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

LO-08-3972
LO-08-3973

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

AND IN THE MATTER OF
G
A patient at
London Health Sciences Centre – University Hospital
LONDON, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

A panel of the Board convened at the London Health Sciences Centre – University Hospital ("University Hospital") at the request of Dr. R. Butler, a health practitioner. Dr. Butler brought a Form G Application to the Board under Section 37 (1) of the *Health Care Consent* Act for a determination as to whether or not the substitute decision maker in this case has complied with the principles for substitute decision-making as they are set out in the *Health Care Consent Act* with respect to proposed treatment for G.

Dr. Butler's proposed treatment for G was the withdrawal of life support including by way of withdrawal of ventilator, removal of endotracheal tube, placing of a do not resuscitate (DNR) order in G's personal health information record (chart) and use of optimal palliative care medication.

An Application to the Board under Section 37 of the *Health Care Consent Act* is deemed, pursuant to subsections 37.1 of the *Health Care Consent Act* to include an application to the Board under Section 32 by G with respect to her capacity to consent to treatment proposed by a health practitioner unless the person's capacity to consent to such treatment has been determined by the Board within the previous six months.

DATES OF THE HEARING, DECISIONS AND REASONS

The hearing took place on Monday February 9, 2009. The next day on February 10, 2009 the panel released its Decision. Reasons were released on February 20, 2009.

LEGISLATION CONSIDERED

The *Health Care Consent Act*, including s.2, 4, 21, 11, 32, 37 and 37.1

PARTIES

G's Deemed Form A – Treatment Application
G, patient
Dr. R. Butler, health practitioner

Dr. R. Butler's Form G – Treatment Application concerning G
Dr. R. Butler, health practitioner
G, patient
MG, G's daughter and substitute decision maker.

G did not attend the Hearing. However, the panel and all counsel attended in her room, in the intensive care unit, where she was questioned by her counsel. Dr. Butler attended a portion of the Hearing and was excused after his oral testimony. MG attended the Hearing and gave evidence.

PANEL MEMBERS

Michael Newman, Presiding Lawyer Member
John Pellettier, psychiatrist member
Gary Strang, public member

APPEARANCES

G was represented at the hearing by counsel, Mr. J. Szpytman
Dr. Butler was represented at the Hearing by counsel, Ms. J. Zamprogna-Balles
MG was represented by counsel, Mr. J. Gundry

PRELIMINARY MATTERS

The panel was advised that there had not been within the previous six months a determination by the Board of G's capacity to consent to the proposed treatment in this case. The panel was also advised that G did not have a Guardian of the Person or a Power of Attorney for Personal Care containing a provision waiving her right to apply for the review of the health practitioner's findings in accordance with Section 32 of the *Health Care Consent Act*. She did have a Power of Attorney for Personal Care, which was filed. We determined that the Board had jurisdiction to continue with the Hearing.

THE EVIDENCE

The evidence at the hearing consisted of the oral testimony of seven witnesses, Dr. Butler, Dr. Young, MG (G's daughter and substitute decision maker), JE (G's daughter), SH (G's daughter), SG (G's son) and G and four Exhibits:

1. Dr. Butler's Clinical Summary dated February 6, 2009
2. G's Notarized Power of Attorney for Personal Care dated July 13, 2005
3. CG's letter dated February 8, 2009 (typed)
4. MG's letter dated February 8, 2009 (hand written)

INTRODUCTION

G was an eighty one year old woman. She had been residing in a nursing home until her recent admission to hospital. G's medical history prior to January 22, 2009 included diabetes, chronic renal insufficiency, hypertension, hiatus hernia and gastroesophageal reflux, recurrent urinary tract infections, osteoarthritis, depression, anxiety disorder, prior cholecystectomy and a hysterectomy.

G also had two prior strokes which affected the left side of her body, left her wheelchair dependent requiring a mechanical lift for transfers and a limited ability to propel herself in the wheelchair. In addition as a result of the two prior strokes, G had been able to feed herself but otherwise required care for other activities of daily living.

On January 22, 2009 G was sent to the University Hospital from her residence in a long-term care facility. Earlier in the evening she had complained of a headache. She was noted to become non-verbal, and developed a right sided facial droop and paralysis in the right arm and leg. On arrival in the Emergency department G was orotracheally intubated to protect her airway. The intensive care unit team was consulted and G was evaluated by the stroke team at University Hospital. Dr. Butler then became G's attending physician. An urgent CT scan was obtained which demonstrated chronic ischemic changes but no acute stroke. The opinion of the neurology team at the time was that G had likely suffered a brainstem stroke and further evaluation with an MRI was needed. On January 23, 2009 an MRI was carried out which demonstrated a central pontine (brainstem) infarct or stroke, described by Dr. Butler as blood flow lost to an area of the brain with "greater involvement on the left side of the pons than the right". Dr. Butler noted in his clinical summary that "these findings were supportive of the clinical findings".

G has remained on a ventilator since admission to hospital. Dr. Butler said she was paralyzed on the right side of her body and profoundly weak on the left side of her body from her two prior strokes. Dr. Butler noted that the current stroke, which left G functionally quadriplegic, also involved her facial muscles. However she was able to blink her eyes. She could also wiggle her left foot toes and had minimal movement in her left hand. She was able to trigger the ventilator but has required assistance with the work of breathing since admission. She received her nutrition through a nasogastric feeding tube.

Although G was conscious i.e. could open her eyes to voice, could track movements with her eyes and could intermittently obey simple one step commands, Dr. Butler's opinion as set out in his summary was:

> "it has not been possible to communicate with her. Repeated attempts have been made to try and utilize a system of blinks (one = yes, two = no) or with toe movement. Every attempt has been unsuccessful. There is a high incidence of delirium (acute cognitive dysfunction) in the critically ill patient population. It is highly probable that G is delirious and that this has precluded the establishment of an effective communication system".

This opinion was shared by Dr. Young, G's consulting neurologist.

In Dr. Butler's further opinion G's current functional capacity was unlikely to improve measurably. He said she would remain completely paralyzed on the right side (in addition to the left-sided weakness from the prior stroke) and that the paralysis involved the facial muscles including the tongue. He said she was unlikely to be able to understandably vocalize because of the facial involvement. This weakness also made it unlikely that G would be able to effectively swallow and protect her airway from her own oral secretions. He said she may not be able to maintain her airway if the breathing tube was removed. She would remain non-communicative, paralyzed and completely dependent for her care needs. She was at risk for infectious complications including urinary tract infections and pneumonia which often leads to death after strokes as severe as the one G recently suffered. Dr. Butler called the most recent stroke "devastating".

On January 24, 2009 Dr. Butler assessed G's capacity with respect to her treatment. As he noted earlier, Dr. Butler said that G had been severely disabled as a consequence of the recent devastating stroke. She was paralyzed with the exceptions that she could wiggle the toes on her left foot, weakly move her left hand and shake her head and blink her eyes. She was able to rouse to voice, attempts to track visual objects with her eyes, and could follow one-step commands but did so inconsistently. She has blinked to command and wiggled toes to command. Dr. Butler said G's responses have remained inconsistent. He said many attempts have been made to try and establish communication with G using a simple system of blinks. When this has been done G has not been able to provide correct responses to simple questions e.g. is your name G, do you live at the nursing home, are you in hospital? G fails to blink, provides a series of blinks 6 - 8 in a row or appears to drift off to sleep. Repeated coaching of G on the system for communication has not improved her responsiveness.

Dr. Butler believed that his inability to set up a form of communication with G evidenced that she did not have the cognitive ability to understand the information that was relevant to her treatment or the consequences of any treatment decisions. Dr. Butler noted that he could not get G's attention long enough for her to learn or understand.

