**COURT FILE NO.:** 61165

**ONTARIO**

**SUPERIOR COURT OF JUSTICE**

IN THE MATTER OF an appeal from a decision of the
Consent and Capacity Board
Pursuant to the *Health Care Consent Act,* S.O. 1996 c. 2, Schedule A

AND IN THE MATTER OF
**Phyllis Rose Mary Grover**
a patient at
London Health Sciences Centre – University Hospital, London, ON



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| **B E T W E E N:** | ) | |
| | ) | |
| MARJORIE GROVER | ) | Mark Handelman and Janice E. Blackburn, for the Appellant |
| | ) | |
| Appellant | ) | |
| | ) | |
| **- and -** | ) | |
| | ) | |
| PHYLLIS ROSE MARY GROVER | ) | Jim Szpytman, for the Respondent, Phyllis Rose Mary Grover |
| | ) | |
| Respondent | ) | Julie A. Zamprogna Ballés, for the Respondent, Dr. Ron Butler |
| - and – | ) | |
| | ) | |
| DR. RON BUTLER | ) | |
| | ) | |
| Respondent | ) | |
| | ) | |
| | ) | **HEARD:** April 6, 2009 |

**HOCKIN J.**

**REASONS FOR DECISION**



[1] This is an appeal under s. 80(1) of the *Health Care Consent Act,*1996 from a decision of the Consent and Capacity Board dated February 10, 2009 after a hearing conducted on February 9, 2009 at the University Campus of the London Health Sciences Centre.

[2] The appeal is an appeal of the decision of the Board to require the appellant, Marjorie Grover to consent to the withdrawal of life support, including withdrawal of her ventilator and endotracheal tube from her mother, Mary Grover. Mary Grover is eighty-one years of age and suffered a brainstem stroke on January 22, 2009. At the time of the hearing, she was a patient of the respondent, Dr. R. Butler at this hospital. Marjorie Grover is her substitute decision-maker.

[3] The parties have been diligent and the hearing of this appeal proceeded on an urgent basis seven days ago. The parties and the children of Mary Grover, in the circumstances of this case, deserve the considered view of the court and the timely disposition of the appeal. I have been assisted by counsel by the precision of their facta and their submissions. The medical history of Mrs. Grover and her present medical circumstances are well set out in the facta and the reasons of the Board, delivered February 19, 2009. For my purpose, I need not repeat at length, the evidence. A great deal of the evidence was evidence on the issue of Mrs. Grover's capacity to consent to treatment but that aspect of the Board's decision is not the subject of the appeal.

[4] The record on the appeal included the transcript of the hearing before the Board on February 9, 2009, the reasons for decision of the Board, and at the behest of the appellant, a three page document entitled McCormick Home Health Care Directive. There was no objection to the receipt of the document and in any event, additional evidence may be received under s. 80(9) of the *Act*. Its relevance was whether the Board was fully informed on the wishes of Mary Grover with respect to treatment while capable.

[5] Mrs. Grover's medical history is a complicated one and includes two earlier strokes. The brainstem infarct or stroke of January 22, 2009 was a significant medical event and when its

effect was added to the level of disability she suffered from as a result of the two earlier strokes, she was left in a non-communicative state and functionally, a quadriplegic. From the time of Mrs. Grover's transfer from the nursing home to the hospital, life support measures including the continuous use of a ventilator and endotracheal tube have been in place to sustain her.

[6] Mrs. Grover's principal treating physician is Dr. Butler. Dr. Butler consulted the appellant, Marjorie Grover and her siblings on two treatment plans for Mrs. Grover. The first plan involved the withdrawal of life support by taking away the ventilator and removing the endotracheal tube. It was explained that if Mrs. Grover was unable to breathe on her own or adequately, she would receive palliative care only to prevent discomfort. If she is able to breathe on her own, she would receive nutrition and hydration and at some point be transferred from the hospital to a long term care facility. Drs. Butler and Mrs. Grover's neurologist, Dr. Young, are of the view, however, that the likelihood is that Mrs. Grover's life expectancy is short if her life support is removed.

[7] The second treatment plan was described as the full treatment care plan. It will require a surgical tracheostomy under a general anaesthetic and the insertion of a gastrojejunostomy tube to her stomach and small bowel by which Mrs. Grover would receive her nutrition. Mrs. Grover's life expectancy in the event the second plan is followed is less than a year and she will be at risk at all times from complications which were outlined in the evidence.

[8] The evidence of the neurologist was that it was possible for Mrs. Grover to experience some physical or mental improvement if she could avoid the complications, but his view was that there had not been improvement at the time of the hearing. Dr. Young's view of the difference between the two plans was described as follows at pp. 183-185 of the transcript as follows:

> The first option would ensure that she would pass away and it would be peaceful. It would ensure that she would not suffer. The other option, I think puts her at risk for a number of complications, her ability to enjoy any quality of life, for most people it would not be a very attractive option… I think that she would be likely to suffer complications which would be, could be distressing for her family.

