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

16-1922-01
16-1922-02

IN THE MATTER OF
the ***Health Care Consent Act, 1996***
R.S.O. 1990, chapter M.7
as amended

AND IN THE MATTER OF
EI
A patient at
TRILLIUM HEALTH PARTNERS – MISSISSAUGA HOSPITAL
MISSISSAUGA, ONTARIO

REASONS FOR RULING

PURPOSE OF THE HEARING

EI was a patient at Trillium Health Partners – Mississauga Hospital ("Mississauga Hospital") where she was taken subsequent to an automobile accident. Mechanical ventilation and other treatments were initiated. EI's doctors had issued a Death Certificate on July 20, 2016 having found EI to meet the neurological criteria for brain death on July 18th. On July 25th, a doctor and other representatives of the hospital wrote to EI's sister, TO, to advise that mechanical ventilation would be removed by July 28th. TO was opposed to this action and, on July 27th, she applied to the Board pursuant to section 35 of the *Health Care Consent Act, 1996* (the "*HCCA*"), asking that the Board provide directions as to consent for this action. A deemed application about EI's capacity to consent to treatment was initiated as a result. On July 30th, EI experienced cardiac death.

DATES OF THE HEARING, DECISION, AND REASONS

The prehearing commenced on July 28th and continued on August 12th and September 9th. By

agreement, my Ruling was issued on September 12th. Reasons for Ruling, contained in this document, were released on September 30th.

LEGISLATION CONSIDERED

The *HCCA*, including sections 1, 35, 32
Statutory Powers Procedure Act, R.S.O. 1990, c. S.22, including s. 23
Trillium Gift of Life Network Act, R.S.O. 1990, c. H.20, including s. 7
Consent and Capacity Board Rules of Practice, including Rule 10

PARTIES & APPEARANCES

Mr. D. Hiltz was appointed by Legal Aid Ontario, pursuant to section 81 of the *HCCA* to represent the patient, EI. Following EI's cardiac death, Mr. Hiltz agreed to remain to assist the panel as *amicus*.

TO, EI's sister and substitute decision-maker, was represented by an agent, LN (as a friend of the family her full name may be identifying and has been removed).

Drs. Milosevic, Murthy and Maham, the health practitioners, were represented by counsel, Ms E. Baron.

Trillium Health Partners, although not a party, participated throughout to provide assistance to the Board and parties, and were represented by counsel Ms N. Vaz (on July 28 and September 9) and Ms M. Dykeman (on August 4).

TO elected not to participate further in the proceedings after EI's cardiac death on July 30, 2016.

PANEL MEMBERS

Lora Patton, senior lawyer and presiding member

THE EVIDENCE

The evidence at the hearing consisted of the oral testimony of Drs. Murthy and Milosevic, and the following Exhibits:

1) Letter to TO from Dr. Maham, Dr. Ginzburg and Ms Hayward-Murray, dated July 25, 2016;
2) Letter to TO (not sent) from Dr. Maham, Dr. Ginzburg and Ms Hayward-Murray, dated July 25, 2016 (identical to Exhibit 1 but correcting an error at the end of the first paragraph in which the Medical Certificate of Death was completed on July 20, 2016 rather than July 22);
3) Declaration of Death by Neurologic Criteria Checklist, signed by Dr. Murthy, dated July 18, 2016;
4) Confirmation of Neurological Determination of Death, signed by Dr. Milosevic, dated July 18, 2016;
5) "Brain arrest: the neurological determination of death and organ donor management in Canada," *CMAJ* Vol. 174, No. 6, (Suppl): S1-30 (pages 1-12);
6) Excerpt from "Donation Resource Manual: A tool to assist hospitals with the process of organ and tissue donation," 2010; and
7) Clinical Notes
    a. Report, prepared by B. Atwal SW, dated July 19, 2016;
    b. ICU Attending Daily Report, signed by Dr. Maham, dated July 27, 2016;
    c. Clinical Note setting out Declaration of Death as per neurological criteria, dated July 18, 2016

NOTE: The Medical Certificate of Death, signed by Dr. Milosevic, dated July 20, 2016 was viewed by me and all parties; however, as it cannot be legally copied, it was not made an Exhibit. It noted date of death as July 18, 2016 with a cause of death listed as "subarachnoid hemorrhage."