Dr. Butler said that in addition to failing the first branch of the test for capacity G also failed on the basis of her inability to appreciate the reasonably foreseeable consequences of a decision or lack of decision. He said G failed this second part of the two part capacity test for the same reasons she failed the first branch of the test. Dr. Butler said G's incapacity was a consequence of the effect of her recent stroke on her, including the delirium she suffered as a result. He described this delirium as an acute cognitive disorder affecting G's memory and attention, from which G had no reasonable prospect for recovery.

G was declared incapable on January 24, 2009 with respect to the proposed treatment. Dr. Butler then turned to G's substitute decision-maker, her daughter MG to provide treatment decisions for G. MG was one of G's ten children and the oldest child.

The treatment plan that Dr. Butler proposed was withdrawal of life support (Option A). Dr. Butler wrote:

> "Given the severe and disabling nature of the stroke it is proposed that the focus of care provided to G be comfort only. To that end we would propose to not provide resuscitative measures should a cardiac arrest occur, and we would propose to withdraw the ventilator and remove the breathing tube. If G breathed comfortably on her own she would continue to receive nutrition and hydration and she could potentially be transferred back to her care facility. If, during the process of withdrawing the ventilator or removing the endotracheal tube G could not sustain her breathing adequately, she would be treated with medications to provide optimal palliative care to prevent discomfort, but the life support would be withdrawn and the expectation would be that G would die".

According to both Dr. Butler and Dr. Young the proposed treatment plan avoided the need for surgical interventions, represented the minimally invasive approach to dealing with the devastating consequences of the stroke and therefore was in G's best interests. If G was able to survive after the ventilator was withdrawn she would potentially be able to return to her home. Dr. Butler recommended this treatment approach because, in his experience:

> "most patients do not desire ongoing life support therapies in the face of this sort of disability - particularly elderly patients who may have faced diminishing physical or mental function as a consequence of disease and prefer not to prolong the dying process if they cannot have a good quality of life".

Dr. Butler noted the risk of the proposed treatment was that, if G was unable to breathe adequately, she would die during or shortly after the life support was withdrawn.

Dr. Butler's treatment alternative to withdrawal of life support was to try and extend the duration of G's life with medical means. In order to do that G would require the surgical placement of a tracheostomy tube and the placement of a gastrojejunostomy tube. G would receive ongoing hydration and nutritional support, and efforts would be made to wean her from the ventilator. It was likely, though not guaranteed, that weaning from the ventilator would be successful. Once off the ventilator, the tracheostomy and gastrojejunostomy tubes would be permanently required. G would then remain dependent for all her care needs. She would remain in hospital while long term placement was sought as it was not possible for her to return to her nursing home with a tracheostomy. He expected she would remain in hospital for 1-2 years waiting for placement. Dr. Butler said it was possible to extend the duration of G's life by months, or possibly years, with this approach. However, she would still be at risk for the development of life threatening infectious complications.

Dr. Butler said the alternative treatment plan would involve a surgical tracheostomy. This was a surgical procedure performed at the bedside under general anaesthesia. More commonly he said the associated risks were infections at the site of the tracheostomy stoma and common problems with skin breakdown at the site. Occasionally the tube can become blocked with secretions. If this was not recognized it could lead to death. The placement of the tracheostomy would ensure that G's airway was open and unblocked, that the risk of aspiration of oral secretions was minimized, and that her pulmonary secretions could be suctioned. There was a remote risk of death with the procedure, an uncommon risk of bleeding requiring transfusion, an uncommon risk of puncture of the lung requiring a chest tube, and a rare complication of erosion of the tracheostomy into a major artery usually resulting in death.

The alternative treatment would also involve the placement of a gastrojejunostomy tube. This was a tube inserted into the stomach and passed into the small bowel through a puncture in the abdominal wall. The procedure was performed in the radiology department under local anaesthesia. The major risk at insertion is the development of a leak of gastric contents into the peritoneal cavity which rarely requires a surgical procedure to correct. Longer term issues with the tube involve skin breakdown and infection at the site of insertion. The tube would provide a stable access point to provide nutrition.

According to both Dr. Butler and Dr. Young these procedures (tracheostomy and gastrojejunostomy tube) increased the likelihood that G would live for a longer period of time. However both doctors agreed that neither of these procedures would improve the overall quality of G’s life nor lessen the disability associated with the recent stroke. They simply extended life. Both procedures were required if the focus of care was life extension. Neither physician recommended this Option in terms of improving G’s well-being.

Dr. Butler said that the two treatment options he put forward were dependent on G’s values. However, in his view G had not expressed any particular wish that she wanted her life extended. He said he asked MG about any prior capable wishes expressed by G, and understood there were none. He noted that Option 2 would not improve the quality or well-being of G's life. Dr. Butler said that G's well-being was based on personal views and preferences and did not necessarily mean life extension. In his opinion improving well-being included someone choosing the manner of their own death.

Dr. Butler noted that while MG, G's substitute decision maker preferred Option B, all of G's remaining nine children agreed that Option A was the treatment G would have felt was in her best interests. In Dr. Butler's opinion the treatment proposed in Option A was the recommended way of considering her well-being through maintaining G's dignity. Dr. Butler said that in discussing the situation with MG she made reference to her preferences being more important than those of her mother.

Under questioning by MG's counsel Dr. Butler acknowledged that when G arrived in the emergency department she was a "full code". He said the hospital was aware G wanted full resuscitative measures instituted. However, after speaking with family members Dr. Butler noted that the very things G enjoyed in life would be lost to her as a consequence of her most recent devastating stroke, especially when cumulatively viewed with affects of her two prior two strokes. In Dr. Butler's opinion MG's desire for treatment Option B was not acting in G's best interests.

Dr. Young, the consulting neurologist on G's case noted that G had no voluntary control in her face, tongue, jaw and throat and was totally dependent for activities of daily living. He said she required artificial feeding and could only move her left foot a little. In his opinion as a neurologist and staff physician at the hospital her airway would not likely remain open if ventilation was removed. He had assessed her as recently as the morning of the Hearing and said there were no changes since he previously saw her. He agreed with Dr. Butler's diagnosis and recommended treatment (Option A), risks and benefits. He said G lacked capacity because she lacked the ability to both understand information and appreciate consequences. She needed to be able to concentrate and process information, neither of which she was able to do.

Dr. Young's discussions with G's children other than MG were that their mother G would not have wanted to prolong her life without a realistic hope for a meaningfully recovery, which he said did not exist. He said that MG wanted her mother's life prolonged.

Dr. Young described his view of well being as dealing with quality of life issues, such as pursuing one's ordinary activities, ability to interact with others, caring for one's self. In his opinion, Option A would be peaceful and compassionate for G, and she would not suffer. Option B, in Dr. Young's opinion would lead to a risk of a number of likely complications, would not be an attractive choice and would not improve G's well being. G would remain as incapacitated as she was currently and based on his experience that would be distressing to her family.

MG was her mother's attorney for personal care, appointed by G pursuant to a standard form Power of Attorney for Personal Care dated July 13, 2005. MG said that she had been involved in her mother's care since July 2005. MG said her mother enjoyed outings to the mall and doing things. In MG's opinion, her mother would still want to live "because of the way she was". MG said she visited her mother daily and felt G was much more alert during the week prior to the Hearing with more eye contact more swallowing and tracking of the TV.

MG said that on January 6, 2009 G had a yearly review at the nursing home. At that time the issue of resuscitation had been raised by the doctors. Her wish at that time was to receive full resuscitation measures. MG said G was adamant that she wanted a full Code 4, for full resuscitation, that she did not want to go down one Code level. MG acknowledged however, that there was never any discussion with G about her having a third stroke of the devastating nature of the one she recently suffered, and what her wishes would be in that circumstance. MG said however that her mother had always adapted to any disability she had. MG believed that her mother would still want to live because she always appreciated living.

