Consent and Capacity Board Commission du consentement et de la capacité

Ontario

File Number LO-09-1216
LO-09-1217

IN THE MATTER OF
The ***HEALTH CARE CONSENT ACT***
S.O. 1996 c.2,
As amended

AND IN THE MATTER OF
N
A PATIENT OF
GRAND RIVER HOSPITAL CORPORATION
KITCHENER-WATERLOO SITE
KITCHENER, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

At the time of the Hearing, N was an 85 year old (date of birth- July 1, 1924) widow, who had four children. Grand River Hospital Corporation (GRH) admitted N on April 18, 2009. At that time, she had a perforated diverticuli, which required emergency surgery. Since that surgery she had been on life support without the ability to come off same.

Mr. NP was the son and substitute decision-maker of N. As treatment for N, Dr. Plaxton proposed an order not to resuscitate, withdrawal of life support and palliative care.

Mr. NP would not consent to this plan of treatment and therefore, Dr. Plaxton applied to the Board to determine if that refusal was in accordance with the principles for giving or refusing consent to treatment as set out in The *Health Care Consent Act* (*HCCA*).

DATES OF THE HEARING, DECISIONS AND REASONS

The hearing took place on July 16, 2009. The panel released its decisions on July 17, 2009. Dr. Plaxton requested written Reasons for Decision on July 21, 2009 which Reasons were released on July 23, 2009.

2009 CanLII 42576 (ON C.C.B.)

LEGISLATION CONSIDERED

The *Health Care Consent Act, 1966*, S.O. 1996 c.2, as amended including ss. 4(1), 20, 21, 37, and 37.1.

PANEL MEMBERS

Mr. B. Comiskey, Senior Lawyer-Presiding Member
Dr. J. Pellettier, Psychiatrist Member
Ms P. Muldowney-Brooks, Public Member

PARTIES

N, the patient
Mr. NP, the substitute decision maker
Dr. W. Plaxton, the health practitioner

APPEARANCES

For W, Ms K. Khanna, lawyer, as friend of the Board
Mr. NP chose to represent himself.
Dr. Plaxton represented himself.

PRELIMINARY MATTERS

N had four adult children, one of whom was Mr. NP, the substitute decision-maker (SDM). The panel canvassed the children to determine if Mr. NP was their choice to act as SDM. After a short private meeting, the family advised that Mr. NP was the SDM.

The family was of Vietnamese origin with the first language for all members being Vietnamese.

Even though Mr. NP and the other family members could speak and understand English, they were more comfortable speaking Vietnamese. An interpreter was present at the hearing to translate both questions and responses, when necessary. The panel advised Mr. NP that he should interrupt the evidence of the doctors, if he required a translation of any evidence.

The panel advised Mr. NP and the family members, that Mr. NP could have a lawyer to assist him during the hearing. After a short private meeting, Mr. NP indicated that the family wished to proceed without the aid of a lawyer.

As another preliminary matter, Ms Khanna advised that she could not get instructions from N, the patient. Consequently, she advised that she would not act as her lawyer but would act for N as a friend of the Board. The panel accepted Ms Khanna on that basis.

THE EVIDENCE

The evidence at the hearing consisted of the oral testimony of Dr. Plaxton, Dr. P. Hosek, Mr. NP, Mr. NN and Ms TP.

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INTRODUCTION

Dr. Plaxton proposed the following treatment for N: an order not to resuscitate, withdrawal of life support and palliative care. Mr. NP, SDM of N did not consent to the proposed treatment except that some time prior to the hearing he had consented to an order not to resuscitate. Consequently, Dr. Plaxton brought a Form G application to the Board under the *HCCA* which prompted a hearing under the Act to determine if the patient was capable of consenting to her own treatment.

This deemed capacity hearing was a condition precedent to the hearing under the Form G application.

THE LAW

The relevant sections of the *Health Care Consent Act* are as follows:

4. (1) 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.