PRELIMINARY ISSUES

July 28th Jurisdiction Question and Adjournment Request:

On July 28th, Ms Baron brought a preliminary motion on behalf of the health practitioners seeking a ruling as to whether the *HCCA* applied in this case as EI had been pronounced dead by neurologic criteria and, consequently, whether the Board had jurisdiction to proceed.

Mr. Hiltz and TO sought an adjournment of the prehearing. Mr. Hiltz noted that he had been contacted the day before about representing his client and, as a result, had not yet had time to review her records. Further, he was unaware that there was a preliminary issue relating to the Board's jurisdiction and had not had the opportunity to review or prepare for this issue. TO, through her agent, indicated that she would like to speak with a lawyer and potentially have a lawyer represent her.

Ms Baron's clients were opposed to the adjournment, noting that EI's physical condition was deteriorating rapidly. If EI were to experience cardiac death prior to the next prehearing date, the determination of the jurisdiction issue, which was of great importance to the physicians, may become moot.

I ordered an adjournment to allow TO to consult and retain counsel and to allow Mr. Hiltz to properly prepare for the preliminary and substantive issues. While there was some urgency to the situation, that urgency related to the potential mootness of the application, a factor that was significantly outweighed by TO's right to have counsel and to have all counsel sufficiently prepared to deal with a matter that was novel and significant.

The parties were ultimately able to reach an agreement as to the next prehearing date, August 4th, just less than a week later. To assist in reaching the agreement, the Board arranged to have a separate panel available to immediately proceed with the substance of the application, together with a Form G application which would be filed by the physicians to determine the SDM's compliance with the legislative requirements for decision-making (under section 37, *HCCA*) in the event that I ruled in such a way that did not dismiss the matters.

It was clarified that TO was the correct substitute decision-maker as EI's parents, who lived overseas, had spoken with TO, were in agreement with her, and had declined to act, although they would have been the highest ranking class of persons in the *HCCA* section 20 hierarchy.

August 12th Proceeding Notwithstanding Withdrawal of the Application and Mootness of the Application:

On August 3rd, Ms Baron wrote to the Board to advise that EI's heart had stopped beating and that the Form D application (as well as the pending Form G application) would not be required. However, in her letter, Ms Baron stated that her clients wished to proceed with the jurisdiction argument. On August 3rd, the Board wrote to the parties to advise that the Form D application was still before the Board and the prehearing would proceed.

In a letter received later on August 3rd, TO, through her agent, wrote to the Board to withdraw her application. No other applications had been filed. The Board wrote to all parties to advise that there continued to be an issue before the panel and the pre-hearing would proceed. The matter was ultimately rescheduled to August 12th to accommodate counsel.

When the prehearing reconvened on August 12th, Mr. Hiltz raised three matters. First, he noted that his role in the proceeding was uncertain in light of his client's death. He noted that he had been appointed by Board order, pursuant to section 81 of the *HCCA*, and that the appointment would have come to an end. While the standing was uncertain, Mr. Hiltz agreed to remain as *amicus* to assist the Board with resolving the outstanding issues.

Second, Mr. Hiltz noted that the status of the application was in question. Specifically he noted that the application, brought by TO, had been subsequently withdrawn by her. Thirdly, he noted that there was an issue as to whether the Board should proceed in light of the fact that the matter had become moot. These last two issues were the subject of written and oral submissions and are set out below. I determined that there was sufficient reason to continue on August 12th to hear the issues and the evidence, particularly in light of the fact that two doctors were available to offer evidence. I therefore reserved my Rulings on both the impact of the withdrawal and mootness.

ANALYSIS

The Order of Issues to be Determined:

It was Ms Baron's submission that the panel ought to first determine whether or not the Board had jurisdiction in situations such as this: where a Medical Certificate of Death had been issued and where, in her submission, the *HCCA* had no application. It was her position that in accepting the application and scheduling a time for hearing, the Board had apparently accepted jurisdiction. The issue of withdrawal and mootness were subsequent and, as such, the preliminary matter must be determined before the others.