MG said she did not question the doctor's diagnosis. She did however question the prognosis because she felt there was a little bit of "hope". She accepted that G would "not be able to go to the mall again". MG said that her mother was not in the same condition after her most recent stroke as she had been prior to the stroke. MG also said she never went into things extensively with her mother about her wishes and never had a conversation with her mother about her wishes should she become quadriplegic or as MG put it "went into a vegetative state" or was "pretty much gone" as she was presently.

MG said she believed that people who had strokes could rehabilitate. However, she had not checked out the kind of stroke her mother recently had. MG said she wanted the Option B, extension of life option. MG agreed that her mother was not capable of making her own treatment decisions, because she was not conscious and could not be communicated with. She did not think the blinking communication system used to try and communicate with G was working. In terms of her siblings, MG said they visited G, but not that often. She said they were there for special occasions. They did not work their lives and their plans around G and she did.

JE, another of G's children said her relationship with G was a mother-daughter relationship. They loved each other and her mother taught "life lessons". She recalled when G's mother was dying after a stroke many years ago that G said she never wanted to be put in a situation of lingering. JE said that all of G's children except for MG were in agreement with Option A proposed by Dr. Butler, that no one wanted their mother to suffer. All preferred to see G die with dignity with all her children around her. JE believed that MG was making decisions in her own best interests not their mother's best interests.

SH, another daughter said she had a good relationship with G. She also never heard her mother express any wishes about the treatment she wanted if she ever suffered a devastating stroke such as the one she recently suffered. SH said MG believed that a person's every breath was important.

SG, G son's confirmed that all of G's children except for MG supported treatment Option A. He said he had a close relationship with his mother and agreed with sisters SH and JE that G never expressed a wish to prolong her life. He said that as far as he was concerned his mother would not want life support maintained in her current state. He believed that MG did not want to withdraw life support for their mother because G was MG's "whole life."

G's counsel questioned her in her room. He asked her to move her left foot in response to multiple choices questions posed. She was (i) given a choice of three years and asked to express her birth year, without response; (ii) given a choice of three children and asked to express which one was her attorney, without response; (iii) given a choice of her age, without response; and (iv) given a choice of three months as asked for the current month, and moved her foot to the word January.

Letters were also filed as Exhibits from two of G's other sons, CG and MG, both of whom supported Dr. Butler's recommended treatment, Option A.

THE LAW

General

The onus is always on the health practitioner at a Board Hearing to prove his or her case. The case must be proved on a civil balance of probabilities. In order for the Board to find in favour of the health practitioner, it must hear cogent and compelling evidence in support of the health practitioner's case. The patient appearing before the Board does not have to prove anything; the onus being entirely on the health practitioner. The Board may consider both direct and hearsay evidence, although hearsay must be assigned only that weight which is appropriate to it in the circumstances.

Incapacity with Respect to Treatment

The *Health Care Consent Act, 1996* states that a health practitioner who proposes a treatment for a person shall ensure that it is not administered unless, he or she is of the opinion that the person has given consent; or he or she is of the opinion that the person is incapable with respect to the treatment, and another person has given consent in accordance with the *Health Care Consent Act, 1996.*

A person is capable with respect to a treatment if the person is able to understand the information that is relevant to making a decision concerning the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

The test for capacity is set out in Section 4(1) of the *Health Care Consent Act, 1996* which states that a person is capable with respect to treatment if the person is able to understand the information that is relevant to making a decision about the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

The section goes on to say that a person is presumed to be capable with respect to treatment and that a person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment.

Section 2 of the *Health Care Consent Act* in part reads as follows:

> "plan of treatment" means a plan that,
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> (a) is developed by one or more health practitioners,

(b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and

(c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition; ("plan de traitement")

"treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other

health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan,

but does not include,

(a) the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the *Substitute Decisions Act, 1992* of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,

(b) the assessment or examination of a person to determine the general nature of the person's condition,

(c) the taking of a person's health history,

(d) the communication of an assessment or diagnosis,

(e) the admission of a person to a hospital or other facility,

(f) a personal assistance service,

(g) a treatment that in the circumstances poses little or no risk of harm to the person,

(h) anything prescribed by the regulations as not constituting treatment. ("traitement") 1996, c. 2, Sched. A, s. 2 (1); 2000, c. 9, s. 31.

Section 5 of *Health Care Consent Act* read as follows:

Wishes

5. (1) A person may, while capable, express wishes with respect to treatment, admission to a care facility or a personal assistance service. 1996, c. 2, Sched. A, s. 5 (1).

Manner of expression

(2) Wishes may be expressed in a power of attorney, in a form prescribed by the regulations, in any other written form, orally or in any other manner. 1996, c. 2, Sched. A, s. 5 (2).

Later wishes prevail

(3) Later wishes expressed while capable prevail over earlier wishes. 1996, c. 2, Sched. A, s. 5 (3).

Sections 21 and 37 of the *Health Care Consent* Act read as follows:

21. (1) A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles:

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.
2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.

21.(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;

(b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1) ; and

(c) the following factors:

1. Whether the treatment is likely to,
   - i. improve the incapable person's condition or well-being,
   - ii. prevent the incapable person's condition or well-being from deteriorating, or
   - iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

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. 1996, c. 2, Sched. A, s. 37 (1).

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. 1996, c. 2, Sched. A, s. 37 (2).

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. 1996, c. 2, Sched. A, s. 37 (3).

Directions

(4) If the Board determines that the substitute decision-maker did not comply with section 21, it may give him or her directions and, in doing so, shall apply section 21. 1996, c. 2, Sched. A, s. 37 (4).

Time for compliance

(5) The Board shall specify the time within which its directions must be complied with. 1996, c. 2, Sched. A, s. 37 (5).

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). 1996, c. 2, Sched. A, s. 37 (6).

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. 2000, c. 9, s. 35.

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. 2000, c. 9, s. 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. 2000, c. 9, s. 35.

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. 1996, c. 2, Sched. A, s. 37 (7).

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 consent to treatment proposed by a health practitioner unless the person's capacity to consent to such treatment has been determined by the Board within the previous six months. 2000, c. 9, s. 36.

Conway v Jacques 2002 CanLII 41558 (ON C.A.), (2002), 59 O.R. (3d) 737, was an appeal from the Consent and Capacity Board in which the Court of Appeal discussed the principles for substitute consent to treatment. The case addressed psychiatric medication rather than end of life decision-making. Justice Sharpe's analysis is on point and binding:

> "[30] Ontario's *Health Care Consent Act*, 1996 is the legislature's response to the successful *Charter* challenge in *Fleming*. The Act requires close attention to the patient's wishes by those who make

