Consent and
Capacity Board

Commission du consentement
et de la capacité

Ontario

2013 CanLII 76685 (ON CCB)

TO-13-3125
TO-13-3126

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

AND IN THE MATTER OF
CA
A patient at the
HUMBER RIVER REGIONAL HOSPITAL – CHURCH STREET SITE
TORONTO, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

A hearing of the Consent and Capacity Board (the "Board") was convened at the Humber River Regional Hospital - Church Street Site (the "Hospital") to consider two matters: a "Form G" application to determine whether or not MA, CA's substitute decision-maker (the "SDM") had complied with the principles for substitute decision-making set out in section 37 (1) of the *Health Care Consent Act,* and a deemed "Form A" application under subsection 37.1 to review the capacity of CA to make her own treatment decisions.

DATES OF THE HEARING, DECISIONS AND REASONS

The hearing took place at the Hospital on September 27, 2013. The Board released its Decisions on September 28, 2013. At the hearing, counsel for Dr. Manocha requested written Reasons for Decision (contained in this document), which were released on October 7, 2013.

LEGISLATION CONSIDERED

The *Health Care Consent Act*, (HCCA)

PARTIES

CA, the incapable person.
MA, the SDM for CA.
Dr. Sanjay Manocha, the health practitioner who proposed the treatment.

MA and Dr. Manocha attended the hearing. CA did not attend the hearing; however the hearing was convened for a time at her bedside.

BOARD MEMBER

Mr. Paul DeVillers, senior lawyer - presiding member.

APPEARANCES

CA was represented at the hearing by counsel, Ms. Maureen Tucker.
Dr. Manocha was represented at the hearing by counsel, Mr. Andrew McCutcheon.
MA was represented at the hearing by her daughter NA as agent.

Prehearing Conference

This matter had been set for hearing on September 20, 2013 but at the suggestion of the Board Member hearing it and with the consent of all parties that hearing was converted to a prehearing conference. The Order and/or Endorsement from this prehearing confirmed that the SDM, MA was informed of her right to be represented at this hearing by counsel.

PRELIMINARY MATTERS

The parties reported that there were no preliminary matters and no issues that could be agreed upon by the parties prior to commencing the hearing.

THE EVIDENCE

The evidence at the hearing consisted of the oral testimony of six witnesses:

1) Dr. Manocha
2) NA, CA's sister
3) MA
4) CA's Pastor, by teleconference
5) ZA one of CA's brothers
6) Mr. CA another of CA's brothers

There were 7 Exhibits:

1) Document Brief filed by Counsel on behalf of Dr. Manocha containing 229 pages.
2) Dr. Manocha's Note (Consultation Report) dated September 25, 2013.
3) Package of Articles from the internet filed on behalf of MA.
4) Copy of Seventh-Day Adventist's Statement of Consensus on "Care for the Dying" from Adventist.org
5) Seventh-Day Adventist's Pamphlet.
6) Excerpt from Bayside Natural Health Centre website.
7) Letter from The Cleansing Way Lifestyle Change Program dated December 19, 2010.

INTRODUCTION

CA was a 45 year old woman who had been at the hospital since September 2011 in what Dr. Manocha described as a persistent vegetative state. She had a medical history of myasthenia gravis with previous respiratory failure. CA suffered cardiac arrest in August 2011 while in the United States. This resulted in severe anoxic brain injury. She was transferred back to Toronto for her continuing care. CA had developed numerous infections, pressure sores, required a tracheostomy and feed tube which was permanent. Numerous unsuccessful attempts have been made to wean her from the ventilator.

THE LAW

On any review of incapacity to consent to treatment under the *HCCA*, and any application under that *Act* to determine if the principles of substitute decision-making are complied with, the onus of proof at a Board hearing is always on the attending physician/health practitioner to prove the case. The standard of proof is proof on a balance of probabilities. The Board must be satisfied on the basis of cogent and compelling evidence that the physician's onus has been discharged.

The Board must consider all evidence properly before it. Hearsay evidence may be accepted and considered, but it must be carefully weighed.

Capacity to Consent to Treatment

Section 37.1 of the *HCCA* provides that:

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

Section 32(4) of the *HCCA* provides that:

32(4) The Board may confirm the health practitioner's finding that a person is incapable with respect to the treatment, or may determine that the person is capable with respect to the treatment, and in so doing may substitute its opinion for that of the health practitioner.