I disagreed. As Mr. Hiltz noted, when the Board receives an application that is valid on its face, it is obligated by legislation to schedule a Hearing (or pre-hearing) as it did in this case. In doing so, the Board did not accept jurisdiction to proceed. Prior to any determinations being made, both the withdrawal and mootness issues arose. In my view, the issues had to be determined in the following order:

1) Whether the Board had jurisdiction to proceed in light of the applicant's withdrawal of the application;
2) Whether the Board should proceed in light of the fact that the application was moot; and
3) Whether the Board had jurisdiction to consider an application about directions where a Medical Certificate of Death had issued with respect to the person.

The Effect of the Withdrawal of the Application:

The application to the Board to give directions with respect to a wish made by an incapable person was withdrawn by the substitute decision-maker on August 3rd. Ms Baron submitted that the panel could refuse to accept that withdrawal based on authority arising from the *Statutory Powers Procedures Act* ("*SPPA*") and the *Consent and Capacity Board Rules of Practice* ("*CCB Rules*"). She noted that the Board had previously refused to accept withdrawals in certain circumstances such as those in *JL* ([2004] O.C.C.B.D. No. 512, HA 04-2652; included in the health practitioners' Submissions Brief).

In reviewing the *SPPA*, the *CCB Rules* and the caselaw on this point, I could not agree that this was an appropriate case to refuse to accept the applicant's withdrawal of the application. The *SPPA* at subsection 23(1) states that "A tribunal may make such orders or give such directions in proceedings before it as it considers proper to prevent abuse of its processes." The *CCB Rules* do not specifically address refusal to accept withdrawals except to reference receipt of appropriate documentation to confirm the withdrawal. Caselaw referencing refusal to accept withdrawals speaks to the Board's authority to control its process by preventing abuse of process; in *JL* (supra), the evidence of the health practitioner had concluded before the request to withdraw was submitted. Although not clearly set out in the reasoning and there was little analysis, it appeared that the panel considered abuse of process in proceeding to the Hearing's conclusion.

There was no suggestion that the withdrawal was in any way an abuse of process. Nor would the withdrawal, even if made in good faith, lead to mischief. Indeed, the withdrawal was made at an extraordinarily emotional and difficult time for EI's family, who were no longer interested in a legal process about her treatment and care in light of her death. I saw no reason to refuse the withdrawal on this basis.

Ms Baron also submitted that the application triggered a deemed hearing about EI's capacity to consent to treatment and that this application remained before the Board. I disagreed. A deemed hearing about capacity (section 37.1, *HCCA*) only arises when a triggering application is made to the Board as occurred in this case, under section 35, *HCCA*, with the application for directions. Where that application is resolved, the deemed hearing is no longer required and is no longer before the Board.

Finally, Ms Baron submitted that an application about directions, and indeed other applications made under the *HCCA* relating to the treatment of a potentially incapable person, involved the determination of issues that were of importance to all parties. She noted that the health practitioners had a clear interest in a panel's determination about a patient's prior capable wishes or their best interests when such an application is initiated by a substitute decision-maker. She

noted that, in this case, there was a significant issue relevant to the practice of medicine and the processes available to health practitioners and families where a person has been declared dead by neurological testing.

I found this argument compelling and agreed that all parties to such an application had an interest in the issues raised by an application. However, in this case, the health practitioners were not seeking a decision relating to an outstanding treatment decision: any such decision was rendered moot by EI's cardiac death. Rather, their interest arose in the answer to a secondary, legal question about the Board's role in matters following the issuance of a Medical Certificate of Death. This interest is of a different nature than the substantive one and the primary role of the Board in determining these types of applications. This was to be contrasted with the very personal involvement in the issue for TO and to EI's family. TO clearly did not want to proceed with the application.

I determined that the ancillary interest of the health practitioners did not warrant refusal of a withdrawal by the applicant. The withdrawal was accepted and there was no matter before the Board to adjudicate.

