TO-10-0633
TO-10-0634

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

AND IN THE MATTER OF
DP
A patient at
Humber River Regional Hospital-Finch Avenue Site
TORONTO, ONTARIO

REASONS FOR DISMISSAL

PURPOSE OF THE HEARING

A panel of the Board convened at the Humber River Regional Hospital-Finch Avenue Site at the request of Dr. Ali Ghafouri, a health practitioner. Dr. Ghafouri brought a Form G Application to the Board under Section 37 (1) of the *Health Care Consent* Act for a determination as to whether or not the substitute decision maker in this case complied with Section 21 of the *Health Care Consent Act*, the principles for substitute decision-making, with respect to proposed treatment for DP. Dr. Manocha as DP's current health practitioner took over carriage of the Form G Application from Dr. Ghafouri. The proposed treatment was set out in a Plan of Treatment filed as an Exhibit.

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

DATES OF THE HEARING, DISMISSAL AND REASONS

The hearing took place on Monday June 28, 2010 and Tuesday June 29, 2010. The applications were dismissed on July 5, 2010. Reasons were released on July 11, 2010.

LEGISLATION CONSIDERED

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

PARTIES

DP's Deemed Form A – Treatment Application
DP, patient
Dr. S. Manocha, health practitioner

Dr. S. Manocha's Form G – Treatment Application concerning DP
Dr. S. Manocha, health practitioner
DP, patient
GP, DP's wife and substitute decision maker.

DP did not attend the Hearing. Dr. Manocha attended a portion of the Hearing and was excused after his oral testimony. GP attended the Hearing and gave evidence.

PANEL MEMBERS

Michael Newman, Vice-Chair, Presiding Lawyer Member
Nural Alam, psychiatrist member
Takis Pappas, public member

APPEARANCES

DP was represented at the Hearing by counsel, Mr. D. Hiltz
Dr. Manocha was represented at the Hearing by counsel, Mr. M. Handelman
GP was represented at the Hearing by counsel, Mr. R. Bohm

PRELIMINARY MATTERS

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

THE EVIDENCE

The evidence at the hearing consisted of the oral testimony of nine witnesses, Dr. S. Manocha, E. Lo, registered dietician, S. Hill, registered nurse and clinical practice leader, B. Parkes, hospital ethicist, GP, DP's wife and substitute decision maker, CP, DP's friend, TP, DP's daughter, CP, DP's daughter and RF, DP's sister and thirteen Exhibits:

1. Dr. Manocha's Summary
2. proposed Plan of Treatment
3. Ms. Lo's Nutrition Case Report dated May 19, 2010
4. Ms. Hill's Note dated May 20, 2010
5. Dr. Morgenthau's Consultation Report dated April 1, 2008
6. Dr. Manocha's Consultation Report dated March 26, 2010
7. Dr. Morgenthau's Consultation Report dated March 26, 2010
8. Elaine Lo's Key Skills and Experience
9. Dr. Sanjay Manocha's Resume
10. Sonia Hill's Professional Work History
11. Medical glossary
12. Dr. Levitan's Report dated April 14, 2010
13. Mr. Parke's note of March 26, 2010 (1805)

INTRODUCTION

This case presented with very difficult and sad circumstances. DP a forty seven year old married father of three children came to hospital on December 20, 2007 with complaints diagnosed as a chest infection. He was discharged from hospital the same day. The next day on December 21, 2007 DP returned to hospital when he developed nausea, vomiting, had abdominal pain, and difficulty breathing. He was discharged on December 26, 2007. On December 28, 2007, DP was brought to hospital by ambulance with a fever associated in part with tachycardia and dyspnea. In the emergency room, DP suffered a cardiac arrest and in the words of Dr. Levitan, the consultant neurologist, suffered from "ischemic anoxic encephalopathy" related to cardiac arrest. DP was admitted to hospital on December 30, 2007 and transferred to the hospital's intensive care unit.

