Consent and Capacity Board

Commission du consentement et de la capacité

Ontario

HA-10-5153
HA-10-5154

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

AND IN THE MATTER OF
BS
A PATIENT OF
WILLIAM OSLER HEALTH CENTRE – BRAMPTON CIVIC HOSPITAL
BRAMPTON, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

A panel of the Board convened at the William Osler Health Centre – Brampton Civic Hospital ("Brampton Civic Hospital") at the request of Dr. Amin, a health practitioner. Dr. Amin brought a Form G Application to the Board under Section 37(1) of the *Health Care Consent Act* ("*HCCA*" or the "*Act*") for a determination as to whether or not the substitute decision-maker in this case had complied with Section 21 of the *HCCA*, the principles for substitute decision-making, when making a decision about proposed treatment for BS.

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

DATES OF THE HEARING, DECISIONS AND REASONS

The hearing took place on April 19, 2011 and the Decisions were released the same day. Counsel for BS and counsel for Dr. Amin both requested written Reasons for these Decisions, and those Reasons, contained in this document, were released on April 28, 2011.

LEGISLATION CONSIDERED

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

PANEL MEMBERS

Lora Patton, lawyer and presiding member
Dr. John Johnson, psychiatrist member
Earl Campbell, public member

PARTIES & APPEARANCES

Deemed Form A Application

BS, the patient, was represented by Mr. McIver.
Dr. Amin, the health practitioner, was represented by Ms Ranganathan.

Form G Application

BS, the patient, was represented by Mr. McIver.
MS, BS's substitute decision-maker, was represented by her son, AS, who acted as her agent.
Dr. Amin, the health practitioner, was represented by Ms Ranganathan.

All parties attended the hearing except BS.

PRELIMINARY MATTERS

MS was not represented by counsel. Although a previous hearing date had been adjourned to allow her to obtain counsel, she had been unsuccessful. MS stated that she wanted to proceed without a lawyer and asked that her sons represent her. After discussion, it was agreed that one son, AS, would act as her agent. The panel advised MS and AS that they could request clarification of the process at any point and should advise us if they required other assistance.

THE EVIDENCE

The evidence at the hearing consisted of the oral testimony of four witnesses, Dr. Amin, the attending physician; James Watters, a social worker assigned to the Intensive Care Unit; MS, the substitute decision-maker; and AS, the son of MS and BS. There were four Exhibits taken into evidence:

1. The "Clinical Summary and Brief of Dr. Reham Amin," which included the following ten TABs:
    1. Clinical Summary, prepared by Dr. Amin, undated;
    2. Progress Report, prepared by Dr. Amin, dated March 28, 2011;
    3. Progress Notes, various authors, dated October 15, 2010 to November 16, 2010;
    4. Consultation Report, Prepared by Dr. Gerald Tullio, dated October 18, 2010;
    5. Consultation Report, prepared by Dr. Andrew Cooper, dated February 21, 2011;
    6. Progress Report, prepared by Dr. Pieter Jugovic, dated March 10, 2011;
    7. Progress Notes, various authors, dated January 6, 2011 to March 31, 2011;
    8. Consultation Report, prepared by Dr. Muhammad Chaudhry, dated March 10, 2011;
    9. Consultation and Progress Reports, various authors, dated October 14, 2010 to March 28, 2011; and
    10. Social Worker Notes, prepared by James Watters, dated October 18, 2010 to March 11, 2011.

2. Policy Statement #1-06 of the College of Physicians and Surgeons, titled "Decision-Making for the End of Life";
3. Letter from Dr. Amin to MS, also signed by a number of Brampton Civic Hospital physicians, dated March 27, 2011; and
4. Pamphlet by William Osler Health Centre, titled "Making Decisions for Other People."

INTRODUCTION

BS was a sixty-three year old man who, on October 14, 2010 had suffered a cardiac arrest while at work. BS fell and sustained a neck fracture. Neurological assessments determined that BS would not regain meaningful cognitive function. Dr. Amin and the treatment team believed that BS's brain had suffered a period of oxygen deprivation during the cardiac arrest, leading to irreparable damage.