Whether to proceed notwithstanding the issue had become moot:

In light of the above Ruling, it was unnecessary to consider whether or not the Board had jurisdiction to consider the application notwithstanding the cardiac death of EI and the application becoming moot. However, in light of the evidence and submissions received on the point, I have provided my preliminary thoughts.

I was persuaded by the importance of the issue for health practitioners, health care teams and family members. It was Dr. Murthy's evidence that at Mississauga Hospital, there had been 56 determinations of death by neurological criteria in the two and a half years prior to the hearing. Of those, approximately 5 cases had resulted in a conflict with family members in that the family did not accept the declaration of death. Dr. Murthy explained that, in these circumstances, treatment that had been initiated for the purposes of saving a life (or determining whether a life could be saved) was continued as did general care while efforts were made to inform and support

the family and to reach consensus on next steps. While cardiac death typically results in fairly short order following death by neurological criteria due to the role of the brain stem in supporting all body functions, it may take days or weeks, leaving the health care team and family in a legal and medical limbo.

Such a circumstance creates a number of concerns for the health practitioners and broader healthcare team. Continuation of "treatment" for someone declared dead offers, obviously, no medical benefit and there would be no ethical or moral reason to continue. Further, questions were raised as to initiating new treatments (for example the treatment of infections with anti-biotics) which also offer no benefit but which a family may demand. The appropriate allocation of resources also becomes an issue when those resources (particularly intensive care beds and other supportive technology) cannot be offered to others. Finally, but of significant importance, was the distress that on-going "care" of a person declared dead causes the health care team and the uncertainty and lack of legal clarity for everyone involved.

I was also persuaded that it was unlikely that the issue of the Board's jurisdiction in such a case would be adjudicated in other circumstances. In the present case, a prehearing conference was scheduled by the Board and commenced within 24 hours. In light of the need to ensure procedural fairness (with resulting delays to ensure counsel, if sought, was retained, and all parties were afforded the necessary time to prepare for an issue of such import and novelty) and the likelihood that a person found to meet the neurological criteria for death would experience cardiac death in relatively short order thereafter, it would be very unlikely that a hearing (even on the preliminary issue of jurisdiction) could conclude.

I was concerned about the degree to which the matter was fully adjudicated in this case. While the health practitioners were represented, the interests of patients, substitute decision-makers and possible other parties (should they seek and be granted party status) were limited in this case. Mr. Hiltz's role as *amicus* was extremely helpful; however, as he acknowledged, his ability to raise issues and provide full argument was restricted by the nature of his involvement following his client's cardiac death. The substitute decision-maker elected not to participate in the continued prehearing. While many of the issues were raised by counsel and *amicus* (for which I

thank them both), it was not clear to me that this hearing offered a "sufficient adversarial context" to satisfy the *Borowski* test (*Borowski v. Canada (Attorney General)* [1989] 1 S.C.R. 342).

I was also uncertain as to whether this was an issue best determined by legislation. Other provinces have chosen to set out in legislation a legal definition of death. Ontario has not done so. While it may be within the role of the Board to delineate its jurisdiction, the determination of such a question has much more expansive policy implications than could be considered in an application before this Board.

Whether the* HCCA *applies and whether the Board has jurisdiction to hear applications about a person for whom a Death Certificate has issued:

Although I determined that I was unable to rule on this issue, in light of the significance of the problem for the medical community, family members and future panels, I spent a significant amount of time considering the evidence. In this section I am not commenting on the specific parties before me but, rather, providing my analysis on the more general legal question.

I would have found that the Board does not have jurisdiction to hear an application relevant to the treatment of a person where a Medical Certificate of Death has issued in respect to that person. I note that the language in this case is difficult and "person" may not be the correct legal terminology following death and query whether there is a "person" subject to a "treatment" such that the *HCCA* would be triggered in any event but this issue was not argued.