The test as to capacity is set out in section 4(1) of the *HCCA* as follows:

4(1) A person is capable with respect to a treatment, admissions 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 maybe, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

Compliance with the principles of substitute decision-making

Section 37. of the *HCCA* provides that:

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 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 substitution decision-maker complied with section 21.

37. (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.*

37. (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.

37. (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.

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

37. (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).

37. (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 (6.2) and (6.3), comply with the directions given by the Board on the application within the time specified by the Board.

37. (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.

37. (6.3) Directions given by the Board under section 35 on a subsequent decision-maker's application brought with leave under subsection (6.2) prevail over inconsistent directions under subsection (4) to the extent of the inconsistency.

37. (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.

Section 21 of the HCCA provides that:

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 it is impossible to comply with the wish, the person shall act in the incapable person's best interest.*

(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 of well-being,*

> *ii. prevent the incapable person's condition of well-being from deteriorating, or*
> *iii. reduce the extent to which, or the rate at which, the incapable person's condition of 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 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.*

Subsection 20(2) of the *HCCA* provides that:

> *20. (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.*

Section 5 of the HCCA provides that:

> *5. (1) A person may, while capable, express wishes with respect to treatment, admission to a care facility or a personal assistance service.*
> *(2) Wishes may be expressed in a power of attorney, in a form prescribed by the Regulations, in any other written form, orally or in any other manner.*
> *(3) Later wishes expressed while capable prevail over earlier wishes.*

Cases reviewed and considered

Barbulov v Ciron, [2009] OJ No 1439, 176 ACWS (3d) 1157.

Marsden v Taylor, [2006] OJ No 4045, 15 ACWS (3d) 725.

Scardoni v Hawtyluck, [2004] OJ No 300, 69 OR (3d) 700.

M(A) v Benes, [1999] OJ No 4236 OR (3d) 271.

P; File HA-05-6365 (re), [2005] OCCBD N0 180.

Rasouli v Sunnybrook Health Sciences Centre, [2011] ONCA 482

Janzen v Janzen (2002), 44 E.T.R. (2d) 217 (S.C.J.)

DD (Re), 2013 CanL11 18799 (ON CCB)
SS (Re), 2012 CanL11 85612 (ON CCB)

ANALYSIS

Capacity to Consent to Treatment

Did the evidence establish that CA was unable to understand the information relevant to making a decision about the treatment in question and unable to appreciate the reasonably foreseeable consequences of the current and proposed treatment?

Dr. Manocha stated that CA had been incapable of consenting to treatment since her admission. He conducted a formal capacity assessment on September 19, 2013 which is found at tab 17 of Exhibit #1. In his Consent and Capacity Board Summary found at tab B of Exhibit #1 Dr. Manocha stated that CA "has been in a persistent vegetative state since September 2011. She is not able to understand or respond to any of the proposed treatment plans or discuss prognosis since 2011."

This summary also indicated that Dr. Manocha considered the reasonably foreseeable consequences of the current treatment to be that "the patient will continue in the ICU with ongoing life support and interventions, and ongoing pain and suffering. She will also be subject to the ongoing risk of recurrent infections." In this summary Dr. Manocha indicated that the reasonably foreseeable consequences of the proposed treatment were that CA "will pass naturally and peacefully without suffering." Dr. Manocha referred to his comments that because she was in a persistent vegetative state, CA could not appreciate these consequences.

This evidence from Dr. Manocha was neither contested nor contradicted.

In her final submissions counsel for CA stated that she could not communicate with CA and therefore could not get any instructions from her about her capacity and consequently could not make any submissions on the issue of CA's capacity to consent to treatment.

The Board found that the evidence established that CA was not able to understand the information relevant to making a decision about the treatment in question and unable to appreciate the foreseeable consequences of the current and proposed treatment. The Board therefore found CA was not capable to consent to treatment.

Compliance with principles of substitute decision-making

Dr. Manocha was the first witness to give oral evidence. He told the Board that he had been at the hospital since 2005. He had obtained his medical degree from Memorial University and specialized in internal medicine. Before coming to the hospital he had worked in Vancouver where he obtained experience as an intensivist. He had also worked in Winnipeg in critical care and respirology. Dr. Manocha was the director of the Intensive Care Unit (the "ICU) at the hospital but described that as involving mostly administrative duties. He stated that he attended medical conferences regularly for ongoing training.