Since October, BS had remained in a persistent vegetative state. A decision had been made to forgo surgery to repair the neck fracture and BS continued to wear a cervical collar while the spinal cord healed, albeit in a displaced fashion. BS had been weaned from a ventilator for a short period of time but continued to receive supplemental oxygen. Over the course of his admission to the intensive care unit, BS had developed a number of complications, which included C-Difficile infections, pneumonias, urinary tract infections and sores from contact with the cervical collar and bed.

Dr. Amin had proposed a palliative care plan of treatment for BS. The plan of treatment would include ongoing tracheostomy care, nutrition via feeding tube, and medications. It would also include a decision to not re-initiate ventilation for anticipated respiratory failure. MS refused to consent to the plan. Dr. Amin did not believe that MS had complied with the principles of substitute decision-making when she refused the plan of treatment and, as a result, an application was made to the Board.

THE LAW

Capacity to Consent to Proposed Treatment

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

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

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

> A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

Obligations of Substitute Decision-Making

The *HCCA* identifies the principles that a substitute decision-maker must apply when making a decision about a proposed treatment. Those principles are outlined in Section 21:

> 21. (1) A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles:
> 1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.
> 2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.
>
> 21.(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;
(b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and
(c) the following factors:

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

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

37. (1) If consent to a treatment is given or refused on an incapable person's behalf by his or her substitute decision-maker, and if the health practitioner who proposed the treatment is of the opinion that the substitute decision-maker did not comply with section 21, the health practitioner may apply to the Board for a determination as to whether the substitute decision-maker complied with section 21.

Parties
(2) The parties to the application are:

1. The health practitioner who proposed the treatment.
2. The incapable person.
3. The substitute decision-maker.
4. Any other person whom the Board specifies.

Power of Board
(3) In determining whether the substitute decision-maker complied with section 21, the Board may substitute its opinion for that of the substitute decision-maker.

Directions
(4) If the Board determines that the substitute decision-maker did not comply with section 21, it may give him or her direction and, in doing so, shall apply section 21.

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

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

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

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

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

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

> **Deemed application concerning capacity**
> 37.1 An application to the Board under section 33, 34, 35, 36 or 37 shall be deemed to include an application to the Board under section 32 with respect to the person's capacity to capacity to treatment proposed by a health practitioner unless the person's capacity to consent to such treatment has been determined by the Board within the previous six months.

BS'S CAPACITY TO CONSENT TO THE PROPOSED TREATMENT

Dr. Amin testified that on November 16, 2010, Dr. Ciric had made a finding that BS was incapable of making decisions about the proposed treatment (Exhibit 1, TAB 3, pages 31-32). Dr. Amin stated that BS was in a persistent vegetative state and was unable, in any manner, to interact with his environment. The clinical notes and records provided indicated that no change had occurred since the November finding. None of this evidence was in dispute.

The panel determined that BS was incapable of making decisions about the proposed treatment. We held that BS was unable to understand the information relevant to such a decision and unable to appreciate the reasonably foreseeable consequences of the decision due to a severe brain injury that had resulted from a cardiac arrest.

APPLICATION TO DETERMINE COMPLIANCE WITH THE *HCCA*

1. BS's Medical Condition

Dr. Amin testified that shortly after the October cardiac arrest, BS's cardiac function had been resuscitated by ambulance emergency workers and he was transported to Brampton Civic Hospital. Hypothermia protocols were initiated to allow for maximum recovery. Over the next several days, BS was carefully observed for signs of consciousness, awareness and neurological activity; however he remained unconscious and unresponsive.

On October 17th, Dr. Yufe, a neurologist, examined BS. He noted minimal neurological indicators (Exhibit 1, TAB 3, pages 15-17). On October 18th, a second neurologist, Dr. Tullio examined BS and made similar findings (Exhibit 1, TAB 4). In particular, Dr. Tullio found that BS had suffered an "anoxic brain injury" and that he was "unlikely to return to baseline functioning" (Exhibit 1, TAB 4, page 2). A neurological follow-up occurred on October 20th, following an MRI. The MRI noted a "diffuse, severe anoxic brain injury" (Exhibit 1, TAB 3, page 24).