According to hospital notes referred to in Dr. Levitan's April 14, 2008 report filed as well as other evidence DP's mentation improved to the point that he became conversant. GP substantiated that her husband awoke and reportedly made some "real recoveries of neurologic function" according to the medical and other evidence. However, following insertion of a PEG tube for feeding on February 5, 2008 DP's presentation declined when he developed septic shock, according to Dr. Levitan in his report and other medical evidence around the time of a "gastric perforation and malposition of the PEG tube". Dr. Manocha's evidence was that DP suffered a hypoxemic brain injury or lack of oxygen to the brain causing him to remain in a vegetative state since on or about February 6, 2008, some 2½ years ago.

DP now forty nine years old has been totally dependent on his wife GP as his substitute decision maker for all treatment decisions since February 6, 2008. He has been receiving full medical treatment and support in accordance with his wife's consent since that time.

On March 26, 2010 a meeting was called at the hospital attended by GP as her husband's substitute decision maker, DP's sister and brother as well as a number of hospital staff including Dr. Manocha, the new head of the Intensive Care Unit ("ICU"), Dr. Morganthau, the Chief of Medicine, other members of the ICU team, social work and Mr. Parke, the clinical ethicist. The meeting ended according to Dr. Manocha when GP clearly indicated she "wanted full supportive interventions with the goal of keeping him alive" insofar as her husband's care was concerned.

At the time of the March 26, 2010 meeting, the plan for DP's treatment was to continue with the Plan of Treatment in place at the time and continuing as of the Hearing, according to Dr. Manocha, with full supportive measures and care for DP. Dr. Manocha's evidence included that the hospital team would have further discussions as a team and make a further presentation to the family, after a number of weeks. According to the uncontraverted oral and documentary evidence filed that did not take place.

The proposed Plan of Treatment did not exist on March 26, 2010. According to Mr. Parke the hospital ethicist, the proposed Plan of Treatment was drawn up sometime in May, 2010 and presented to GP when it was sent to her lawyer later in May 2010 together with the Form G Application before the Board. According to Mr. Parke, as of the Hearing no attempt had been made to implement the proposed Plan of Treatment. Dr. Manocha said that if implemented the proposed Plan of Treatment would see the primary treatment goal being palliative in nature. Dr. Manocha also said that as of the Hearing DP remained stable and was being treated according to the current Plan of Treatment including full supportive measures. According to Dr. Manocha while a major concern remained whether insertion of a central line would be able to occur, the most recent central line was inserted on May 30, 2010 after the previous central line had remained in place for 1½ years.

THE LAW

General

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

Incapacity with Respect to Treatment

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

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

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

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

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

"**plan of treatment**" means a plan that,

(a) is developed by one or more health practitioners,

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

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

"**treatment**" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include,

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

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

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

(d) the communication of an assessment or diagnosis,

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

(f) a personal assistance service,

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

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

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

Wishes

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

Manner of expression

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

Later wishes prevail

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

Sections 10, 11, 12, and 13 of the *Health Care Consent Act* provide that:

No treatment without consent

10. (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

(a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or

(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).

Opinion of Board or court governs

(2) If the health practitioner is of the opinion that the person is incapable with respect to the treatment, but the person is found to be capable with respect to the treatment by the Board on an application for review of the health practitioner's finding, or by a court on an appeal of the Board's decision, the health practitioner shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless the person has given consent. 1996, c. 2, Sched. A, s. 10 (2).

Elements of consent

11. (1) The following are the elements required for consent to treatment:

1. The consent must relate to the treatment.

2. The consent must be informed.

3. The consent must be given voluntarily.

4. The consent must not be obtained through misrepresentation or fraud. 1996, c. 2, Sched. A, s. 11 (1).

Informed consent

(2) A consent to treatment is informed if, before giving it,

(a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and

(b) the person received responses to his or her requests for additional information about those matters. 1996, c. 2, Sched. A, s. 11 (2).