Drs. Murthy and Milosevic set out very clearly the required testing and documentation that must be completed to confirm death by neurologic criteria in accordance with the accepted medical standard in Canada. Dr. Murthy specifically noted that since the 1960s, when technological advances permitted life to be extended through the use of artificial support for the heart and lungs, the Canadian medical community had been considering and refining means of establishing death. Specifically, investigations and refinements have taken place over these decades to determine the best means to establish that a brain no longer functions such that a person has experienced "brain death" or death by neurological criteria. The Canadian medical community

reached a key consensus in 2003 regarding the medical standards surrounding neurological determination of death which was published in the *Canadian Medical Association Journal* in 2006. That article, titled "Brain arrest: the neurological determination of death and organ donor management in Canada," sets out the definition, qualification for physicians who declare death by neurological testing and the criteria to be employed when doing so (Exhibit 5).

In that article neurologically determined death is defined as "the irreversible loss of the capacity for consciousness combined with the irreversible loss of all brain stem functions... including the capacity to breathe" (at page S3). Dr. Murthy explained that the focus on the brain stem relates to the fact that this portion of the brain is the integrative centre that controls all aspects of the body, including breathing, organ management and temperature control.

The first step in assessing a patient in these circumstances (as set out in Dr. Murthy's testimony as well as the two documents used by the physicians to declare death by neurologic criteria at Exhibits 3 and 4) is to determine whether or not there has been an injury in the brain capable of causing brain death. Further consideration is given to the factors that may confound the diagnosis (such as sedation, hypothermia or pre-existing conditions). At that stage, a bedside examination takes place to test the brain function (pupil responses, reflexive reaction to protect the eye, gag and cough reflexes, pain response, apnea (breathing capacity) testing). Only if all criteria are established may a physician declare death by neurological criteria.

Such a declaration is significantly different from declaring a patient to be in a "persistent vegetative state" or "minimally conscious state." In those cases, some brain stem function remains, even if limited, and the person will not meet all of the criteria required to declare death by neurological testing.

In Ontario, the legal declaration is within the domain of physicians and death by neurological criteria is an accepted standard to apply, both medically and legally. Although there are few cases on point, those that exist accept the fact that physicians make this determination and they accept death by neurological criteria (*Re: Christou* [2007 CanLII 82699 (ON OCCO)]; *Leclerc (Succession) v. Turmel* [(2005) CarswellQue 13718]; *Re: A (A Child)* [2015] EWCA 443 (Fam)).

The *Trillium Gift of Life Network Act*, which permits the donation of organs following the death of a person, does not define "death" although the *Donation Resource Manual* published by the Network sets out its acceptance of neurologically determined death for the purposes of organ donation (although it requires determination by two physicians which is not required for issuance of a Medical Certificate of Death) (Exhibit 6). I do not feel it necessary to consider these cases or the legislation in detail here. The primary issue to be resolved is whether or not there is a role for the Board to play in questioning a determination of death made by a physician. There is not. If there is a role for a legal review of such a determination, it must lay with the Courts.

Once a declaration of death by neurological criteria is made, (distinct from the time at which a Medical Declaration of Death document is completed), the *HCCA* can have no application. The Board would have no jurisdiction to hear applications in such a case.

Future Applications:

In light of the above, particularly because the Board could not proceed in such a case, I propose the following process be followed in any future applications with similar circumstances.

- Where the Board receives an application under *HCCA*, sections 33-37, it will proceed (as it does) to order Legal Aid Ontario to appoint counsel to represent the potentially incapable person.
- Upon learning of the application, the health practitioner or his or her delegate, shall advise the Board that a Medical Certificate of Death has been issued with respect of that person.
- The Board, having been advised of the Medical Certificate of Death, shall schedule a pre-hearing as soon as possible thereafter, ideally with a court reporter in attendance.
- The health practitioner or his or her delegate, shall facilitate an opportunity for counsel appointed to represent the person, the substitute decision-maker(s) and the Board to inspect the Medical Certificate of Death.
- Where there is confirmation of the existence of a Medical Certificate of Death, the Board would, if applying the analysis provided above, lack jurisdiction to proceed and the application will be dismissed.

RESULT

For the foregoing reasons, the panel determined that it lacked the ability to proceed as the application was no longer before it.

Dated: September 30, 2016

Lora Patton
Presiding Member