of statutory compliance as related to the process followed by staff members at Oakville Trafalgar when making this application. Concerns were raised about the fact that no formal finding of DW's capacity had been conducted until the morning of the hearing despite his being a patient of the facility for more than one year and reliance on substitute decision-making throughout. It was argued that MW had not, before she retained counsel, received adequate information about the proposed treatment plan which would allow her to provide informed consent to the proposed treatment. Similarly, it was argued that MW had not, in a timely way, been advised of her obligations under the *HCCA* as substitute decision-maker or the internal processes underway at the hospital, including the purpose of the February 3rd family meeting and subsequent filing of the Form G application.

The evidence on the issues was not particularly clear. Although MW denied having received information about the treatment, the clinical notes contradicted her position. The process leading up to the February 3rd meeting was less apparent from the records. The panel had been urged to dismiss the application on the basis of these multiple failures to meet the health care practitioner's statutory obligations. As we determined that MW had complied with the *Act*, it was unnecessary to make that ruling. However, the panel wished to urge the facility to make changes to the process in subsequent applications of this nature. The nature of the issues to be decided combined with the difficult task faced by family members during a difficult and emotional time requires that the process be as clear and transparent as possible. Steps taken should be documented in the clinical record. Appreciating that the ever-changing and sometimes urgent situations that exist in such applications may make it difficult, from time to time, to meet the highest standards of accountability, the statutory obligations must be respected in a manner that withstands scrutiny.

RESULT

We held that MW, the substitute decision-maker, had complied with the principles for substitute decision making set out in the *HCCA*.

Dated: March 22, 2011

Lora Patton, Presiding Member