> treatment decisions on the patient's behalf. The wishes of the patient are to be considered by the substitute decision-maker at two stages under the Act: 1) in acting in accordance with a prior capable wish applicable to the circumstances pursuant to s. 2 1 (1) 1; and 2) in determining the incapable person's best interests pursuant to s. 2 1 (2) where there is no prior capable wish applicable to the circumstances.
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> [31] At the first stage, the substitute decision-maker must act in accordance with a wish expressed while capable that is applicable to the circumstances. However, I agree with the appeal judge that prior capable wishes are not to be applied mechanically or literally without regard to relevant changes in circumstances. Even wishes expressed in categorical or absolute terms must be interpreted in light of the circumstances prevailing at the time the wish was expressed. As Robins J.A. held in *Fleming* at p. 94:
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>> In my view, no objection can be taken to procedural requirements designed to determine more accurately the intended effect or scope of an incompetent patient's prior competent wishes or instructions. As the Act now stands, the substitute consent-giver's decision must be governed by wishes which may range from an isolated or casual statement of refusal to reliable and informed instructions based on the patient's knowledge of the effect of the drug on him or her. Furthermore, there may be questions as to the clarity or currency of the wishes, their applicability to the patient's present circumstances, and whether they have been revoked or revised by subsequent wishes or a subsequently accepted treatment program.
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> [32] At the second stage, the substitute decision-maker must decide whether or not to consent to treatment on the basis of the best interests test under s. 21 (2). Under s. 21 (2) (b), the substitute decision-maker must take into account "any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under s. 21 (l) 1 ", namely any wishes that are not prior capable wishes applicable to the circumstances. It is only at the second stage that the Act allows for consideration of the decision the patient would have made in light of changed circumstances.
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> [33] The appeal judge held that the Board failed to consider whether Paul Conway would have consented to the anti-psychotic medication suggested by Dr. Jacques if he had been capable of giving or refusing consent. In my respectful opinion, that is not the test mandated by the Act for determining whether a prior capable wish is applicable to the circumstances. To require the substitute decision-maker or the Board to consider what the incapable person would have decided in light of changed circumstances would replace the two-stage test mandated by the Act with a different test that is not supportable under the language of the Act. Paul Conway's prior capable wish was either applicable to the circumstances or not applicable to the circumstances. If a prior capable wish is not applicable to the circumstances, the question for the substitute decision-maker is not what the patient would have decided in light of the change, but rather what is in the best interests of the patient. I would therefore reject the analysis of the appeal judge and his conclusion that the Board erred in law and failed to make a crucial factual finding”.

M., A. v. Benes, 1999 CanLlI 3807 (ON C.A.), (1999), 46 O.R. (3d) 271 was another Court of Appeal decision on appeal from the Consent and Capacity Board. The case involved psychiatric treatment but also contains general principles applicable to any review by the Board of treatment decisions made by substitute decision-makers.

> “[42] An S.D.M. does not stand in the shoes of an incapable person at least on questions of consent to treatment. The S.D.M. is important but only as part of a statutory regime which, by its terms, tries to respect an incapable person’s well-being and dignity where that person’s consent or refusal to treatment cannot be established.
>
> [45] Values, beliefs and non-binding wishes are not the only elements of the best interests test. The likely effect of the proposed treatment is a key element as well. The S.D.M. is not likely to have special knowledge about the possible effects of medical treatment and thus, as a general rule, must rely on the expertise of the treating health practitioner.
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> [46] A case will come before the Board only when the health practitioner disagrees with the S.D.M.'s application of the best interests test under s.21 (2). The Board will then have before it two parties who disagree about the application of s.21: the S.D.M., who may have better knowledge than the health practitioner about the incapable person's values, beliefs and non-binding wishes; and the health practitioner, who is the expert on the likely medical outcomes of the proposed treatment. The disagreement between the S.D.M. and the health practitioner potentially creates tension and the Act recognizes this by providing for a neutral expert board to resolve the disagreement. Indeed, after hearing submissions from all parties, the Board is likely better placed than either the S.D.M. or the health practitioner to decide what is in the incapable person's best interests. Thus, the Board should not be required to accord any deference to the S.D.M.'s decision.”

Scardoni v. Hawryluck, 2004 CanLII 34326 (ON S.C.), (2004), 69 O.R. (3d) 700 was another appeal from the Consent and Capacity Board. Justice Cullity made these observations about the Board's interpretation of the phrase, "well-being”.

> “[45] A question of statutory interpretation that was more directly in issue in the appeal concerned the meaning of the word "well-being" in section 21 (2) (c) of the Act. The interpretation accepted by the Board was central to its finding that further treatment in the intensive care unit was not in Mrs. Holland's best interests. At page 20 of its Reasons for Decision, the Board stated:
>
>> “We thought "well-being" involved more than mere life itself. The phrase is subjective as used because it was used in conjunction with the word "condition," which connoted to us a more objective assessment of the status of a person's illnesses and physical situation. "Well-being" includes considerations such as the person's dignity and levels of pain”.
>
> [46] This interpretation was challenged by Ms Chan who submitted that matters that are to be considered relevant to the well-being of a patient were intended to be confined to those relating to her health. In her submission, the Board erred in law in taking into consideration evidence with respect to Mrs. Holland's quality of life and, particularly, that of the discomfort and indignity she had

experienced in undergoing treatment in the intensive care unit and would experience again if she was returned there.

[47] The phrase "quality of life" is used in other sections of the Act in connection with decisions with respect to an incapable person’s best interests. It does not appear in the section relating to consent to treatment. Whether or not the considerations on which the Board relied are aptly encapsulated by the phrase, I am satisfied that the Board's interpretation of the reference to the "well-being" of a patient is to be preferred to the more narrow definition that Ms Chan urged me to accept.

[48] The interpretation accepted by the Board is supported by dictionary definitions of wellbeing that refer to a person's state of happiness, contentment and prosperity as well as good health: see for example, the New Oxford Shorter Dictionary; Random House Unabridged Dictionary; and Nelson's Canadian Dictionary of the English language. Generally, the dictionaries treat the term as synonymous with "welfare". Similarly, in *IR.C.* v. *Baddeley*, [1955] A.C. 572 (H.L.), at page 616, Lord Somervell of Harrow referred to a person's "wellbeing" as meaning "a happy or contented state".

[49] Finally, in *Janzen* v. *Janzen* (2002), 44 E T. R. 217 (SC.J.) in which the interpretation of section 21 (2) of the Act was considered in the context of competing applications for appointment as an incapable person's guardian of the person, Aitken J stated:

> “Treatment in the form of a ventilator, medications and periodic heroic interventions as required might improve other medical conditions suffered by Mr. Janzen, such as pneumonia or kidney or heart failure; but according to the medical evidence it would not improve Mr. Jansen's *(sic)* quality of life. I consider the concept of "well-being" a very broad concept which encompasses many considerations, including quality of life. Many of the interventions contemplated as being necessary to prolong Mr. Janzen's life involve procedures that could be painful or uncomfortable for Mr. Janzen. Maria Janzen's guardianship plan focuses on keeping Mr. Janzen comfortable and pain-free. I find that this focus will improve his overall well-being.”

[50] I accept that interpretation and find no error of law in the Board's conclusion on the meaning of “well-being” in the Act.”

ANALYSIS

We carefully carried out our statutory responsibility, considered and reviewed the evidence, submissions, and the law, including the criteria set out in the applicable legislation.

The main application before the Board was the Form G brought pursuant to the *Health Care Consent Act*. Dr. Butler a health practitioner applied for a determination as to whether or not MG as her mother’s substitute decision maker complied with the principles for substitute decision making as set out in the *Health*

Care Consent Act with respect to the proposed treatment. Throughout our deliberations, we imposed the onus of proof upon Dr. Butler. That onus was on a balance of probabilities.

By statute this type of application triggered an application by G with respect to her own capacity to consent to the proposed treatment unless that capacity had been determined by the Board within the previous six months. There was no evidence of any such prior determination. We found the Board had jurisdiction in this matter.

The general law relating to capacity to consent to treatment is set out in the *Health Care Consent Act* (HCCA). That legislation also sets out a scheme for identifying substitute decision makers (SDM's) for incapable persons. It also described how SDM's should make decisions and the available options should SDM's not be making proper decisions.

The Purposes of the HCCA are set out at its very beginning. These include providing rules with respect to consenting to treatment, facilitating treatment for incapable persons, enhancing the autonomy of persons for whom treatment is proposed and promoting communication and understanding between health practitioners and their patients.

Furthermore, the HCCA in Section 2 requires that a health practitioner <u>must</u> (emphasis mine) determine whether a person is capable to consent to treatment. The HCCA also provided that all health practitioners must be members of their respective professional colleges in Ontario. Physicians are included as health practitioners.