Dr. Manocha stated that he was part of a team of intensivists that rotated through the ICU. This team met regularly and discussed treatment for their shared patients. Dr. Manocha said that he had discussed CA's situation with the medical team and he had prepared the proposed treatment plan with the entire team's agreement.

Since her admission at the hospital in September 2011 CA had been in a persistent vegetative state. Her level of care had been that of full supportive care. This included the use of a ventilator by means of a tracheotomy, a feeding tube, treatment of infections and resuscitation in the event of cardiac arrest. He described CA as being ventilator dependent. There had been numerous attempts to wean her from the ventilator and all had failed. The most recent attempt at weaning her from the ventilator had been several months ago.

Dr. Manocha told the Board that the CT scan reported at tab 15 page 224 of Exhibit #1 was consistent with anoxic brain injury. He explained that this scan confirmed that the higher cortical function of the brain had been damaged accounting for CA's loss of being able to engage in her surroundings on an active basis. He also explained that the fact that the cerebellum and the brainstem were described as unremarkable explained why CA retained her basic bodily functions such as normal wake and sleep, opening her eyes and moving her head and limbs.

Dr. Manocha told the Board that it was the loss of cortical function that resulted in CA being in a persistent vegetative state for more than 2 years with no prospect of recovery. He referred to other medical opinions contained in Exhibit #1 to corroborate this opinion. These are as follows:

Tab 6 pages 12 and 13: Consultation Report of Neurologist Dr. David Morgenthau dated June 3, 2013 which stated:

> (CA) is now approaching 2 years post hypoxic encephalopathy from cardiac arrest. She clearly has a stable vegetative state. No change in this is expected until such time as a new medical problem develops that will leave her either with increased deficits or potentially cause death. Prognosis here is undoubtedly hopeless for any real neurologic recovery.

Tab 8 pages 15 and 16: Consultation Report of Dr Terry Cooligan FRCPC dated September 3, 2013, wherein Dr. Cooligan states after giving CA's medical history as described by Dr. Manocha:

> Clinically this patient does not seem to benefit from the treatment we are providing. The treatment is undoubtedly causing repeated harm from ongoing interventions that precipitate sepsis. It is my understanding that one of her sisters does not feel the patient would want this ongoing support in the face of what appears to be inappropriate futile treatment. Certainly the level of care has continued to be provided with dignity; however, in the context of her overall condition the patient ultimately will die of her anoxic brain injury and ultimately complications resulting from it. In that context continued treatment in the big picture, in my opinion, is not dignified or respectful of any patient facing this current scenario. At this time the treatment continues based on principal of autonomy that has been exercised by some of her family members. It is unfortunate that she cannot even benefit from visitation from those family members that are insisting on her care. Suffice it to say that the quality of her life in my opinion is nonexistent. My conversation with the patient's mother indicated that she continued to cling to miracles which is indeed the only thing that would alter the natural history of current ongoing illness.

Tab 14 pages 62 and 63: Consultation Report of Dr. Jan Friedrich dated September 24, 2011 confirms the prognosis for recovery for CA had not been good from the time of arrival at the hospital. This report states:

I arranged a family meeting with the mother and sister on September 21st. (2011) I told them that the chance of any meaningful neurologic recovery was essentially nil. The family stated though that they were very religious and felt that she would improve. They had other family members who had been given a similar poor prognosis and they had gotten better. I told them that if she did not improve, she would continue to suffer from complications associated with prolonged mobility (immobility), such as pressure ulcers, she already has a sacral ulcer and infections. She has also had previous pneumonia and UTI. If she didn't recover, it would be those secondary complications that she likely would pass away from. They both felt that she would want to continue like this and they both felt that she would want it to be a full code, although her mother at one point during the meeting (said) that she felt that she was suffering in her current state.