Same

(3) The matters referred to in subsection (2) are:

1. The nature of the treatment.

2. The expected benefits of the treatment.

3. The material risks of the treatment.

4. The material side effects of the treatment.

5. Alternative courses of action.

6. The likely consequences of not having the treatment. 1996, c. 2, Sched. A, s. 11 (3).

Express or implied

(4) Consent to treatment may be express or implied. 1996, c. 2, Sched. A, s. 11 (4).

Included consent

12. Unless it is not reasonable to do so in the circumstances, a health practitioner is entitled to presume that consent to a treatment includes,

(a) consent to variations or adjustments in the treatment, if the nature, expected benefits, material risks and material side effects of the changed treatment are not significantly different from the nature, expected benefits, material risks and material side effects of the original treatment; and

(b) consent to the continuation of the same treatment in a different setting, if there is no significant change in the expected benefits, material risks or material side effects of the treatment as a result of the change in the setting in which it is administered. 1996, c. 2, Sched. A, s. 12.

Plan of treatment

13. If a plan of treatment is to be proposed for a person, one health practitioner may, on behalf of all the health practitioners involved in the plan of treatment,

(a) propose the plan of treatment;

(b) determine the person's capacity with respect to the treatments referred to in the plan of treatment; and

(c) obtain a consent or refusal of consent in accordance with this Act,

(i) from the person, concerning the treatments with respect to which the person is found to be capable, and

(ii) from the person's substitute decision-maker, concerning the treatments with respect to which the person is found to be incapable. 1996, c. 2, Sched. A, s. 13.

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

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

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.

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

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

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

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

(c) the following factors:

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

37. (1) If consent to a treatment is given or refused on an incapable person's behalf by his or her substitute decision-maker, and if the health practitioner who proposed the treatment is of the opinion that the substitute decision-maker did not comply with section 21, the health practitioner may apply to the Board for a determination as to whether the substitute decision-maker complied with section 21. 1996, c. 2, Sched. A, s. 37 (1).

Parties

(2) The parties to the application are:

1. The health practitioner who proposed the treatment.
2. The incapable person.
3. The substitute decision-maker.

4. Any other person whom the Board specifies. 1996, c. 2, Sched. A, s. 37 (2).

Power of Board

(3) In determining whether the substitute decision-maker complied with section 21, the Board may substitute its opinion for that of the substitute decision-maker. 1996, c. 2, Sched. A, s. 37 (3).

Directions

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

Time for compliance

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

Deemed not authorized

(6) If the substitute decision-maker does not comply with the Board's directions within the time specified by the Board, he or she shall be deemed not to meet the requirements of subsection 20 (2). 1996, c. 2, Sched. A, s. 37 (6).

Subsequent substitute decision-maker

(6.1) If, under subsection (6), the substitute decision-maker is deemed not to meet the requirements of subsection 20 (2), any subsequent substitute decision-maker shall, subject to subsections (6.2) and (6.3), comply with the directions given by the Board on the application within the time specified by the Board. 2000, c. 9, s. 35.

Application for directions

(6.2) If a subsequent substitute decision-maker knows of a wish expressed by the incapable person with respect to the treatment, the substitute decision-maker may, with leave of the Board, apply to the Board for directions under section 35. 2000, c. 9, s. 35.

Inconsistent directions

(6.3) Directions given by the Board under section 35 on a subsequent substitute decision-maker's application brought with leave under subsection (6.2) prevail over inconsistent directions given under subsection (4) to the extent of the inconsistency. 2000, c. 9, s. 35.

P.G.T.

(7) If the substitute decision-maker who is given directions is the Public Guardian and Trustee, he or she is required to comply with the directions, and subsection (6) does not apply to him or her. 1996, c. 2, Sched. A, s. 37 (7).

Deemed application concerning capacity

37.1 An application to the Board under section 33, 34, 35, 36 or 37 shall be deemed to include an application to the Board under section 32 with respect to the person's capacity to consent to treatment proposed by a health practitioner unless the person's capacity to consent to such treatment has been determined by the Board within the previous six months. 2000, c. 9, s. 36.