As noted earlier the test for capacity is set out in Section 4(1) of the HCCA as follows:

> 4. (1) Capacity – a person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.
> (2) Presumption of capacity – a person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services.
> (3) Exception – a person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission or the personal assistance service, as the case may be.

There is a presumption of treatment capacity on which a person is entitled to rely unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment.

By Section 15(1) and (2) capacity can fluctuate and capacity also can vary over time and in relation to the type of treatment. The determination of capacity is therefore issue and time specific. The health practitioner must look at the specific treatment or plan and determine whether the person is capable for the particular treatment.

In the event that a person has been found incapable, a substitute decision maker may give consent to treatment on behalf of the incapable person. Section 16 of the HCCA provides that if the incapable person becomes capable, the person's own decision to give or refuse consent to treatment prevails.

Starson v Swayze (2003) SCC 32 is the leading case in relation to the law on consent to treatment in Ontario. As set out earlier, Section 4(1) of the HCCA provides a two part test to determine whether a person is capable with respect to a treatment.

Justice Major wrote the majority opinion for the Supreme Court in the Starson decision. He commented upon the onus of proof required to displace the statutory presumption of capacity at paragraph 77: "I agree with the Court of Appeal that proof is the civil standard of a balance of probabilities."

Chief Justice McLachlin, who wrote the dissent, agreed on this point. At paragraph 13, she wrote, "the person is presumed to be competent and the standard of proof for a finding of incapacity is a balance of probabilities."

Justice Major analyzed capacity at paragraph 78 of the Starson decision as follows:

> "Capacity involves two criteria. First, a person must be able to understand the information that is relevant to making a treatment decision. This requires the cognitive ability to process, retain and understand the relevant information. Second, a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one. This requires the patient to be able to apply the relevant information to his or her circumstances, and to be able to weigh the foreseeable risks and benefits of a decision or lack thereof.

> Before turning to an analysis of the reviewing judge's decision, two important points regarding this statutory test require comment. First, a patient need not agree with the diagnosis of the attending physician in order to be able to apply the relevant information to her own circumstances. Psychiatry is not an exact science, and "capable but dissident interpretations of information" are to be expected. While a patient need not agree with a particular diagnosis, if it is demonstrated that he has a mental "condition", the patient must be able to recognize the possibility that he is affected by that condition. Professor Weisstub comments on this requirement as follows (at p. 250, note 443):
>
> Condition refers to the broader manifestations of the illness rather than the existence of a discrete diagnosable pathology. The word condition allows the requirement for understanding to focus on the objectively discernible manifestations of the illness rather than the interpretation that is made of these manifestations.
>
> As a result, a patient is not required to describe his mental condition as an "illness", or to otherwise characterize the condition in negative terms. Nor is a patient required to agree with the attending physician's opinion regarding the cause of that condition. Nonetheless, if the patient's condition results in him being unable to recognize that he is affected by its manifestations, he will be unable to apply the relevant information to his circumstances, and unable to appreciate the consequences of his decision.
>
> Secondly, the Act requires a patient to have the ability to appreciate the consequences of a decision. It does not require actual appreciation of those consequences. The distinction is subtle but important… In practice, the determination of capacity should begin with an inquiry into the patient's actual appreciation of the parameters of the decision being made: the nature and purpose of the proposed treatment; the foreseeable benefits and risks of treatment; the alternative courses of action available; and the expected consequences of not having the treatment. If the patient shows an appreciation of these parameters-regardless of whether he weighs or values the information differently that the attending physician and disagrees with the treatment recommendation – he has the ability to appreciate the decision he makes.
>
> However, a patient's failure to demonstrate actual appreciation does not inexorably lead to a conclusion of incapacity. The patient's lack of appreciation may derive from causes that do not undermine his ability to appreciate consequences. For instance, a lack of appreciation may reflect the attending physician's failure to adequately inform the patient of the decision's consequences. Accordingly, it is imperative that the Board inquire into the reasons for the patient's failure to appreciate consequences. A finding of incapacity is justified only if those reasons demonstrate that the patient's mental disorder prevents him from having the ability to appreciate the foreseeable consequences of the decision."

As Justice Day stated in Neto v Klukach [2004] O.J. No. 394 at paragraphs 10-13:

> "Chief Justice McLaughlin, in her dissenting judgment (but not dissenting on this point) quoted with approval three common indicators of a person's ability to meet the second branch of the test, set out by commentators such as B.F. Hoffman in The Law of Consent to Treatment in Ontario (2nd ed. 1997), at p. 18. One indicator is whether the person is able to acknowledge the fact that the condition for which treatment is recommended may affect him or her. A second indicator is whether the person

is able to assess how the proposed treatment and alternatives, including no treatment could affect his or her quality of life. A third indicator is whether the person's choice is substantially based on a delusional belief.

In determining capacity, the court in Starson cautioned that capable individuals have the right to take risks and are presumed free to make decisions that are considered unreasonable. The test is not whether the choice by the patient appears reasonable or wise, but whether the patient is capable, within the meaning of the statute, of making the decision. The Board is not to inject its own personal values, judgments, and priorities into the process. As Justice Harris stated in Bartoszek v Ontario (Consent and Capacity Board), [2002] O.J. No. 3800 (S.C.J.) at para 20, "It is mental capacity, not wisdom, that is at issue here. The appellant, Mrs. Bartoszek carries with her, like all citizens, the right to be wrong".

In addition, the court in Starson held that the Board must avoid the error of equating the presence of a mental disorder with incapacity. People who have mental disorders are perhaps most at risk of having their personal autonomy overridden by the likely unconscious imposition of value judgments. It is easy to conclude that if a person chooses a course of treatment, which appears to be reasonable and wise, then the person is capable; whereas, if a person chooses treatment that doctors consider to be contrary to the best interests of the patient, or even patently unwise, then the person is incapable. Those with mental illness are perhaps most vulnerable to having their experiences with reactions to medications and personal views regarding treatment options not taken seriously, but instead attributed to the mental illness itself, if contrary to what is considered conventional wisdom.

Adjudicators however must take pains to avoid such conclusions. The reasonableness of the patient's wishes, or the patient's best interest, should not be the basis of a judicial finding, as this would treat persons with mental illnesses as person with lesser states. The Court of Appeal in Fleming v Reid (1991), 82 D.L.R. (4th) 298 at 311 stated that:

> "Mentally ill persons are not to be stigmatized because of the nature of their illness or disability; nor should they be treated as persons of lesser status or dignity. Their right to personal autonomy and self-determination is no less significant, and is entitled to no less protection, than that of competent persons suffering from physical ailments."

Indeed, the court in Fleming held at 312 that:

> "The common law right to bodily integrity and person autonomy is so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order of protection. This right forms an essential part of an individual's security of the person and must be included in the liberty interests protected by s. 7 [of the Charter]".

Did the evidence establish that G was unable to understand the information relevant to making a decision about the treatment in question?

G was an eighty one year old woman recently admitted to hospital following a third stroke, medically described by her physician as devastating. Prior strokes had resulted in paralysis to the left side of her body.

The most recent stroke paralyzed the right side of G's body. G could open her eyes to voice, tracks movements with her eyes and intermittently obeys simple one step commands. Repeated attempts to communicate with G by setting up a system of blinks or toe movements have been unsuccessful. The opinions of Dr. Butler, G's attending physician, and Dr. Young, the consulting neurologist were that G's massive recent stroke has left her with an acute cognitive dysfunction, and that she was delirious. According to the physicians this has precluded the establishment of an effective communication system with G. In their opinions, G's functional capacity was unlikely to improve. She was left a quadriplegic. How does the health practitioner in this case assess capacity concerning any proposed treatment? Dr. Butler's evidence noted that many attempts have been made to establish communication with G using a simple system of blinks. However, when this was done, and the Board observed attempts by G's counsel to utilize such a simple system, G was not able to either respond or provide correct responses to simple questions.