20. (1) If a person is incapable with respect to a treatment, consent may be given or refused on his or her behalf by a person described in one of the following paragraphs:

1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.
2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent of the treatment.
3. The incapable person's representative appointed by the Board under section 33, if the representative has authority to give or refuse consent of the treatment.
4. The incapable person's spouse or partner.
5. A child or parent of the incapable person, or the children's aid society or other person who was lawfully entitled to give or refuse consent of the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to treatment in the place of a parent, this paragraph does not include the parent.
6. A parent of the incapable person who has only a right of access.
7. A brother or sister of the incapable person.
8. Any other relative of the incapable person.

(2) A person described in subsection (1) may give or refuse consent only if he or she,
(a) is capable with respect to the treatment;
(b) is at least 16 years old, unless he or she is the incapable person's parent;
(c) is not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf;
(d) is available; and
(e) is willing to assume the responsibility of giving or refusing consent.

(3) A person described in a paragraph of subsection (1) may give or refuse consent only if no person described in an earlier paragraph meets the requirement of subsection (2).

(4) Despite subsection (3), a person described in a paragraph of subsection (1) who is present or has otherwise been contacted may give or refuse consent if he or she believes that no other person described in an earlier paragraph or the same paragraph exists, or that all those such a person exists, the person is not a person described in paragraph 1, 2 or 3 and would not object to him or her making a decision.

(5) If no person described in subsection (1) meets the requirements of subsection (2), the Public Guardian and Trustee shall make the decision to give or refuse consent.

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 obtaining 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 obtaining 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.

(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 determination as to whether the substitute decision-maker complied with section 21.

(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.

(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.

(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.

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

(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).

(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.

(6.2) If a subsequent substitute decision-maker knows the 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.
(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.
(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.

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.

ANALYSIS

Dr. Plaxton advised that he was a medical doctor with specialties in internal medicine and critical care medicine. He said that he worked in those specialized areas since 2000. He said that N was in the intensive care unit (ICU), and had been since her admission to hospital on April 18, 2009. N received care in the ICU from a team composed of nurses, and physicians who were experts in several specialized areas of medicine. He advised that in addition to himself, N was treated by Dr. Hosek, who had specialties in emergency medicine and critical care, Dr. Nethercott, who had specialties in internal medicine and critical care, Dr. McKinnon, who had specialties in anesthesiology and critical care and Dr. Rosenstein who was an nephrologist (kidney specialist).

Did N have the capacity to consent to her own treatment?

Dr. Plaxton advised that at the time of the hearing N did not have the ability to understand the information relevant to making a decision about the treatment proposed for her. He said that she was in septic shock; that she had infections from a number of sources; that she had impaired organs including brain encephalitis; that her brain was injured due to a stroke after surgery; and that her cognitive function was impaired from renal failure which created delirium, as well as from receiving comfort medications, which impaired her perception. Dr. Plaxton said that on admission to hospital N had a perforated diverticuli. Emergency surgery was performed, which left her with a colostomy. He said that enough stool had penetrated her abdomen to make her delirious. Dr. Plaxton said that he assessed N on the day of the hearing. He said that she was in severe pain, and that there was a great loss of dignity. He believed that removal of life support and palliative care was the best treatment for her.

For the same reasons, Dr. Plaxton said that N did not have the ability to appreciate the reasonably foreseeable consequences of making or not making a decision about her treatment.

N was not present at the hearing. Ms Khanna, on behalf of N, submitted that the conditions described by Dr. Plaxton had all played a role since N's admission to hospital.

On the basis of Dr. Plaxton's clear evidence, we held that it was impossible for N to have the ability to understand the information relevant to the treatment proposed for her, nor was it possible for her to have the ability to appreciate the reasonably foreseeable consequences of consenting to or refusing the treatment proposed for her. The panel held that N was incapable of consenting to her own treatment pursuant to the provisions of section 4(1) of the *HCCA*.

We proceeded to hear the evidence as to whether the refusal by Mr. NP, the SDM of N, to consent to the treatment proposed for N was in accordance with the principles for giving or refusing consent pursuant to the *HCCA*.

N's Medical History, Status, Prognosis and the Treatment Plan

Dr. Plaxton and Dr. Hosek gave clear, cogent and compelling evidence.