[9] The appellant Marjorie Grover was appointed Mrs. Grover's attorney for personal care July 13, 2005. In this case, she is her mother's substitute decision-maker. As mentioned, Mrs.

Grover lacks the capacity to make a decision on her course of treatment. On January 6, 2009, Mrs. Grover in the company of Marjorie Grover was interviewed at the McCormick Home by its staff physician, Dr. Lock. This was an annual event when the Home's capable patients were asked what level of care they expected in the event of serious illness. Dr. Lock was not called as a witness at the hearing but there was this description of the interview, by Marjorie Grover, from pp. 211 to 214 and 220 as set out at para. 11 of the appellant's factum:

> The issue of level of resuscitation Mary Grover would want to receive was raised by Dr. Locke and as Marjorie Grover testified, "...they kind of asked her if she would like to go down one level and she said no. She automatically said yes, I want a code 4, full code 4". Marjorie Grover further described her mother as being "quite adamant about it". Marjorie Grover, as SDM, understood this to mean that full resuscitative measures were desired by her mother.

[10] The directive referred to above was then filled out. Code 4 is defined in the document. Its definition reads as follows:

> 4. **ACUTE CARE:**
>
> Includes all of the case measures of moderate care but also means:
>
> - Do everything medically and surgically possible to save me and prolong my life
> - Resuscitate me if my heart stops beating or I cease to breathe
> - Put me on life support systems if necessary to prolong my life
>
> Summary – Do everything possible to cure my illness and prolong my life including heroic measures

[11] It was Dr. Butler's view that Mrs. Grover could not be kept indefinitely in the intensive care unit with a breathing tube in place, hooked up to a ventilator, so he met with Marjorie Grover and her nine siblings on January 25, 2009 to explain the two treatment plans possible for Mrs. Grover in her circumstance. The view of Marjorie Grover was that the second plan or the "heroic measures" plan to extend the life of her mother should be carried into effect but the view of her siblings was that Mrs. Grover would not wish her life prolonged in the circumstances which followed her third stroke. Dr. Butler's recommendation was palliative care only. Dr.

Butler met with Marjorie Grover twice more but her view did not change. Dr. Butler was concerned that Marjorie Grover's decision was based on what she wanted for her mother rather than what her mother would want for herself in the event of a "disabling stroke" and where the prospect of life as she knew it had changed. See Dr. Butler's evidence at p. 134. Dr. Butler's view was that Marjorie Grover, as the substitute decision-maker for Mrs. Grover, was not acting in her best interest and so he turned to the *Act* by application to the Board, under s. 37(1), for a determination as to whether Marjorie Grover, in refusing the first plan, had failed to comply with s. 21 of the *Act.*



**The Decision**

[12] The Board's decision is set out above in the second paragraph of these reasons. The reasons of the Board were delivered February 19, 2009 and are set out in the Record of Appeal.

**The Appeal**

[13] Sixteen days before Mrs. Grover suffered a brainstem stroke, she expressed the wish that in the event she became "seriously ill with a life threatening condition" that the level of care should include "everything possible to cure my illness and prolong my life including heroic measures". This language, in part, is the language of the McCormick Home directive.

[14] The issue of law and fact for the Board was whether this wish was "applicable to the circumstances" and if it was not, what were Mrs. Grover's "best interests" as between the two treatment plans described by Dr. Butler.

[15] Although the Board's reasons were lengthy, the appellant complains that they were insufficient on this issue and so insufficient as to prevent meaningful appellant review. The submission is that the Board's reasons are so inadequate as to prevent me from reviewing properly the correctness of their conclusions on the facts, and the law to be applied to the facts.

[16] On the matter of the sufficiency of the reasons, I am instructed by the following instructions of Binnie J. in *R. v. Sheppard*, [2002] 1 S.C.R. 869 at the following paras:

**Paras. 24, 25, 26:**

> In my opinion, the requirement of reasons is tied to their purpose and the purpose varies with the context. At the trial level, the reasons justify and explain the result. The losing party knows why he or she has lost. Informed consideration can be given to grounds for appeal. Interested members of the public can satisfy themselves that justice has been done, or not, as the case may be.
>
> The issue before us presupposes that the decision has been appealed. In that context the purpose, in my view, is to preserve and enhance meaningful appellate review of the correctness of the decision (which embraces both errors of law and palpable overriding errors of fact). If deficiencies in the reasons do not, in a particular case, foreclose meaningful appellate review, but allow for its full exercise, the deficiency will not justify intervention under s. 686 of the *Criminal Code*. That provision limits the power of the appellate court to intervene to situations where it is of the opinion that (i) the verdict is unreasonable, (ii) the judgment is vitiated by an error or law and it cannot be said that no substantial wrong or miscarriage of justice has occurred, or (iii) on any ground where there has been a miscarriage of justice.
>
> . The appellate court is not given the power to intervene simply because it thinks the trial court did a poor job of expressing itself.