Tab 14 Pages 60 and 61: Consultation Report of Dr. Morgenthau dated September 20, 2011 this early negative prognosis is indicated when he says in the report:

(CA) presents at this time with evidence of a severe brain injury and with a history of arrest, undoubtedly on the basis of ischemia/anoxia. Given the very long time that she has had since the original event, despite the intercurrent illnesses, undoubtedly she has a dismal prognosis for recovery. At present, her myasthenia does not appear to be a significant factor in that she has extraocular movement, she is blinking, she is jaw clenching, she has movement of limbs to noxious stimuli and she is breathing independently though a trach, mask. If the myasthenia was a significant factor in her mobility, these things would not be present. In addition she still should have some attentiveness.

Dr. Manocha's evidence revealed that because of the poor prognosis and no chance of CA making a meaningful recovery he commenced speaking to the SDM about changing CA's level of care and discussed removing CA from the ventilator. This telephone conversation is described in Dr. Manocha's General Clinic Notes dated August 3, 2012 and found at tab 2 page 3 of Exhibit #1.

As previously mentioned Dr. Manocha prepared a proposed treatment plan that had the approval of the intensive care team. His evidence was that this proposed plan was as described in the Consent and Capacity Board Summary at tab A of Exhibit #1: It was to change the focus of care to supporting the relief of any pain or suffering, to withdraw mechanical ventilator and to preclude CPR in the event of cardiac arrest.

Dr. Manocha said he discussed this proposed treatment plan with the SDM and NA in telephone conversations in May 2013. The telephone conversation with the SDM was on May 27, 2013 and the telephone conversation with the sister NA was on May 31, 2013. In these telephone conversations, Dr. Manocha outlined the proposed treatment plan and sought consent from the mother as SDM to implement the proposed treatment plan. The SDM declined to consent and referred Dr. Manocha to her daughter NA and her son in the United States. Dr. Manocha then spoke to NA who told him the family would not consent to the treatment plan because they had strong religious beliefs and felt CA would recover. This note made reference to the hospital assisting the family members in obtaining visas to enter Canada to visit CA. These telephone conversations are described in Dr. Manocha's Consultation Report date June 1, 2013 at tab 5 page 8 of Exhibit #1.

Dr. Manocha described a family meeting he had with the SDM and her daughter NA on September 11, 2013. It was another effort on his part to explain the proposed treatment plan and to seek consent for its implementation from the SDM. Once again he was told that the family did not want to remove the ventilator because they were religious and were holding out for a miracle. This family meeting is described in Dr. Manocha's Consultation Report dated September 11, 2013 and found at tab 9 pages 17 and 18 of Exhibit #1.

Dr. Manocha told the Board the next family meeting was held on September 13, 2013. On this occasion CA's father participated in the meeting by teleconference from his home outside of Canada. Dr. Manocha asked him what his understanding was of his daughter's condition. He replied to the effect that he thought that she was getting better and responding. Dr. Manocha said that he explained to CA's father that that was not the case and explained her condition to him. CA's father repeated that the family believed in God and felt that God would make her better. CA's father confirmed to Dr. Manocha that he was agreeable to allow his wife to act as SDM and agreed with her decisions. Dr. Manocha once again explained the proposed treatment plan and once again the SDM declined to consent to the implementation of the proposed treatment plan. NA told Dr. Manocha that there were some alternative treatments that the family wanted to explore. The Consent and Capacity Board process was explained to the family by Mr. Robert Parke, a Clinical Ethicist, present at the meeting. His note dated September 13, 2013 can be found at tab 12 pages 25 of Exhibit # 1. This family meeting is described in Dr. Manocha's Consultation Report dated September 13, 2013 and can be found at tab 11 pages 23 to 25 of Exhibit #1.

Dr. Manocha reported one final family meeting was held with the SDM and CA's sister NA on September 25, 2013. This meeting was in CA's room. They informed Dr. Manocha that over the previous weekend CA's brother had been able to get a response from CA by repeatedly asking her to close her eyes. The family was interpreting this as CA being able to respond and being aware. However NA did acknowledge there were times when CA did not respond. Dr. Manocha asked the SDM and NA to speak to CA to see if they could get a response. They did not succeed in getting a response. NA informed Dr. Manocha that she had spoken to an alternative practitioner who informed her that using chlorophyl in this situation would help improve CA's neurologic status. Dr. Manocha again asked for consent to the proposed treatment plan and the SDM declined consent. This family meeting is described in Dr. Monacha's Consultation Report dated September 25, 2013 and filed as Exhibit #2.