Dr. Plaxton advised that on April 18, 2009, N had emergency surgery. A segment of her colon, 16 cm in length, was removed. Her rectum was over-sewn. Her abdomen was washed out with saline. After surgery, N was transferred to ICU. She had a complicated course during hospitalization and was unable to improve. She had a stroke and recurrent episodes of septic shock. She required more sedation. Since her blood pressure was unstable. She required blood pressure medication. She had multiple infections. She had inter- abdominal sepsis, which he described as an abscess formation within the abdomen. She had kidney failure, which at the time of the hearing required permanent dialysis. She had continuous ventilative support. She had acquired resistant organisms, which did not respond to antibiotics, commonly referred to as superbugs. She had skin breakdown on her abdomen and buttocks. Dr. Plaxton described this skin breakdown as open bedsores on her buttocks and around her surgical wound. Her blood flow was compromised because of lack of nutrition. She had a rapid heart rate, because of her blood pressure problem. She suffered a cardiac arrest, which required intervention to revive her. Her brain was injured as a consequence of the heart attack. He estimated that N's ability to come off life-support to be well less than 1%.

He said that N had a tracheostomy and that she had intravenous lines both central and peripheral (large and small veins). She had a feeding tube in her abdomen. She had an intermittent (in and out) catheter. She had a very large version of the dialysis. Dr. Plaxton advised that the dialysis was accomplished by a large thick tube removed intermittently, which was done quite often.

Dr. Plaxton advised that on June 21, 2009, a greater deterioration took place. N was not improving, but her condition was worsening. He said that she was not experiencing less pain and narcotics and sedatives were limited in their ability to prevent pain. He said that several medications, especially narcotics required higher doses to gain the same effect.

He said that the ICU team all wanted her to get better. He said that her care had always been in her best interests, and had always been directed to have her removed from life support. He said that life support is often painful and distressful to the patient and that they therefore continued to provide life-support for so long as it was reasonable and in keeping with the patient's wishes. He said that the best treatment for N, at the time of the hearing, was to have in order to not resuscitate. He said that Mr. NP agreed to such an order. He further said that the best treatment for N was removal of life support and palliative care. He said that the treatment team was in agreement with the proposed treatment. Dr. Plaxton said that if they removed life-support, N would pass away in hours. He said that he would give anything to know her true wishes, but it wouldn't change her prognosis. He said that when she was admitted to ICU she was on life-support and at the time of the hearing she was on more life-support.

Dr. Hosek gave evidence and said that he agreed with the evidence of Dr. Plaxton concerning the physical condition of N and her prognosis. Dr. Hosek said that he was one of those persons who took the position that everything that could be done for a patient to continue life should be done. However, at the time of the hearing, he said that he agreed with Dr. Plaxton as to the nature of her medical condition, that she would not recover, and that she would suffer a lot of inordinate pain. He said that she was suffering, and that they were doing what they could to mitigate that suffering, but he would rather allow her to pass away peacefully. He said that based on his experience the treatment team would continue to see more of the suffering that they had already seen.

Position of Family

Dr. Plaxton advised that the question of withdrawing life-support for N was put to the family, but they did not want it. They indicated to him that N wanted to live. He said the family was certain a miracle would happen.

Mr. NP said that his mother's wishes were to live. He said he wanted to honour that wish. He said she had no wishes prior to the hospitalization, because that was not discussed in their culture. He said that her wishes were expressed to them in an interview with Dr. Hosek near the end of May or the first part of June.

Mr. NN, son-in-law of N, said that he was present for the meeting with Dr. Hosek, and his mother-in-law, when she expressed the wish that she wanted to live with life-support. He said he expected the doctors to do their best to keep her alive. He said that if she told him that she wanted off of life support, then they would grant that wish.

Ms TP, a daughter of N, gave evidence. She said that the family asked her mother three times if she wanted to continue to live and she said “yes”.

Prior Wishes of N, the Incapable Person-Section 21

Mr. NP said that N did not have a personal care power of attorney.