**At para 55:**

> The trial judge's duty is satisfied by reasons which are sufficient to serve the purpose for which the duty is imposed, i.e., a decision which, having regard to the particular circumstances of the case, is reasonably intelligible to the parties and provides the basis for meaningful appellate review of the correctness of the trial judge's decision.
>
> Where the trial decision is deficient in explaining the result to the parties, but the appeal court considers itself able to do so, the appeal court's explanation in its own reasons is sufficient. There is no need in such a case for a new trial. The error of law, if it is so found, would be cured under the s. 686(1)(*b*)(iii) proviso.

[17] The impugned passages of the reasons are found at pp. 27, 28 of the reasons. They are as follows:

> **No previously expressed wishes applicable to G's circumstances**
>
> We accepted the unchallenged medical evidence that G had no realistic change 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 effects 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 particularity. 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).

[18] Although Mr. Handelman, for the appellant, focussed only on these paragraphs of the reasons, the following earlier parts of the reasons are relevant to the "prior wish" aspect of the case and should as well be taken into account.

From p. 8

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 effects 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.

From p. 9.

> 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.



[19] The position of the appellant on the sufficiency of the reasons is set out at paras. 69 and 70 of her factum as follows:

> 69. It is respectfully submitted that the Supreme Court in *Sheppard* has ruled that delivery of reasoned decisions is inherent in a judge's role. Reasons have to be sufficient so that the rationale for the decision is reasonably intelligible to the parties and to provide the basis for meaningful appellant review. The ratio in *Sheppard,* a criminal case, has been found to be equally applicable to the administrative law context. It is respectfully submitted that the scant portion of the Reasons devoted to the issue of the applicability of the prior capable wish and the complete failure to address why other prospective, relevant evidence was not sought renders the Reasons within insufficient at law.
>
> 70. Marjorie Grover's counsel gave cogent submissions at the conclusion of the hearing, none of which are referred to in the portion of the Board's reasons finding that there is no applicable wish.

[20] Although a great deal of time was spent by the Board in its reasons on the capacity issue and little time on the prior capable wish issue, I am not, in my view, prevented from a meaningful review of the correctness of the Board's decision. The important issue, in dispute, at the hearing, was whether the so called Code 4 or Level 4 level of care set out in the McCormick Home directive applied to Mrs. Grover's circumstances after January 22, 2009. A fair reading of the reasons, as they are above, with the preface provided at pp. 8 and 9, also set out above, makes it clear that the Board found the wish did not apply because when it was made Mrs. Grover did not take into account the nature and extent of the medical result to her from an event as

devastating as her third stroke turned out to be. On the basis of this statement, I am able to undertake a meaningful review of the correctness of the decision.



**Standard of Review**

[21] From *Conway v. Darby*, October 20, 2008, file 03-53-07 at Toronto, per D. M. Brown J., unreported:

> [7] Section 80(1) of the *HCCA* permits a party to appeal a Board decision on a question of law or fact or both. In *Starson v. Swayze*, 2003 SCC 32, the Supreme Court of Canada identified the applicable standards of review on an appeal from the Board – the interpretation of the legal standard of capacity is a question of law; the determination of capacity is a question of mixed fact and law, and a Board's determination of capacity calls for review on a reasonableness standard: *Starson*, paras. 88 and 110. Application of the reasonableness standard involves respectful attention, although not submission, to the Board's reasons, and an unreasonable decision is one that is not supported by any reasons that can stand up to a somewhat probing examination: *Starson*, para. 88. Reasonableness is concerned mostly with the existence of justification, transparency and intelligibility within the decision-making process, and whether the decision falls within a range of possible, acceptable outcomes which are defensible in respect of the facts and law: *Dunsmuir v. New Brunswick*, 2008 SCC 9, at para: 47.

[22] Before turning to the grounds of appeal set out in the factum of the appellant, reproduced here is the only section of the *Health Care and Consent Act, 1996* which bears on the appeal, s. 21. Set out in its entirety, it is 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. 1996, c. 2, Sched. A, s. 21(1)

(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 wellbeing.

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. 1996, c. 2, Sched. A, s. 21(2).

**Grounds of Appeal**

[23] The first ground of appeal is that the Board failed to take into account Mrs. Grover's wish for full resuscitation and heroic measures, made at a time when she was capable. The Board, on

its own, was obliged to call Dr. Lock, the McCormick Home physician, to explain the circumstances of his interview of Mrs. Grover when the directive was filled out; to review the transfer documentation that travelled with Mrs. Grover from the nursing home to the hospital; to hear from Dr. Schultz on Mrs. Grover's condition in early February 2009; and to review her chart. The position of the appellant is that since none of this was done, the Board's failure to inquire into readily available evidence was unreasonable and that in the result, its decision, in law, was in error.