ANALYSIS

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

The main application before the Board was the Form G brought pursuant to the *Health Care Consent Act*. Dr. Ghafouri a health practitioner applied for a determination as to whether or not GP as her husband DP's substitute decision maker complied with the principles for substitute decision making as set out in the *Health Care Consent Act* with respect to the proposed Plan of Treatment. Dr. Manocha, as DP's current attending physician and health practitioner took over carriage of the Form G application from Dr. Ghafouri. Throughout our deliberations, we imposed the onus of proof upon Dr. Manocha. That onus was on a balance of probabilities.

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

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

The Purposes of the HCCA are set out at its very beginning in Section 1.

> The purposes of this Act are,
>
> (a) to provide rules with respect to consent to treatment that apply consistently in all settings;
>
> (b) to facilitate treatment, admission to care facilities and personal assistance services, for persons lacking the capacity to make decisions about such matters;
>
> (c) to enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed and persons who are to receive personal assistance services by,
>
> (i) allowing those who have been found to be incapable to apply to a tribunal for a review of the finding,
>
> (ii) allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on their behalf concerning treatment, admission to a care facility or personal assistance services, and

(iii) requiring that wishes with respect to treatment, admission to a care facility or personal assistance services, expressed by persons while capable and after attaining 16 years of age, be adhered to;

(d) to promote communication and understanding between health practitioners and their patients or clients;

(e) to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment, admission to a care facility or a personal assistance service; and

(f) to permit intervention by the Public Guardian and Trustee only as a last resort in decisions on behalf of incapable persons concerning treatment, admission to a care facility or personal assistance services. 1996, c. 2, Sched. A, s. 1.

We initially had to determine when the proposed Plan of Treatment was presented to GP for her consideration in accordance with the Act so that the health practitioner could determine from his perspective that GP either did or did not comply with Section 21 of the *Health Care Consent Act*. Though presumed capable in law, DP was found incapable by his health practitioner with respect to his treatment. If we had to decide the issue of DP's capacity all parties submitted that DP was incapable with respect to any form of proposed treatment. Accordingly the evidence was that consent to treatment here would have to come from GP as long as she was her husband's substitute decision maker.

The evidence we received included that hospital staff did not believe GP would consent to any Plan of Treatment other than the plan in place since February 2008, a plan providing for full supportive measures for her husband. In Mr. Parke's opinion the belief by hospital staff that GP would not consent to any other Plan of Treatment was why GP did not receive more than one half hour notice of the March 26, 2010 meeting or why she was not advised of the meeting agenda in advance. The clear, cogent and compelling evidence was that since that March 26, 2010 meeting no communication has taken place between Dr. Manocha as DP's attending physician and health practitioner and GP, and no presentation of the proposed Plan of Treatment to her until it was sent to her lawyer sometime around the third week of May 2010 with the Form G application. According to Mr. Parke the proposed Plan of Treatment did not exist on March 26, 2010 in either oral or written form and was not created until sometime in May, 2010.

As was set out earlier, the *Health Care Consent Act* has a Purposes clause (Section 1) which sets out that the first goal of the Act is to provide rules with respect to consenting to treatment that apply consistently in all

settings. Facilitating treatment and enhancing the autonomy of individuals for whom treatment is proposed are included as other objectives.

The *Health Care Consent Act* also sets out that its provisions apply to treatment decisions wherever and whenever a "treatment" is proposed for an individual. "Treatment" and "Plan of Treatment" as set out earlier, are both statutorily defined in Section 2 of the Act. The provisions of the Act relating to treatment apply within and outside of hospitals. The Act makes it clear that all health practitioners proposing a treatment for a patient must comply with the rules provided for obtaining consent, as set out in Sections 10-14 of the Act.