Dr. Plaxton said that the ICU team wanted to see if they could understand N’s wishes. He said that on June 9, 2009, between septic shock episodes, N was lucid, as she had not had medications for some time. He summoned a translator and the patient's family physician. Dr. Plaxton asked her questions through the interpreter. He asked her if she knew that she was on life support, and she nodded in the affirmative. He asked if she wanted to continue to live that way and she shook her head in the negative. He asked her if she was asked these questions before and she shook her head in the negative. During questioning by the Panel, Dr. Paxton said that “in relative terms, it seemed to be a very good day between septic episodes.” He said that from his experience, it was “as good a day as I have seen.” However he went on to say that he “had a feeling that further due diligence needed to be taken.” He said that he was not absolutely certain on June 9th of N's ability. He said he was certain of what he saw for answers, but he was not certain of her ability to appreciate the risks. He said that she did have some periods of lucidity, which predated her going on dialysis. He said that he was not aware that those questions were asked in other lucid moments. He said that the family was not present when he asked those questions on June 9th. In further questioning, Dr. Plaxton advised that he asked N if she understood that she would not survive and she nodded in the affirmative. He said that he asked her if she wanted to continue to live on a breathing machine, and she shook her head in the negative. He asked if her family had spoken to her about these matters, and she shook her head in the negative.

Mr. NP, said she wanted to live, and that she so indicated during one of her lucid moments with Dr. Hosek present. Dr. Hosek said that there was a meeting with Mr. NP and other family members prior to the meeting described by Dr. Plaxton on June 9th. He said that N was able to sit up in the chair, mouth words, and obey commands. She said that Mr. NP acted as an interpreter. He asked her she understood she was on life support and without it, she would die. She answered “yes”. He asked if she wanted to continue on life support, and she answered in the affirmative. He asked her if she understood that the life support would be permanent, and she answered in the affirmative. When asked about the information given by Dr. Plaxton in reference to her instructions on June 9th, Dr. Hosek said that he can only surmise that she was either not in the correct frame of mind or that she may have changed her mind. He said that she suffered pain of an ongoing nature, such that she may have changed her mind.

Mr. NP said that he wanted what was best for his mother. He said he wanted to respect her wishes. He said that he was unhappy, because he and the other family members were not present for the June 9th interview by Dr. Plaxton, with his mother. Throughout his testimony, Mr. NP insisted that he wanted to follow his mother's wishes as he believed he heard them at the meeting with Dr. Hosek approximately one week before the June 9th meeting referred to by Dr. Plaxton.

Mr. NN and Ms TP agreed with Mr. NP that N expressed a wish at the meeting with Dr. Hosek that she wanted to live on life-support. When asked if his mother was merely trying to protect the family when she indicated she wanted to live, Mr. NP would not acknowledge that possibility. Dr. Plaxton was asked why he did not include the family at a meeting on June 9th. He said that he hoped to ascertain N's true wishes when there were no family members present to influence her.

Scardoni v. Hawryluck, [2004] O.J. No.300 (S.C.), a decision of Mr. Justice Cullity, is considered to be the leading case in end of life decisions. This decision was an appeal from a decision of the Consent and Capacity Board. In that case a woman was suffering from Alzheimer's disease and the physicians proposed to cease providing treatments which had been administered to her in the intensive care unit. When the daughters refused to consent to the proposal, the physician applied to the board for determination of whether the daughters had complied with the principles of substitute decision-making. The daughters appealed after the Board determined that they should not have withheld their consent.

At paragraphs 54 and 55, Mr. Justice Cullity discussed the issue of an incapable person's prior wishes. He said, referring to the decision of *Conway v. Jacques* (2002), 214 D.L.R. (4th) 67 (CA) as follows:

"54 The relevance of an incapable person's wishes was explained by Sharpe J.A. in Conway as follows:

> "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 the prior cable wish applicable to the circumstances pursuant to section 21(1)1; and 2) in determining the incapable person's best interests pursuant to section 21(2) where there is no capable wish applicable the circumstances.
>
> At the first stage, the substitute decision-maker must act in accordance with the 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…
>
> At the second stage, the substitute decision-maker is asked to decide whether or not to consent to treatment on the basis of the best interests tests under section 21(2). Under section 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 [section 21(1)para1]", 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."