Dr. Butler's opinion was that the inability to set up even a simple form of communication with G was evidence she did not have the cognitive ability to understand information about her treatment or the consequences of any treatment decisions. In his opinion G failed both parts of the two part test for treatment capacity.

What considerations did we need to examine to determine this issue on a balance of probabilities for each of the two parts of the test for capacity? We also had to remember that there was a presumption G was capable unless Dr. Butler had reasonable grounds to believe that G was incapable (S4 (3) (HCCA). Dr. Butler had the onus of satisfying the Board on a balance of probabilities that G was incapable.

In terms of the first branch of the test for capacity and the Supreme Court of Canada's decision in Starson what considerations should be utilized to determine whether or not someone is incapable? The Supreme Court of Canada in Starson (paragraph 78) says that the ability to understand relevant information required that G had the cognitive ability to process, retain and understand the relevant information. We found there was no evidence G had such cognitive ability. Furthermore, the medical evidence which we found was not challenged or contradicted was such that G's ability was affected by her recent massive stroke and the consequences to her of that stroke, including the delirium. In our further examination of the first branch of the test we examined the statutory phrase "relevant information".

Starson directs (paragraph 80) that “in practice the determination of capacity should begin with an inquiry into the patient’s actual appreciation of the parameters of the decision being made:

- The nature and purpose of proposed treatment
- The foreseeable benefits and risks of treatment
- Alternative courses of action available
- Expected consequences of not receiving treatment”

We found G was unable to both communicate and understand that her recent devastating stroke and consequential delirium impaired her ability to understand information relevant to treatment decisions, in particular the treatment option (Option A) proposed by Dr. Butler.

We found G was not able to understand information that is relevant to making a decision about the treatment proposed by Dr. Butler. On the basis of this first part of the test, G was not capable with respect to the treatment proposed by Dr. Butler.

Did the evidence establish that G was unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision about the treatment in question?

In Dr. Butler’s opinion G failed this part of the test for the same reasons she failed the first part of the test for capacity.

Neto v. Klukach, [2004] O.J. No. 394, was a decision of Day, J. of the Ontario Superior Court of Justice dated February 10, 2004. In that decision, which was an appeal of a decision of this Board, the Court explained the second branch of the test for capacity (i.e. the ability to appreciate consequences) in light of *Starson*, as follows:

The second branch assesses the ability to evaluate, not just understand, information. The patient must have an ability to appreciate the relevant information as it relates to him or her.

The evidence we received supported conclusions of Dr. Butler and Dr. Young that G was incapable with respect to the proposed treatment. G was unable to communicate and therefore lacked the ability to appreciate she was in fact suffering from manifestations of and the devastating consequences of her stroke.

She was unable to evaluate information concerning the proposed treatment as it related to her own circumstances, a fact which rendered her incapable to make a decision concern her treatment.

The evidence to support a finding of incapacity was clear, cogent and compelling. G had no comprehension about her need for treatment because she was unable to communicate, concentrate or focus. G's lack of insight into her condition rendered her unable to appreciate the information relevant to making a decision and appreciate the consequences of a decision or lack of decision. As a result of her inability to recognize she suffered from the stroke, delirium and then devastating effects of the stroke on her, G also lacked the ability to appreciate the consequences or a treatment decision.

The legal consequence of G being incapable of making her own treatment decisions meant that consent may be given or refused on her behalf by a person described in Section 20 of the *Health Care Consent Act*. G as the incapable person had an attorney for personal care, her daughter MG, appointed by G pursuant to a standard form Power of Attorney for Personal Care dated July 13, 2005. The document did not contain conditions or restrictions, or any specific instructions.

In a case where a substitute decision-maker (SDM) consents to treatment on an incapable person's behalf and the health practitioner is of the opinion that the SDM did not comply with S21 (HCCA), the health practitioner may apply to the Board. This was the Form G application before us in this case. In determining whether the SDM complied with s.21, the Board may substitute its opinion for that of the substitute decision-maker. If the Board determines that the SDM did not comply with s.21, it may give him or her directions, applying s.21 (s.37 (4)). The Board is required to specify the time within which the direction must be complied with. If the SDM does not comply with the Board's directions within the time specified by the Board, he shall be deemed not to meet the requirements of ss.20 (2) (s.37 (6)). If under ss.(6), the SDM is deemed not to meet the requirements of ss.20(2), any subsequent SDM shall, subject to ss.(6.2) and (6.3), comply with the directions given by the Board on the application within the time specified by the Board (s.37(6.1)).

In *Conway v. Jacques*, [2002] O.J. No. 2333 (Ont.C.A.), rev'g (2001), 32 Admin.L.R.(3d) 248 (S.C.J.), leave to appeal to S.C.C. refused [2002] S.C.C.A. No. 341, the respondent's treating psychiatrist brought an application to determine whether the SDM (the respondent's mother) complied with the statutory principles for substitute decision-making under the HCCA. The respondent, who was found guilty by reason of insanity for using a weapon while committing a sexual assault in 1984, had been detained in psychiatric facilities since that time. The respondent denied that he was mentally ill and refused to accept anti-psychotic medication. In 1996, the respondent was found incapable of giving or refusing consent to psychiatric medication. His SDM refused to consent to the recommended anti-psychotic medication on the basis that the respondent refused to consent to other anti-psychotic medication while capable. The CCB found that the SDM had not complied with s.21 of the HCCA and held that the wish expressed by the respondent while he was capable was not applicable to the circumstances because his condition had deteriorated and the medication now available was more effective and had fewer side effects. The Board concluded that the SDM, in making a decision about consent to treatment, must act in the respondent's best interests. The respondent and his SDM successfully appealed to the Superior Court, which held that the Board's decision was unreasonable given the respondent's consistent refusal to consent to anti-psychotic medical while capable of giving or refusing consent. The psychiatrist appealed to the Court of Appeal.

The Court of Appeal held that the Board's decision that the respondent's wish was not applicable to the circumstances was reasonable in fact and law. The court stated (at para. 28):

> "Substitute decision-making concerning medical treatment affects fundamental rights long recognized by the common law and now protected by the *Canadian Charter of Rights and Freedoms.* The right to decide whether to accept or refuse invasive medical treatment is fundamental to an individual's bodily integrity and personal autonomy".

In Conway the Court of Appeal referred to the decision in *Fleming v. Reid* (1991), 4 O.R.(3d) 74 (C.A.) where the court struck down the legislation allowing the SDM to consent to treatment as being in the patient's best interests without regard to the patient's prior wishes and without a right to a hearing. The court noted that the HCCA was a response to this case. In the HCCA, the wishes of the patient are to be considered by the substitute decision-maker at two stages: 1) in acting in accordance with a prior capable wish applicable to the circumstances pursuant to s.21 (1); and 2) in determining the incapable person's best interests pursuant to s.21 (2) where there is no prior capable wish applicable to the circumstances.

In reference to the first stage, the court agreed with the appeal judge that prior capable wishes are not to be applied mechanically or literally without regard to changes in circumstances. The court also noted that even wishes expressed in categorical or absolute terms must be interpreted in light of circumstances prevailing at the time the wish was expressed. In considering the second stage based on the best interests test under s.21(2), the court noted that it was only at this point that the HCCA allowed for consideration of the decision the patient would have made in light of changed circumstances. The court held that the lower court had not applied the correct test for determining whether a prior capable wish was applicable to the circumstances. The lower court held that the Board failed to consider whether the respondent would have consented to the anti-psychotic medication suggested by the doctor if he had been capable of giving or refusing consent. Sharpe J.A. stated (at para. 33):

> “To require the substitute decision-maker or the Board to consider what the incapable person would have decided in light of changed circumstances would replace the two-stage test mandated by the Act with a different test that is not supportable under the language of the Act. Paul Conway’s prior capable wish was either applicable to the circumstances or inapplicable to the circumstances. If a prior capable wish is not applicable to the circumstances, the question for the substitute decision-maker is not what the patient would have decided in light of the change but rather what is in the best interests of the patient.”