MA and three of CA's siblings, her sister NA, and two brothers ZA and Mr. CA all gave oral evidence at the hearing. Their evidence was very sincere and heartfelt. It demonstrated the love they all had for CA as well as their very strong religious faith and beliefs. The common theme to their evidence was that they fervently believed that God would intervene to see CA recover from her brain injury in spite of the strong medical opinion to the contrary. They all told the Board that CA was a very religious person as well and were she capable she would also rely on God and not agree to remove the life support as was being proposed by the medical team.

All family member witnesses confirmed that, prior to her cardiac arrest event CA had led an independent life and was very active in missionary work through her Church.

All of the family member witnesses told the Board that they had had no discussions with CA regarding any prior wishes she may have had concerning life support if she were to find herself in her present situation. Counsel for CA asked NA about a letter CA had sent to her. This letter can be found at tab 14 pages 84 of Exhibit #1. NA said that it was a testamentary document dealing with finances only. NA referred to another letter that CA told her was coming to her by post but she stated she never did receive a second letter.

All of the family member witnesses agreed that CA believed strongly in natural remedies and in fact had been managing her myasthenia gravis with the use of natural remedies up until the time of her cardiac arrest. They all asked that the Board allow more time for these natural remedies to be administered before directing the SDM to consent to the proposed treatment plan.

Another common element of the family member evidence was that they knew of family members who awoke from comas after doctors had told them they would not recover. They made specific reference to one uncle who had been a patient at the Humber River hospital and awoke from a coma after 3 months contrary to medical opinion.

In her evidence NA introduced Exhibit #3 which is a package of articles taken from the internet. The material included information about a naturopathy practice, nutritional supplement information and articles about the "plasticity" of the brain in responding to damage.

NA made reference to a conversation with Dr. Morgenthau and said he told the family that for CA to recover he would have had to have missed something. He affirmed his opinion that she would not recover but admitted it was possible he could be wrong and admitted that in the past there was one patient that recovered when he had diagnosed her not to recover. In her evidence NA emphasized her belief that 90% of CA's difficulty was from the myasthenia gravis and if CA were to take prednisone she would recover. She also emphasized that CA was a strong believer in the use of natural remedies and that that was the source of the bad feelings between CA and another sister who lives in the Toronto area but does not support the family position that CA will recover. See tab 4 page 7 Exhibit #1 Social Work note of telephone discussion of May 28, 2013.

NA confirmed that no one would want to live a life in CA's present condition but because of her conviction that there could be a miracle or a cure through natural remedies she would not agree to turn "the machine off."

Counsel for Dr. Manocha presented NA with a document, entered as Exhibit 4, taken from adventist.org, the website of the Seventh-Day Adventist Church. This document is entitled "A Statement of Consensus of Care for the Dying" and article 4 on page 2 of it speaks of withdrawing life support in certain cases. NA was asked if she believed CA endorsed this position of the Church. NA told the Board she was aware that CA did not agree with the modernization of the Seventh-Day Adventist Church and had joined a new independent group that rejected some of the beliefs of the mainstream Church. NA could not speak specifically to this position on life support policy but confirmed that there were some areas of disagreement between CA's and the main Church's beliefs.

In her evidence MA stated that what she wanted was for CA to get up and "walk and talk". She stated that when she recently saw CA for the first time in approximately a year she thought she looked "not so good". However, the next day she felt that she looked much better and that her "body had come alive". MA confirmed that the family members spend more time with CA than her doctors did and this accounted for their being able to see signs of responses that the medical professionals could not see. She confirmed the wish that CA remain on the ventilator to allow time to try natural remedies to have her recover. She also expressed the belief that CA's myasthenia gravis had more to do with her present condition than the brain injury.

CA's brother ZA gave evidence that corroborated previous evidence from family members that CA was a religious person who believed in miracles and that CA was a fighter who would not want to have the life support removed. He told the Board about he and his wife both having successful results using natural remedies and repeated the request that CA be allowed time to try natural remedies. ZA told the Board that he had been able to illicit responses for CA by repeatedly asking her to close her eyes. ZA repeated Dr. Morgenthau's comments that he could have missed something but that he did not believe he had.