Dr. Amin testified that neurological recovery in this type of case was expected within the first few days. BS showed no sign of such recovery. After three months in hospital, BS had not improved and he was considered to be in a "permanent vegetative state" (Dr. Amin had explained that in non-traumatic brain injuries a vegetative state was considered "permanent" after three months). By the time of the hearing there had still be no improvement. Dr. Amin explained that BS would periodically open his eyes but would not do so on command and would not follow movement. Eye movements of this nature were consistent with a persistent or permanent vegetative state. BS had also shown, at times, a cough reflex and some withdrawal to painful stimuli. However, Dr. Amin explained that these periodic signs were not indicative of recovery. She stated that in assessing neurological states, physicians look for "sustained, reproducible, purposeful or voluntary responses to visual, auditory, tactile or noxious stimuli." Further, physicians look for a positive pattern of change over time. Dr. Amin stated that there had been no progressive pattern in BS's case. Her position was supported by the clinical notes and the supporting opinions of other physicians (see generally Exhibit 1, TABs 2-9).

Dr. Amin noted that BS had also suffered a "C1-C2 fracture" (a spinal break in the neck), with displacement. Typically, such an injury would be repaired with a surgical fusion of the vertebrae; however, a decision was made in this case not to perform such a surgery as it would be of "doubtful benefit" to BS due to his poor neurological prognosis (see Exhibit 1, TAB 9, page 102). A halo vest was also seen as unsuitable (Exhibit 1, TAB 9, page 98). The dislocation had not healed by January 2011 and BS had been maintained in a cervical

collar since his admission to hospital. Dr. Amin stated that the spine would heal but in a displaced manner. The injury had caused quadriplegia.

Over the course of his stay in hospital, BS experienced a number of complications due to his weakened state. He had contracted pneumonia on more than one occasion and was likely to develop further infections due to the tracheostomy and his inability to cough to clear the mid and lower airway. Suctioning was regularly performed but it was only effective in reaching the upper airway. BS also had C-difficile colitis and urinary tract infection. He required regular suctioning of his airway, supplemental oxygen and nutrition through a gastro-intestinal tube. Although BS had been weaned for a few weeks from the ventilator, it was expected that infections would recur and he would be unable over the long-term to breathe on his own. Nutritional and other supports would continue to be required. Dr. Amin stated that BS's general condition would continue to deteriorate, regardless of aggressive medical interventions, due to his weakened physical condition and inevitable opportunistic infections.

MS testified that she had observed changes in BS's condition over the course of his hospitalization. She said that he would open his eyes and make eye contact. He would try to move his mouth to speak. She also had noted that when she cut his nails, he would move his hand away if she cut too closely. MS believed that the fact that ventilation was not currently necessary "could be" a positive sign. While she acknowledged that Dr. Amin had advised that BS's body was deteriorating, MS noted that BS had since been successfully weaned from the ventilator. MS was also concerned that BS had received poor care at Brampton Civic Hospital and that he had, as a result, contracted infections. AS reiterated this concern and stated that the nursing manager had acknowledged poor care on one occasion. MS had not reported this concern or other care concerns to the physicians.

MS said that she had read a poster in the hospital that suggested brain injuries could take two years to heal. She believed that BS should be given at least one year to see whether or not he would recover, that there was a "possibility" he would get better. MS also reported

that a doctor had told her that the spinal fracture could be preventing the brain from healing and that once the fracture healed, things may get better.

AS stated that he was not convinced that his father's condition would not improve and that there was "always the possibility of anything." He noted that Dr. Ciric, another intensive care physician with whom the family have a positive relationship, had not told them that the brain damage was irreversible He acknowledged that he was unsure whether or not there had been deterioration and he was prepared to accept medical opinions on this point.

2. The Proposed Treatment Plan

Dr. Amin had documented the proposed treatment plan in her letter to MS dated March 27th: comfort care with no readmission to the intensive care unit; information about the law was included in that letter (Exhibit 3). Dr. Amin testified that the treatment plan included all palliative care measures, including continued supplemental oxygen, nutrition and medication, but did not include re-ventilation following anticipated respiratory failure. Re-ventilation was the only issue of disagreement between the treatment team and MS. Other members of the health care team had signed Dr. Amin's letter indicating their support for the treatment plan.

Discussion with MS about the obligations of a substitute decision-maker had been initiated on October 19th by Dr. Ciric. Multiple discussions and meetings had occurred since that date (see history of same in Exhibit 1, TAB 2). On November 16th, MS agreed that CPR and inotropes (for blood pressure) should not be offered to BS but she continued to seek more aggressive respiratory treatment.