Sharpe J.A. found that it was open to the Board to conclude that the respondent’s prior capable wish was not applicable to the circumstances. The Board considered that the respondent did occasionally consent to medication for his symptoms while capable of giving or refusing consent. The Board considered that the respondent’s psychiatric condition deteriorated from the time he expressed his prior capable wish. The Board considered that the nature of the anti-psychotic medication had radically improved. In addition, the Board considered that the respondent’s refusal to consent to chemical treatment was fuelled by his denial that he suffers from mental illness. The court noted that the respondent’s SDM was not entitled to make a decision on the basis of the respondent’s views of his own mental health and it was open to the Board to find that the SDM had failed to base her substitute decision refusing treatment on the best interests test under s.21(2) of the Act. Sharpe J.A. noted that the question before the court was not how the Court of Appeal would decide the issue but whether the Board’s decision was unreasonable. Sharpe J.A. held that it was not unreasonable for the Board to conclude that the respondent’s prior capable wish was not applicable in the circumstances.

In *(M.)A. v. Benes* (1999), 46 O.R. (3d) 271 (C.A.), the Court of Appeal held that the Board did not have to defer to a decision of an SDM just because it was made in “good faith and was reasonable.” The Board had the right to review a decision by the SDM in the absence of prior expressed wishes by the incapable person. The SDM refused treatment against the recommendation of the incapable person’s physician and the physician then applied pursuant to s.37 for a review of the decision. The Board found that the SDM had not complied with s.21 of the HCCA and ordered that she consent to the recommended treatment. The SDM appealed arguing that s.37 was unconstitutional because it violated the incapable person's rights under s.7 of the *Charter*. For other reasons, the court held that the section was unconstitutional. The finding was appealed to the Court of Appeal by the Attorney General of Ontario. The SDM argued that as long as the SDM's decision was made in good faith and was reasonable, the CCB should defer to that decision. However, the Court of Appeal disagreed with this argument stating that the standard of "good faith and reasonableness" did not adequately protect the *Charter* interests of the incapable person.

The court made this decision based on the following reasons: the SDM is not always chosen by the incapable person (sometimes authority is conferred by statute) so the SDM might not always know the incapable person's beliefs, values, and non-binding wishes any better than the Board; the "best interests" test involves more than looking at the values, beliefs, and non-binding wishes of the incapable person (the effects of proposed treatments must be considered and this may be best dealt with by a medical expert – the job of the CCB is to resolve tension between the SDM and the medical expert); the HCCA does not require an SDM to follow particular procedural guidelines in making a decision under s.21 but the Board must follow procedural guidelines. The CCB was able to substitute its decision to authorize treatment for the SDM's decision to refuse treatment, even though the SDM was acting in good faith.

The Board found that MG was a person who gives or refuses consent on behalf of G, an incapable person. MG was obliged to follow the principles set out in Section 21 of the *Health Care Consent Act.*

No previously expressed wishes applicable to G's Circumstances

We accepted the unchallenged medical evidence that G had no realistic chance of recovery from a third and devastating stroke. We found that G had not previously expressed a wish applicable to her circumstances as at the Hearing. While there was some evidence that G valued life in general there was absolutely no evidence of her prior consideration of the affects of a devastating third stroke. Mg's statement that her mother would want to live "because of the way she was" extremely vague. Not one of her children, not even the SDM, MG was aware of a prior wish that could consider applicable to the circumstances.

As Justice Sharpe said at paragraph 31 in *Conway* v. *Jacques,* cited above,

> "However, I agree with the appeal judge that prior capable wishes are not to be applied mechanically or literally without regard to relevant changes in circumstances. Even wishes expressed in categorical or absolute terms must be interpreted in light of the circumstances prevailing at the time the wish was expressed".

The comments attributable to G were not precise and lacked particularly. There was no evidence of statements meant that she should be kept alive despite any levels of pain, loss of autonomy or personal dignity. G's comment in January of wanting Level 4 resuscitation did not consider the possibility of the devastating stroke she subsequently suffered. We found no evidence G had her current circumstances in mind when she made any of those comments. Holding that her statements are applicable to her devastating current circumstance would be too mechanical or literal application of her words with complete disregard for changes in her circumstances.

We therefore found that MG did not know of a wish applicable to the circumstances that G expressed while capable and after attaining sixteen years of age. MG was obliged to act in G's best interests as defined in S.21 (2) of the *Health Care Consent Act*. That meant that in deciding what G's best interests are, MG as the person who gives or refuses consent on her behalf shall take into consideration the factors set out in S. 21(2).

Best Interests

The Board applied the factors set out in s. 21 (2) (c) of the *Health Care Consent Act* to G's circumstances to determine her best interests. The absence of previously expressed capable wishes applicable to G's circumstances as at the Hearing meant we had to determine consent based upon G's best interests, in light of Justice Sharpe's observations in this regard at paragraph 33 in *Conway v Jacques*. It did not mean we would determine what G would do in those circumstances. We also noted that G's values and beliefs were only one of the factors to be considered in assessing her best interests. Given MG's position including that to her life meant "hope", that she would not consent to Option A and discontinuing of life support we were in a better position that MG to determine G's best interests as recognized by the Court of Appeal in *Benes*.

MG was asked about G's values and beliefs that she knew G held when capable and believes she would still act on if capable. MG said her mother would have wanted everything done that was possible to do based on her instruction in the nursing home for Level 4 resuscitation. MG said her mother enjoyed doing things and would still want to live because of the way she was. MG said her belief was that life meant "hope".

MG did not provide the Board with any of G’s specific values and beliefs that she knew her mother held when capable and believed she would still act on if capable. The comments provided by MG that her mother would have wanted everything done that was possible to do were not specific to her current life situation. We found the comments not to be prior capable wishes applicable to the circumstances. If they are put forward as values, we found them to be quite vague to be values. They were certainly not mandatory directions. In addition, we received evidence from G’s other children that their mother would not have wanted to linger in the event of a stroke and that from the perspective of dignity and their knowledge of their mother, she would have preferred no surgical interventions.

Dr. Butler’s proposed treatment plan was a withdrawal of G’s life support. His plan was supported by Dr. Young. They were the only medical opinions we received and we accepted them. The plan avoided the need for any surgical interventions and recognized that well-being involved more that just living, that there were qualitative aspects to it. Both Dr. Butler and Dr. Young noted this plan was the minimally invasive approach to the devastating consequences of the third stroke. If G was able to survive after the ventilator was withdrawn, she was potentially able to return to her former residence with the focus of care provided to G to be comfort only. To that end the proposal was to not provide resuscitative measures should a cardiac arrest occur, and would include withdrawal of the ventilator and removal of the breathing tube. If G breathed comfortably on her own she would continue to receive nutrition and hydration and she could potentially be transferred back to her former home. If, during the process of withdrawing the ventilator or removing the endotracheal tube G could not sustain her breathing adequately, she would be treated with medications to provide optimal palliative care to prevent discomfort, but the life support would be withdrawn and the expectation would be that G would die. The risk of the proposed treatment was that, if G was unable to breathe adequately, she would die during or shortly after the life support is withdrawn.