CA's brother Mr. CA also gave evidence. As noted previously his evidence on the main was in keeping with that of the other family members. He confirmed that CA was a religious person and believed strongly in natural remedies. He told the Board he was a Certified Medical Missionary, certified by his Church and Conferences. He stated that he had made the contact with the alternative practitioner. He stated that the practitioner was unable to attend to examine CA because his schedule did not permit it.

CA's counsel asked Mr. CA what remedies would be introduced he replied "natural raw foods".

He also referred to lecithin and natural foods with no pesticides.

The Board also heard evidence from CA's pastor by way of teleconference from the United States. He was the pastor of an Independent Church that had separated from the Seventh-Day Adventist Church but still held many of the same beliefs. The pastor told the Board he had been CA's pastor for 2 years prior to her cardiac arrest event in 2011. He said that CA was very religious and worked hard for the Church.

The pastor stated that when CA was a member of his Church she had expressed to him that she was very concerned about becoming bedridden as a result of her myasthenia gravis. He stated that she had told him that she knew of people who became bedridden. CA told him she could not do the service of the Lord if she became bedridden so she preferred that the Lord "let her sleep until he comes again". Under questioning from Dr. Manocha's counsel the pastor explained this to mean to "die and reawaken later on". The pastor said he had had no conversations with CA dealing specifically with the life support situation.

The pastor confirmed CA's belief in miracles. He told the Board that when he met her she had already had an anointment, which is a process whereby a person is prayed over by the pastor and church elders invoking a cure for a medical condition. She asked him for another anointment.

The pastor stated that CA told him that the Lord had seen her through two previous relapses. Through her faith the Lord blessed her and she had recovered. The pastor also confirmed CA's strong belief in natural remedies. In answer to the specific question from NA the pastor acknowledged that he believed that God had stopped CA from dying when her heart stopped.

The pastor was also asked if he agreed with the Consensus Statement marked as Exhibit #4 and specifically article 4 which reads:

4) Christian love is practical and responsible (Romans 13:8-10; Corinthians 13; James 1:27;2:14 14-17). Such love does not deny faith nor obligate us to offer or to accept medical interventions whose burdens outweigh the probable benefits. For example, when medical care merely preserves bodily functions, without hope of returning a patient to mental awareness, it is futile and may, in good conscience, be withheld or withdrawn. Similarly, life-extending medical

treatment may be omitted or stopped if they only add to the patient's suffering or needlessly prolong the process of dying. Any action taken should be in harmony with legal mandates.

The pastor responded that he agreed with this article.

Did the evidence establish that there existed a Prior Capable Wish?

The Board found that the evidence did not establish that there existed a prior capable wish.

There was no evidence of a Power of Attorney or Living Will. The only testamentary document that existed was the letter to NA that dealt only with finances. There was mention of a second letter but, in her evidence, NA said that she did not receive a second letter.

All of the family members confirmed that they had had no discussions with CA dealing with the eventuality of her being in a life support situation. They said that the reason for this was that neither CA nor any of them had contemplated that this situation would ever come to pass.

The comments made to the pastor to the effect that she would rather have the Lord let her sleep until he comes again could easily have been interpreted that CA was expressing her wish to die rather than be bedridden. The difficulty with finding these comments to constitute a prior capable wish is that they do not contemplate a life sustaining situation and for this reason the Board rejects them as constituting a prior capable wish.

Best Interests

Having found that no prior capable wish existed in the Board then needed to decide, as provided in subsection 21 (1) (2) of the HCCA, whether MA as substitute decision maker was acting in CA's best interests.

The evidence at the hearing revealed that a disagreement existed between the family member substitute decision-maker and the health practitioner. This is what the provisions of the *HCCA* were designed to resolve. The Board acknowledged its role was as described in *M(A) v Benes:*

> A case will come before the Board only when the health practitioner disagrees with the S.D.M.'s application of the best interests tests under s. 21(2). The Board will then have before it two parties who disagree about the application of s.21: the S.D.M., who may have better knowledge than the health practitioner about the incapable person's values, beliefs and non-binding wishes; and the health practitioner, who is the expert on the likely medical outcomes of the proposed treatment. The disagreement between the S.D.M. and the health practitioner potentially creates tension and the Act recognizes this by providing for a neutral expert Board to resolve the disagreement. Indeed, after hearing submissions from all parties, the Board is likely better placed than either the S.D.M. or the health practitioner to decide what is in the incapable person's best interests. Thus, the Board should not be required to accord any deference to the S.D.M.'s decision.