At paragraph 55, Justice Cullity said the following:

"55 In light of that reasoning, I cannot agree that wishes expressed by an adult person that do not fall within section 21(1) because they are insufficiently specific to permit an inference that they are 'applicable in the circumstances' cannot be 'wishes… that are not required to be followed' under section 21(1) for the purposes of section 21(1)(b). Unless the changed circumstances to which Sharpe J.A. referred are shown to have been in the contemplation of the donor at the time her wishes were expressed they will not be 'applicable to the circumstances' referred to in section 21(1). Such wishes may, however, still permit an inference with respect to the decision that the incapable person would have made in new circumstances - an inference that is to be taken into consideration when applying section 21(2). As such an inference will necessarily be speculative to some extent, it is not to be treated by the substitute decision-maker as conclusive. It is just one of the factors to be considered under section 21(2) and the weight to be given to it will depend upon the facts. Expressed wishes that, for example, are held to be outside section 21(1), because they are insufficiently specific to satisfy the substitute decision-maker - or the Board - that they were in the contemplation of the patient when capable, may still permit an inference with respect to what the patient's wishes would have been in the changed circumstances. In my opinion, section 21(1)(b) directs that they be considered in determining the patient's best interests and the Board erred in law in finding to the contrary."

We agreed with the reasoning of Mr. Justice Cullity as described above. The presence of the family at the meeting described by Dr. Hosek and Mr. NP may have adversely influenced N to say things that were protection for her family. Perhaps she had a lucid moment at that meeting, and wanted to live with all the life-support. Perhaps she was not capable to make her wishes known, by reason of the fact that she suffered delirium from the perforation of her diverticuli and the penetration of fecal matter into her abdomen combined with the fact that she suffered post surgery, cardiac arrest and stroke. Dr. Hosek said that she might have changed her mind by the time of the June 9th meeting with Dr. Plaxton. Dr. Plaxton was not sure that she appreciated the risks, and if so, she was not capable to make a wish. Given all the circumstances of N's physical and mental difficulties, delirium brought about by her various episodes with septic shock, delirium brought about by the medications she was receiving, the influence of the family being present at the meeting with Dr. Hosek and the feeling of Dr. Plaxton that she may not have appreciated the consequences of the wishes expressed at the June 9th meeting, we held as a fact that the prior wishes expressed on two occasions, within a week of each other, were not capable wishes. We held that there was no prior capable wish that pertained to the circumstances.

At the second stage, as set out in *Conway,* we had to consider the family's belief of what the patient would have wanted if she had been aware of the circumstances in which she found herself at the time of the hearing. What the family believed was only one of the factors that the Panel had to consider. We looked at all the factors including what had been going on for the preceding three and a half in months for N. The physicians pulled her back from the brink of death upon her arrival to hospital and later after she suffered cardiac failure. There were multiple new complications. The evidence that came from Mr. NP and the other family members convinced us that their sole consideration was what they believed she would have wanted without giving consideration to section 21(2)(c) and the patient's true state. None of them accepted the medical opinion of the intensivists that N was in a state where there was no hope of any recovery. If they couldn't accept or believe the expert physicians, then how could they possibly consider what N would have wanted if she was aware of those expert medical opinions? In our view, under those circumstances, Mr. NP and the family members could not have known what N would have wanted.

Section 21 Criteria for Best Interests

We had to determine whether Mr. NP was acting in the best interests his mother, as her substitute decision-maker.

We referred specifically to the House of Lords decision in *Airedale NHS Trust v. Bland, [1993] 1 All ER 821,* the leading decision on the issue of withdrawal of treatment for patients in a persistent or permanent vegetative state with no hope of recovery. *Airedale* involved a 17-year-old person in such a condition.

Respecting best interests, there are several important considerations enunciated in that decision which one must consider.

At page 872, Lord Goff stated as follows:

> "The truth is that, in the course of their work, doctors frequently have to make decisions which may affect the continued survival of their patients, and are in reality far more experienced in matters of this kind than are the judges. It is nevertheless the function of the judges to state the legal principles upon which the lawfulness of the actions of doctors depend; but in the end the decisions to be made in individual cases must rest with the doctors themselves."