The alternate plan was to try and extend the duration of G’s life by medical means. This alternate plan required surgical placements of both a tracheostomy tube and a gastrojejunostomy tube. G would receive ongoing hydration and nutritional support and efforts would be made to wean her from the ventilator. Once off the ventilator the tracheostomy and gastrojejunostomy tubes would be permanently required. G would remain dependent for all her care needs. She would remain in hospital while long term placement was sought as it was not possible for her to return to her home with a tracheostomy. She would likely remain in hospital for a considerable period of time of 1-2 years, according to the medical evidence. It was possible to extend the duration of G's life by months, or possibly years, with this approach. She would still be at risk for the development of life threatening infectious complications. The risks associated with this included infections at the site of the tracheostomy stoma and common problems with skin breakdown at the site: a remote risk of death with the procedure, an uncommon risk of bleeding requiring transfusion, an uncommon risk of puncture of the lung requiring a chest tube, and a rare complication of erosion of the tracheostomy into a major artery usually resulting in death. Occasionally the tube can become blocked with secretions. If this is not recognized it can lead to death. The major risk of the gastrojejunostomy tube at insertion is the development of a leak of gastric contents into the peritoneal cavity which rarely requires a surgical procedure to correct. Longer term issues with the tube involve skin breakdown and infection at the site of insertion. The tube would provide a stable access point to provide nutrition to the patient.

The alternative treatment would also involve the placement of a gastrojejunostomy tube. This is a tube inserted into the stomach and passed into the small bowel through a puncture in the abdominal wall. The procedure is done in the radiology department under local anaesthesia.

Both of the (tracheostomy and gastrojejunostomy tube increased the likelihood that G will live for a longer period of time. However, according to the only medical evidence and opinions we received and accepted, those coming from Dr. Butler and Dr. Young, neither of these surgical interventions will improve the overall quality of G’s life nor lessen the disability associated with having had three strokes, the last a devastating one. Both facilitated full care of G if the focus of care was life extension.

The question for us was whether it was in G’s best interests to be kept alive by these means of prolonging or extending her life with surgical interventions, and the likely risk of infections and pain, without hope of recovery? In other words in determining the S.21(2) (c) considerations including G’s well-being in this case we had to consider the invasiveness of the interventions required to extend G’s life, and that these would not, according to the medical evidence improve G’s current condition, resulting from a third stroke.

As the Court of Appeal set out (paragraph 45) in *Benes* values, beliefs and non-binding wishes are not the only elements of the best interests test. The likely affect of the proposed treatment is a key element as well. What impact would withdrawal of life support as set out in Plan A, or the non-provision of it, have upon G’s “condition or well-being?” That term is used in paragraph 21(2) (c) 2 of the Act, “Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.”

In *Scardoni v. Hawryluck*, 2004 CanLII 34326 (ON S.C.), an appeal from a Decision of this Board, Justice Cullity analyzed how the Board interpreted “well-being.” The Board’s used this definition:

> We thought "well-being" involved more than mere life itself. The phrase is subjective as used because it was used in conjunction with the word "condition," which connoted to us a more objective assessment of the status of a person's illnesses and physical situation. "Well-being" includes considerations such as the person’s dignity and levels of pain. (Quoted from Paragraph 45 of Justice Cullity’s Judgment)

Justice Cullity approved of that approach, though he reversed the Board’s decision on other grounds. In this case before us we found “condition” refers to a person’s overall health which can involve many factors. We also found that “well-being” has a broad meaning to an incapable person’s overall situation and quality of life.

In our view G’s well-being included consideration of her dignity and quality in her life. The surgical interventions provided in the alternate plan (Option B) were more detrimental than beneficial in terms of well-being. Put another way not only were the treatment provisions of the alternate plan (Option B) not in G’s best interests, they were not in her interest at all. We found on the evidence that neither of the surgical interventions in Option B, ongoing hospitalization of an 81 year old, and likely infections will improve the overall quality of G’s life nor lessen the disability associated with having had three strokes, the last a devastating one. Both facilitated full care of G if the focus of care was life extension. How was that in G’s best or any interest given her current state? MG based part of her objection to the proposed treatment on hope. We questioned the efficacy of treatment decisions by substitute decision makers for others based on hope, and not experienced medical opinions, when the legal requirement is best interests. One of her siblings described MG as working her life plans around their mother.

G was described by JE as a very intelligent woman who had previously socialized, had liked to read and loved people. More recently according to CG’s written evidence G liked doing crosswords, reading and shopping. In her current condition, G could not perform even simple tasks for herself or communicate.

We found that the evidence supported a finding that G will remain non-communicative, paralysed and completely dependent for her care needs. Furthermore, we agreed with the clear, cogent, and compelling medical evidence that the treatment plan of withdrawal of life support (Option A) was in G’s best interests.

We knew from the medical evidence about the impact of withdrawing life support upon G's condition was that she would likely die within days. Did well-being to G's life simply mean quantity of life and not quality of life? Everyone eventually dies. So the risk is not whether G dies, but when and how she dies and what transpires in the interim. These are some of the factors that must be considered in determining well-being.

The withdrawal of life support and provision of comfort care was less intrusive than the surgeries and the likely infections. These were important factors to consider. To the extent that "well-being" includes considerations of G's dignity and potential for improvement in the quality of her life, we believed the withdrawal of life support was more beneficial. The Board found therefore, that G has not complied with s. 21 of the *Health Care Consent Act* as she did not support the recommended treatment plan.

On the other hand, while the various surgical interventions in Option B would extend G's life, we found it would not provide her with comfort or dignity in that extended state, subject to likely infections. We found that the quality of G's life will further deteriorate with Option B. We concluded that it was more important to die a comfortable dignified death.

We found the benefit G was expected to obtain from the proposed treatment outweighed the risk of negative consequences to her. G's dignity and independence will be respected and she will not likely linger or suffer. We found that the alternative treatment was not a course of action that is less restrictive than the proposed treatment with surgical interventions, and likely infections and is not appropriate in the circumstances.

These are extremely difficult cases. In considering the evidence and law the panel believed on a balance of probabilities that our decision was reasonably supported by the evidence. We recognize that G chose her daughter MG as her attorney for personal care and therefore her substitute decision maker. However we also found that G's best interests would be served by following treatment Option A proposed by Dr. Butler. MG was clearly motivated by her commitment, love and support for her mother and was clearly acting in good faith. However, her mother's condition was "devastating" and MG's plan to extend her mother's life was not in her mother's best interests.

As Justice Aitken in Janzen cited in the Scardoni decision above said:

> “Treatment in the form of a ventilator, medications and periodic heroic interventions as required might improve other medical conditions suffered by Mr. Janzen, such as pneumonia or kidney or heart failure; but according to the medical evidence it would not improve Mr. Jansen's *(sic)* quality of life. I consider the concept of "well-being" a very broad concept which encompasses many considerations, including quality of life. Many of the interventions contemplated as being necessary to prolong Mr. Janzen's life involve procedures that could be painful or uncomfortable for Mr. Janzen. Maria Janzen's guardianship plan focuses on keeping Mr. Janzen comfortable and pain-free. I find that this focus will improve his overall well-being.”

Both Dr. Butler and Dr. Young gave evidence that the recommended treatment (Option A) proposed of G was the option considering G’s well-being. It was clearly the less intrusive of the two plans. We accepted their expert opinion and agreed with them. We also found that withdrawal of the ventilator, removal of the endotracheal tube, the DNR order and providing optimal palliative care medication would be the best way to respect the factors set out in paragraph 21(2)(c) of the HCCA relevant to G’s best interests. This treatment avoided any surgical intervention and was minimally invasive. We found that G’s well-being and dignity were respected with Option A.

RESULT

We confirmed Dr. Butler's finding that G was incapable of giving or refusing consent to the proposed treatment. We also directed MG to consent to withdrawal of G’s life support including withdrawal of ventilator, removal of endotracheal tube, placing of a do not resuscitated (DNR) order in her personal health information record (chart) and use of optimal palliative care medication. We gave her until 5:00 p.m. February 14, 2009.

Dated: February 19th, 2009 ______________________________

Michael Newman
Presiding Lawyer Member