Save in the case of an emergency as defined in the *Health Care Consent Act* treatment cannot be given without appropriate consent. That consent must come from either the patient if capable or the patient's substitute decision maker if the patient is incapable (Section 10). Importantly as well the *Health Care Consent Act* provides the consent must be obtained "in accordance with this Act". By Section 11 the consent obtained must be "informed consent".

In M.A. v Benes, 46 O.R. (3d) 274 (Ont. C.A) at paragraphs 18-20, the Ontario Court of Appeal interpreted the requirement of obtaining consent "in accordance with this Act" as imposing on the health practitioner an obligation to make sure the substitute decision maker understands the Section 21 HCCA criteria when deciding whether consent to a proposed treatment should be given or refused.

Specifically the Court of Appeal wrote, (paragraphs 19-24):

> "[19] For reasons which need not be detailed, Sutherland J. refused to interpret s. 10(1)(b) in the manner suggested by the Attorney General. In short, he construed the words "in accordance with this Act" narrowly and restrictively and found that they did not impose a statutory obligation on health practitioners to ensure that S.D.M.'s understand the requirements of s. 21 of the Act.
>
> [20] With respect, we are of the view that Sutherland J. erred in his approach to the interpretation of s. 10(1)(b). In particular, he incorrectly applied the principles of statutory interpretation to the words "in accordance with this Act."
>
> [21] The first of those principles is found in Rizzo v. Rizzo Shoes Limited (R.E.), 1998 CanLII 837 (S.C.C.), [1998] 1 S.C.R. 27, where, at paragraph 21, Iacobucci J. adopted the following passage from Driedger's Construction of Statutes (2 ed.1983):

> Today there is only one principle or approach, namely, the words of an Act are to be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament.

At paragraph 22 of the same decision, Iacobucci J. went on to state that every Act shall receive "such fair, large and liberal construction and interpretation" as will best attain the objects of the Act.

[22] The second governing principle, enunciated in Slaight Communications Inc. v. Davidson, 1989 CanLII 92 (S.C.C.), [1989] 1 S.C.R. 1038 at 1078, per Lamer J., provides that where legislation is open to more than one interpretation, it should be construed in a manner consistent with the Charter. (See also Canada (Attorney General) v. Mossop, [1993] 1 S.C.R. 544 at pp. 581-82; Alssco Building Products Ltd. v. U.F.C.W., Local 1288P, [1999] S.C.J. No. 45 at p. 9; Winko v. British Columbia (Forensic Psychiatric Unit) 1999 CanLII 694 (S.C.C.), (1999), 135 C.C.C. (3d) 129 at 158 (S.C.C.)).

[23] When the words "in accordance with this Act" are construed in a manner consistent with the Charter and afforded the fair, large and liberal interpretation they deserve to best attain the objects of the Act, we are satisfied that s. 10(1)(b) does impose an obligation on health practitioners to ensure that S.D.M.'s understand the requirements of s. 21 of the Act when deciding whether consent to a proposed treatment should be given or refused. Notably, the respondents take no issue with this interpretation and concede that it provides a complete answer to Sutherland J.'s concern that absent actual notice, S.D.M.'s may make treatment decisions in violation of an incapable person's s.7 Charter rights.

[24] Turning next to Sutherland J.'s concern that S.D.M.'s are not informed at an early stage of the criteria applied by the Board in reviewing their treatment decisions and the powers of the Board to override such decisions, we fail to see how the absence of such information could lead to a violation of an incapable person's s. 7 Charter rights. What is important is that S.D.M.'s be made aware of the requirements of s. 21 when deciding whether to give or refuse consent to a proposed treatment. As indicated, s. 10(1)(b) of the Act sees to that. The Board only becomes involved if a health practitioner concludes that an S.D.M.'s decision does not accord with the principles in s. 21. In that event, under s. 6(2) of the SPPA, S.D.M.'s are entitled to reasonable notice of the hearing, including notice of its purpose. Under s. 8 of that Act, S.D.M.'s are entitled, prior to the hearing, to be furnished with reasonable information regarding any allegations of improper conduct on their part."