Values and Beliefs

The Board accepted the evidence from the family members and the pastor that, prior to her cardiac arrest event, CA was an energetic and independent person who held very strong religious beliefs. She was also very active in the work of her Church. The evidence revealed that CA also had a strong belief in natural remedies. The evidence revealed that Dr. Manocha had treated CA in 2009 for her myasthenia gravis but he offered no evidence with respect to her values and beliefs.

MA and the family members suggested that CA, because of her strong religious beliefs, would share their desire to allow more time for a miracle to occur that would lead to her recovery contrary to the medical evidence and opinion of Dr. Manocha and the numerous other health practitioners.

The Board did not accept that the fact that CA had strong religious beliefs meant that she would choose to live in her present condition indeterminately waiting for a miracle to occur. There was in fact evidence to the contrary. The evidence from the pastor that CA had told him she would rather go to sleep and wait for the Lord to come again rather than be bedridden was the evidence that the Board accepted to find that CA would not want to remain in her present condition. The Board did not accept this evidence as a prior capable wish because it did not refer to the life support situation but accepted it as evidence that countered the proposition that CA would choose to live indefinitely in her present condition.

The evidence of the pastor also convinced the Board that strong religious beliefs would not preclude the adoption of the proposed treatment plan. The pastor indicated that he had established an independent Church because he disagreed with some of the modernization adopted by the Seventh-Day Adventist Church. However, when article 4 of Exhibit # 4
"Statement of Consensus on Care for the Dying" was put to him he said that he agree with it. The Board found that CA would likely have had similar views as her pastor because she had left the mainstream Seventh-Day Adventist Church to join his independent Church. The Board therefore found that AC's strong religious beliefs did not mean she would not have agreed that it was time to remove life support and place her fate in the hands of God.

MA and the family members also suggested that the evidence that CA had strong belief in natural remedies signified that she would want to postpone the implementation of the treatment plan proposed by Dr. Manocha, in order to allow natural remedies to be applied. Dr. Manocha told the Board that the family had not made this suggestion at any time during the over two years that CA was in the hospital. The suggestion of exploring natural remedies came only two weeks before the hearing. Dr. Manocha stated that had the suggestion been made at the beginning of CA's hospitalization it is something he would have cautiously considered but at this stage he felt it did not justify a delay and would only prolong CA's suffering.

The Board reviewed the material on natural remedies and brain rejuvenation contained in Exhibit # 3 and found that, as Dr. Manocha had stated, there did not appear to be much relevance to CA's situation. Firstly, the articles dealing with nutrition were more about prevention than rejuvenation or repair of an injured brain. Secondly, the articles dealing with "plasticity" dealt with situations where one area of the brain that provided higher cortical function had been injured and other areas were functioning. In these circumstances there was evidence of neurons working to rejuvenate the injured areas. The evidence of CA's injury was that the entire higher cortical functioning level of her brain was damaged beyond repair.

The Board considered the evidence from several family members that their uncle had recovered from a coma after three months. There was no evidence of what medical condition the uncle had to cause his being in a coma and consequently it was impossible to draw any similarities to CA's condition. The Board also distinguished the uncle's situation on the basis that his alleged coma was for three month duration and the evidence presented at the hearing was that CA had been in the persistent vegetative state for over two years.

Prior wishes expressed not required to be followed under paragraph 1 of subsection (1)

As previously outlined the Board found that CA's statement to her pastor that she would rather sleep until the Lord came again than be bedridden by her myasthenia gravis did not constitute a prior capable wish because it referred to being bedridden and not being on life support. Also as mentioned the Board did not accept that CA's religious beliefs would preclude her agreeing to the proposed treatment plan focusing on palliative care. As support for this finding the Board considered that the situation of being bedridden she was referring to was much less restrictive than her situation at the time of the hearing where she was existing on life support equipment.

Well-being

There are four components of section 21(2) that refer to well-being. They are:

1. Subsection 21(2)(c)1.i. Whether the treatment is likely to improve the incapable person's condition or well-being:
2. Subsection 21(2)(c)l.ii. Whether the treatment is likely to prevent the incapable person's condition or well-being from deteriorating:
3. Subsection 21(2)(c)1.iii. Whether the treatment is likely to reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
4. Subsection 21(2)(c)2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.