Certainly in this matter, the expert physicians clearly supported the view that withdrawal of life support and palliative care was the correct course of treatment for N.

The House of Lords said that the extent of pain that the incapable person was likely to be suffering was one consideration but there were other considerations that were relevant to the patient's best interests.

At page 846, Lord Sloss said as follows:

> "The quality of life has already been recognized as a factor and placed in the equation to allow a life not to be prolonged and any costs (…) To limit the quality of life to extreme pain is to take a demeaning view of a human being. There must be something more for the humanity of the person of a PVS patient. He remains a person and not an object of concern."

At page 848, he added the following:

> "[The incompetent patient] has the right to be respected. Consequently he has a right to avoid unnecessary humiliation and the degrading invasion of his body for no good purpose.
> (…)
> The considerations as to the quality of life of Mr. Bland now and in the future in this extreme situation are in my opinion rightly to be placed on the other side of the critical equation from the general principle of the sanctity and inviolability of life. In this appeal those factors which include the reality of Mr. Bland's existence outweigh the abstract requirement to preserve life (…). The duty of the doctors towards a PVS patient at the extreme end of the spectrum does not extend to prolonging his life at all costs."

At page 853 Lord Justice Hoffman said that Mr. Bland "is alive but has no life at all." In concluding that life support should be withdrawn he said: "we would be showing more respect to him as an individual than by keeping him alive."

At page 870 Lord Goff said:

> "I cannot see that medical treatment is appropriate or requisite simply to prolong a patient's life when such treatment has no therapeutic purpose of any kind, as where it is futile because the patient is unconscious and there is no prospect of any improvement in his condition. It is reasonable also that account should be taken of the invasiveness of the treatment and of the indignity to which as the present case shows, a person has to be subjected if his life is prolonged by artificial means, which must cause considerable distress to his family - a stress which reflects not only their own feelings but their perception of the situation of their relative who was being kept alive. But in the end, in a case such as the present, it is the futility of the treatment which justifies its termination."

In the matter before the panel, N was in just that situation. Dr. Plaxton gave evidence that N had less than 1% chance of being off life-support which he said meant really no chance. She had no quality of life. She suffered from pain. Her physical condition was going to continue to deteriorate. There was no prospect that there would be any improvement in her condition. She would never recover. She had bedsores on her buttocks and sores around her operation wounds which were getting worse. They said that these bedsores would only get worse and would not get better .The artificial means by which she was being kept alive had no therapeutic purpose of any kind. As Lord Goff said; "… it is the futility of the treatment which justifies its termination."

At page 839-840 Sir Thomas Bingham said:

> "While the respect accorded to human life always raises a presumption in favour of prolonging it, that presumption is not irrebuttable. Mere prolongation of the life of a PVS patient such as Mr. Bland, with no hope of any recovery, is not necessarily in his best interests, if indeed such prolongation is in his interests at all. In making an objective judgment of Mr. Bland's best interests, account can be taken not only of pain and suffering which prolonged feeding and medication might cause but also wider, less tangible considerations.
> (…)
>
> I cannot conceive what benefit his continued existence could be thought to give him. It might be different where it possible to hope that, if he lived long enough, means might be found to restore some part of his faculties, but no grounds have been suggested for cherishing such a hope and the physiological findings appear to preclude it.
> It is of course true that pain and suffering, which may (if the foregoing reasoning is sound) weigh in the balance against the presumption in favour of life, are here to be ignored because of Mr. Bland's insensible condition. An objective assessment of Mr. Bland's best interests, viewed through his eyes, would in my opinion give weight to the constant invasions and humiliations to which his inert body is subject (…)."

Hope is exactly what Mr. NP and the family had. Having heard the evidence of Dr. Plaxton and Dr. Hosek, it was clear to us that the family's hope was not at all realistic. N would not recover.