The Court of Appeal in Benes also noted at paragraph 46

"A case will come before the Board only when the health practitioner disagrees with the S.D.M.'s application of the best interests test under s.21(2). The Board will then have before it two parties who disagree about the application of s.21: the S.D.M., who may have better knowledge than the health practitioner about the incapable person's values, beliefs and non-binding wishes; and the health practitioner, who is the expert on the likely medical outcomes of the proposed treatment. The disagreement between the S.D.M. and the health practitioner potentially creates tension and the Act recognizes this by providing for a neutral expert board to resolve the disagreement. Indeed, after hearing submissions from all parties, the Board is likely better placed than either the S.D.M. or the

> health practitioner to decide what is in the incapable person's best interests. Thus, the Board should not be required to accord any deference to the S.D.M.'s decision."

It was clear to the Board that on reading the *Health Care Consent Act* (including Sections 10-14) and case law such as Benes, that a health practitioner must inform a substitute decision maker about the rules which govern substitute decision making. Consent requires that the elements set out in Section 11 of the *Health Care Consent Act* be adhered to. Consent must relate to the proposed treatment, be informed and given voluntarily without being obtained through misrepresentation or fraud (Section 11). Besides information about the treatment which must be provided (Section 11(2)) where consent of a substitute decision maker is required on behalf of an incapable person, the health practitioner must provide certain information about the law.

The *Health Care Consent Act* continues in Section 11 (2) to require that consent to treatment is "informed" if, before giving it, the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment and the person received responses to his or her requests for additional information about those matters. Section 11 (3) further provides that informed consent requires the nature of the treatment expected benefits of the treatment material side-effects of the treatment, alternate courses of action and the likely consequences of not having the treatment.

How could GP as her husband's substitute decision maker consider consenting or refusing to consent without being presented or provided with the Plan of Treatment and being given an opportunity to become "informed", in accordance with the legislation? In the Board's view GP was never given an opportunity to consent or to refuse consent to the proposed Plan of Treatment as she has never been given an opportunity to be informed in accordance with the *Health Care Consent Act.*

The proposed Plan of Treatment was drastically different than the current Plan of Treatment in place. With little to no communication in place, the health practitioner had to do more before he could determine that GP "did not comply" in terms of Section 37 of the *Health Care Consent Act.* We found there was no evidence GP did not comply with the proposed Plan of Treatment.

The current situation driven by a clear lack of communication was not in DP's best interests. Rectification of the current lack of communication must commence with the health practitioner presenting the proposed Plan

of Treatment to the substitute decision maker GP, and then GP being permitted a reasonable time to consider it and consult about it, meet to discuss it, have her questions or concerns answered. Only after the required efforts have been made in accordance with the Act, will the health practitioner be in a position to determine from his perspective the issue of compliance by the substitute decision maker and whether a Form G application was necessary.

The Board recognizes the undeniably important role of health practitioners. In our legislative scheme of health care decision making, and particularly in view of the Purposes and substance set out in the Act, substitute decision makers also have a significant role. The process for the health practitioner to determine compliance set out in the Act must be respected and followed. Clearly in this case what could not be relied upon was a belief that the substitute decision maker would not agree to any other treatment without following the procedure set out in the Act to actually determine the issue of compliance and whether a Form G application should be considered.

In dismissing the Form G application we also dismissed the deemed Form A application of DP, brought by way of the deeming process set out in the Act (s37.1). Under the circumstances we saw no need to determine that issue; effectively leaving in place the health practitioner's finding that DP was incapable with respect to the proposed treatment.

RESULT

For all of the above reasons, the Form G Application before us and the deemed Form A Application were both dismissed.

Dated at Toronto, this 11th day of July, 2010.

_____

Michael Newman – Vice-Chair, Presiding Lawyer Member