Dr. Amin met with MS on March 24th and 26th to discuss the plan of treatment, the obligations of a substitute decision-maker, and the possibility of an application to the Board.

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

None of the parties asserted that BS had made a prior capable wish applicable to the proposed treatment plan or about end of life decision-making. There was no known power of attorney for personal care.

We held that BS had made no known prior capable wish and, as a result, MS was required to apply s. 21(2) of the *HCCA* when making decisions about his treatment.

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

Dr. Amin had documented that inquiries had been made of MS and other family members about BS's values and beliefs. Dr. Amin reported that MS had stated that BS was not particularly religious and that he was dedicated to his family and enjoyed sports and being at home. MS had said that she was very religious and that she believed in miracles but these same beliefs were not ascribed to BS (Exhibit 1, TAB 3, page 32; also see discussion between the ethicist and MS at Exhibit 1, TAB 7, page 65). Dr. Amin believed that BS's described values and beliefs supported implementation of the proposed treatment plan.

MS testified that she had not discussed end-of-life decision-making with BS. She was not aware of any discussions that he may have had with others. She stated that while BS was of the Hindu faith, and that he believed that God would take a person when He was ready, she did not provide any specific information about BS's values and beliefs. She believed that he would want her to continue to insist on re-ventilation. MS also said that BS's family needed him and that after more than forty years of marriage, she knew him well enough to read his thoughts.

There was very little evidence to assist the panel in understanding BS's values and beliefs. There was no evidence about his values and beliefs about end of life decision making.

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

Dr. Amin's evidence was carefully documented throughout the Exhibits. It was clear that the intensive care physicians and the neurologists were in agreement in that BS's neurological condition would not improve. MS had a different perspective and the panel could appreciate how she continued to retain hope. However, MS was not herself certain in her evidence that BS was improving and her evidence was stated in terms of her hope of what might happen if BS had more time with full ventilation options. The medical evidence, which the panel found to be clear, cogent and compelling, indicated that more than enough time had passed to conclude that BS would not improve.

Where the evidence conflicted as to BS's condition, the panel accepted Dr. Amin's evidence. We held that BS was in a permanent vegetative state and that he was not going to recover. Our decision was based on the seriousness of the brain injury, the lack of immediate recovery in the week after the cardiac arrest and the lack of improvement in the more than six months since. BS would remain unaware of his environment, unable to interact with others, and unable to recognize or appreciate the presence of family or other comforts. Complications arising from BS's weakened state would continue to require medical interventions. Beyond interventions from infections, BS would require mechanical support for supplemental oxygen, suctioning and nutrition.

Nothing in the evidence suggested that, in these circumstances, BS would want to be subject to unnecessary medical interventions. In *Scardoni v. Hawryluck* (2004), CanLII 34326 (ON S.C.), the court held that "best interests" should be interpreted broadly to include issues of dignity and quality of life. All of the evidence made plain that BS had a very poor quality of life and the situation would not improve. BS was subjected to daily indignities through

invasive medical procedures that were required to keep him alive without increasing the likelihood that he would recover any awareness or consciousness.

The panel determined that MS had not considered the proposed treatment plan in light of these factors. Understandably, MS was influenced by her own wants and needs and was unable to interpret the legislation without emotional attachment. It is for this reason that the legislation requires that a panel of the Board substitute its own judgment for that of a substitute decision-maker if, after hearing all of the evidence from all parties, the panel determines that the decision is not the correct one (*Scardoni*, supra; *M(A) v. Benes* (1999), 46 O.R. (3d) 271 (C.A.)).

AS raised the issue of the *Convention on the Rights of Persons with Disabilities* in his submissions, specifically a portion of Article 25 stating that "that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability." We did not believe the *Convention* had applicability in this matter. It is unclear what applicability the *Convention* has here absent "transformation" into Canadian law and no evidence was led related to discrimination.

RESULT

We held that MS, the substitute decision-maker, had not complied with the principles for substitute decision making set out in the *HCCA*. Based on our assessment of s.21, we directed MS to consent to the proposed treatment plan that included a decision to not re-initiate ventilation in the event of anticipated respiratory failure. We ordered that this consent be given no later than April 26, 2011.

Dated: April 28, 2011

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Lora Patton
Presiding Member