Lord Sloss at page 847 referred to a passage from the American case of *Re Conroy (1985) 98 NJ 321 at 398-399*, wherein that court stated:

> "The medical and nursing treatment of individuals in extremis and suffering from these conditions entails the constant and extensive handling and manipulation of the body. At some point, such a course of treatment upon the insensate patient is bound to touch the sensibilities of even the most detached observer. Eventually, pervasive bodily intrusions, even for the best motives, will rouse feelings akin to humiliation and mortification for the helpless patient. When

cherished values of human dignity and personal privacy, which belong to every person living or dying, are sufficiently transgressed by what is being done to the individual, we should be ready to say: enough."

The foregoing quote from Re Conroy was cited with approval by a panel of this Board, in the decision of EJG (2007) CanLII 44704 (ON C.C.B.) at page 22.

Dr. Hosek said that he had been approached by certain nurses who wished to remain anonymous. Those nurses requested not to be assigned to the care of N. They were upset at providing care and interventions that were painful. They indicated that there was a constant barrage of painful things for N, and that every day they inflicted pain on her. He said that it was an extremely unusual request from those nurses, and that he could count on one hand the number of times such a request had been made in the past. This is the same or similar concern as addressed above in the case of Mr. Bland. We could not be blind to the constant invasions and humiliations suffered by N.

In this matter, the family was adamant that they wanted N to live by any artificial means in the hope that there would be recovery. They could not acknowledge the predictive likelihood that N would not recover, as expressed by Dr. Plaxton and the other treating physicians.

In his evidence, Dr. Plaxton said that Dr. Rosenstein, a kidney specialist, examined N on July 1, 2009. Dr. Plaxton read Dr. Rosenstein's clinical note that was contained in the chart. In that note, Dr. Rosenstein indicated that N remained fully ventilated. She had absolutely no chance of recovery. She had progressively deteriorated and in every aspect remained in a state of multisystem organ failure. Dr. Rosenstein said that he believed ongoing aggressive interventions were "futile, pointless, inappropriate, cruel and lacking in the dignity an 85-year-old woman deserves."

We agreed with the evidence of Dr. Plaxton and Dr. Hosek. In our view, the clinical note of Dr. Rosenstein summed up the view of N's treating team. There was no hope that N would have any recovery and in fact would get worse. She had complete kidney failure with absolutely no hope or chance of it recovering. While we felt a great deal of empathy for the family in their desire to have N recover and go home, we held that their view was not in any way realistic. The family members were blinded by their obvious love for N and could not view her situation objectively nor were they able to put themselves into her position. After months in hospital hooked up to tubes and machines, after suffering from pain, after suffering several bouts of septic shock, after being brought back from the brink of death, after losing her cognitive ability, after being in a state where recovery was not possible, after suffering from very large bedsores, after suffering from the invasion of personal privacy, after suffering human indignities, it was time for the family to say “enough”. In our minds, there was no disputing the clear, cogent and compelling evidence of Dr. Plaxton and Dr. Hosek. We agreed with Dr. Plaxton that N should be allowed to die with dignity and that the treatment for N, in her best interests, would be withdrawal of life-support and palliative care.

It was clear to us, having taken into consideration all of the evidence, that Mr. NP was not acting in accordance with the best interests of N as set out in the section 21 criteria.

RESULT

The Board held that N was incapable with respect to the treatment proposed for her.

We granted Dr. Plaxton's application and determined that the refusal of accepting Dr. Plaxton's treatment plan for N was not done in accordance with the principles for giving or refusing consent to treatment as set out in The *Health Care Consent Act* (*HCCA*). We directed Mr. NP to consent to the proposed treatment plan, namely: an order not to resuscitate, withdrawal of life support and palliative care.

We delivered the decisions to the parties by fax on July 17, 2009. We gave Mr. NP until 10:00 a.m. on Monday, July 20, 2009 to consent to the treatment in accordance with our decision. The decision clearly sets out that if they fail to comply with the Board's directions within the time specified, that they shall be deemed not to meet the requirements for substitute decision-making as set out in section 20 (2) of the Act and Dr. Plaxton can then seek consent in accordance with our decision from the next ranking substitute decision-maker as set out in section 20.

Dated at Chatham, Ontario this 23rd day of July, 2009.

Bernard Comiskey, Presiding Member