[24] I do not agree.

[25] In this case, Marjorie Grover was represented by counsel. Dr. Lock could have been called as a witness. In my view, it was not for the Board to intervene at any point for the purpose of securing Dr. Lock's evidence on its own. In any event, Dr. Lock, it seems to me, could not have taken Marjorie Grover's position higher than the Level 4 level of care which was in evidence before the Board. The Board had in mind, through the medical witnesses and Marjorie Grover, Mrs. Grover's wish for the prolongation of her life by heroic measures including resuscitation. There was as well, the evidence of Dr. Butler that the second treatment plan was, in kind, in keeping with the full resuscitation order from the McCormick Home: See p. 133 of the evidence of Dr. Butler. I have reviewed the complete transfer document; it would not have added appreciably to Dr. Butler's view that Mrs. Grover's wish, without other relevant considerations after her third stroke, was the second treatment plan. I do not consider the absence of Dr. Schultz from the hearing as important. In any event, she could have been called as a witness at the behest of Marjorie Grover.

[26] I conclude that the record on the prior wish included sufficient and relevant evidence and that it was taken into account by the Board on the s. 21(1) inquiry. That record included the following evidence of Marjorie Grover on whether the prior wish was relevant or applicable after the occurrence of the third stroke. That evidence included the following;

> Q. And what do you understand a full code 4 to mean?
>
> A. To me that is resuscitating a person, giving CPR if necessary. If they had, like say a heart attack or stroke, getting them into the hospital.

Q. Have you had conversations with your mother specifically about how she would want to be dealt with in circumstances such as this where she had a third stroke, a brain stem stroke?

A. Well we didn't really talk about a third stroke, but as I say, she did adapt pretty well to any disability that she had.

P. 214, evidence of Marjorie Grover:

Q. With respect to --- you mentioned one of the values or beliefs that your mother simply accepted disability, accepted the way she was, when you are talking about accepting the way she was, that was the prior stroke which was not nearly as devastating as the brain stem stroke, correct?

A. Yes.

Q. So the context in which she is mentioning these things to you and the context of where she finds herself are two different things, you agree:

A. That's true, yes.

Q. And there was never any discussion with respect to, you know, if I am effectively paralyzed --- the other doctor even used the word quadriplegic, there was no discussion of that with your mother, was there?

A. No.

PP. 223, 224, evidence of Marjorie Grover:

…

Q. Alright, I just wanted to know then if you ever got in --- it sounds as though you didn't, but did you ever get into the conversation where a person who may have been resuscitated and so that means they still are breathing, but really nothing much is left other than that, did you have that conversation with her, if that was how she was left after having the CPR and the immediate stuff, if she was left kind of in a sort of a vegetative state, how she would want to have that handled?

A. No, we really didn't discuss that..

[27] The effect of this evidence could only be that given to it by the Board at p. 28 of its reasons. I see no error in the Board's treatment of this evidence. Likewise, the Board correctly applied the dictum of Sharpe J. A. in *Conway v. Jacques* (2002), 214 D.L.R. (4th) 67 at para. 31:

> …, I agree with the appeal judge that prior capable wishes are not to be applied mechanically or literally without regard to relevant change 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.

[28] I choose not to give effect to this ground of appeal.

[29] The second ground of appeal is that the Board failed to find a lack of capacity in Mrs. Grover with respect to the second treatment plan. This is clearly an oversight but in any event, there is a clear finding of a lack of capacity which on any view of the evidence must apply to both treatment plans. Indeed, in argument, Mrs. Grover's general lack of capacity to treatment, I thought, was conceded and fairly so.

[30] The third ground of appeal set out in the factum is that the reasons were insufficient. That has been dealt with above.

[31] For these reasons, the appeal is dismissed. The Board's decision that Mary Grover's prior capable wish was not applicable to the circumstances was reasonable both in fact and in law. There was no appeal with respect to the finding of "best interests". The decision of the Board will stand.

[32] This is a difficult case and particularly so because the prior wish was one made so close in time to Mrs. Grover's third stroke. I view this case as different, however, from *Scardoni and Hawryluck*, the decision of Cullity J. Here the evidence is clear that there is no chance of any appreciable recovery. Mrs. Grover is functionally a quadriplegic and lacks the ability to communicate beyond blinking. There is no evidence of cognition.

[33] There will be no order for costs. This proceeding was non-adversarial. The parties, in good faith, took positions which were entirely understandable.

"Justice P. B. Hockin"
Justice P. B. Hockin

**Released:** April 14, 2009