The court in the case of *Scardoni v Hawryluck*, Cullity J. accepted the Board's definition of the word well-being as follows:

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

The court in *Scardoni* referred to *Janzen v Janzen* in which Aiken J. held:

> I consider the concept of "well-being" a very broad concept which encompasses many considerations, including quality of life.

Aiken J., in the *Janzen* case also dealt with the issue of treatments that are not likely to improve an incapable person's condition when he stated:

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

In considering the evidence on the issue of well-being and whether expected benefits to be gained from the proposed treatment outweighed the risk of harm, the Board bore in mind the words of Quigley J. in the case of *Marsden v Taylor* when in paragraph 96 he said:

> With respect to the criteria set out in section 21(2)(c) of the Act, deference must be paid to those qualified to provide medical advice. At its root, the questions that were in front of the Board were medical questions

Dr. Manocha's corroborated evidence was that CA had no chance of making a truly meaningful recovery. CA had been in a persistent vegetative state for more than two years. Dr. Manocha was proposing a plan of treatment that was focused on palliative care and would improve her well being. Although it would shorten her life, it would ensure that she was kept comfortable and would improve her quality of life and respect her dignity. Dr. Manocha told the Board he was certain that CA felt pain and was uncomfortable when the numerous life preserving procedures were being performed. He interpreted her facial grimaces and pulling away as evidence that she was feeling pain and was uncomfortable. The Board accepted this evidence from Dr. Manocha.

Dr. Manocha interpreted the family's efforts to recognize signs of response on the part of CA as their completely understandable desire to find hope for her recovery. He attributed the movements they interpreted as response as reflexive and random movements. The Board agreed with Dr. Manocha's interpretation and shared his empathy with the family's desire to see hope for CA's recovery.

The Board considered it entirely understandable that MA and the family would advocate strongly on behalf of their loved one. However, the Board found that the desire to preserve CA's life did not allow for any consideration by MA and the family of the cogent and compelling medical evidence.

If CA's condition could not be improved the Board could not see how her quality of life or well-being could be made to improve.

Expected benefits to treatment outweigh risk of harm

Section 21(2)(c)3 requires that consideration be given as to whether the expected benefit from treatment outweighs the risk of harm to the incapable person. It has already been indicated that this is an area that the Board found that deference should be given to the medical practitioner.

Also, as previously stated, Dr. Manocha's corroborated evidence was that CA's condition could not be improved. He stated that many of the treatment measures which were being eliminated in his proposed treatment plan but were being advocated by MA and the family members would result in pain and discomfort to CA. Dr. Manocha acknowledged that his proposed plan of treatment would hasten CA's death but he believed that the benefit of dying pain free and with dignity outweighed the risk of harm. The Board agreed.

Less restrictive and less intrusive treatment

Section 21(2)(c)4 requires that consideration be given to the possibility that less restrictive and less intrusive treatment could be beneficial.

The Board considered this to be the crux of the disagreement between MA and the family members and Dr. Manocha and the medical team. Dr. Manocha's evidence was that there was no less restrictive and less intrusive treatment that could be beneficial to CA because there was no chance of her condition improving. He was therefore proposing a treatment plan that would no longer keep CA alive artificially and allow her to pass with respect and dignity. MA and the family members would not consent to it.

Conclusion

The Board found that CA was not capable to consent to treatment.

The Board also found after considering all of the provisions of section 21 of the HCCA that on the balance of probabilities the treatment plan proposed by Dr. Manocha was in the best interests of CA. In the *Scardoni* case the court held that "best interests" should be interpreted broadly to include issues of dignity and quality of life. All of the medical evidence made plain that CA had a very poor quality of life and the situation would not improve. CA was subjected to daily indignities through invasive medical procedures without increasing the likelihood that she would recover any awareness or consciousness.

RESULT

For the foregoing reasons, the Board found CA not capable with respect to treatment. The Board also found that MA had not complied with the principles of substitute decision-making in the Act and directed her to consent to the treatment plan proposed by Dr.

Manocha by 6 p.m. on September 30, 2013. The treatment plan included withdrawal of mechanical ventilator and focused on palliative care without cardio-pulmonary resuscitation.

Dated: October 7, 2013

Paul DeVillers
Senior Lawyer-Presiding Member