**Consent and**
**Capacity Board**

**Commission du consentement**
**et de la capacité**

Ontario

19-5087-01
19-5087-02

2020 CanLII 36914 (ON CCB)

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

AND IN THE MATTER OF
**GG**,
A RESIDENT
OF OTTAWA, ONTARIO

## CORRIGENDUM

This is a corrigendum to the Reasons for Decisions dated May 11, 2020.

At pages 7 and 8 under the title "**THE EVIDENCE**" the numbering of exhibits 12. To 18 should be as follows:

12. a) Notes from Dr. Chomienne from December 29, 2019 to January 3, 2020 (1-15 pages)

12. b) Notes from Dr. Chomienne, continuation of 12a (16-31 pages)

13. Form no. 2294716, Ministry of Health and Long-Term Care, January 1, 2020

14. a) Notes from Dr. Bourgeois, January 18 to 24, 2020 (1-14 pages)

14. b) Notes from Dr. Bourgeois, continuation of 14a (15-27 pages)

15. Power of attorney for personal care for GG, January 24, 2014

16. Statements from: LL, March 1, 2020; DL, February 12, 2020; DP, February 15, 2020; AS, February 16, 2020; NP, February 20, 2020; HL, February 15, 2020

Date : May 25, 2020

## CORRIGENDUM

This is a corrigendum to the Reasons for Decisions dated May 11, 2020.

At page 7, paragraph 1, line 3, the words « **pièce no.17** » are replaced by « **pièce no. 15** »

Date : May 14, 2020

## REASONS FOR DECISIONS

### PURPOSE OF THE HEARING

The Consent and Capacity Board ("the Board") called a hearing at the request of Dr. O'Meara, one of GG's attending physicians. Dr. O'Meara had made an application to the Board under subsection 37(1) of the *Health Care Consent Act* ("the Form G application") to determine whether the decisions made by ML, GG's substitute decision maker ("the decision maker") about the treatment proposed for GG complied with the principles for making decisions on behalf of an incapable person pursuant to section 21 of the *Health Care Consent Act* (*HCCA*).

Section 37.1 of the *HCCA* specifies that an application made to the Board under subsection 37(1) of the *HCCA* is also deemed to include an application to the Board under section 32 to review GG's capacity to consent to treatment proposed by a health practitioner ("the Form A application"). A review of the patient's capacity is not required if the Board has determined the patient's capacity to consent to such treatment within the previous six months. The parties agreed that the issue of GG's capacity to consent to treatment could be determined before proceeding with the review of the Form G application.

### DATES OF THE HEARING, DECISIONS AND REASONS

The hearing took place on March 10 and 11 in person. Due to the physical distancing restrictions required by the COVID-19 pandemic, the remainder of the hearing was held using electronic means. The parties and the panel met on March 27 and 30, April 8, 15, 20 and 27, and May 1, 2020 by videoconference. The panel rendered its decision on May 2, 2020. At the hearing, GG's lawyer asked for the reasons for the decisions (contained in this document). They were sent to the parties on May 11, 2020.

### LEGISLATION CONSIDERED

The *Health Care Consent Act, 1996,* sections and subsections 2, 4, 5, 11, 13, 21, 22, 37(1) and 37.1

## PARTIES TO THE DEEMED FORM A APPLICATION

GG, the person subject to the finding of incapacity with regard to the proposed treatment
Dr. O'Meara, the attending physician and health care practitioner proposing the treatment

## PARTIES TO THE FORM G APPLICATION

GG, the person subject to the finding of incapacity with regard to a proposed treatment
Dr. O'Meara, the attending physician and health care practitioner proposing the treatment
ML, GG's substitute decision maker
The parties were present at the hearing, with the exception of GG.

## MEMBERS OF THE PANEL

Brigitte Pilon, lawyer and Presiding Member
Robert Rainboth, member of the public
Kim Brisson, member of the public

## APPEARANCES

GG was represented at the hearing by Earl Atnikov
Dr. O'Meara was represented at the hearing by Chantal Tourigny and Marie-Eve Caissie
ML represented herself

## PRELIMINARY MATTERS

### **Interpreter**

The hearing participants had access to the services of an interpreter who translated from French to English and from English to French, as required.

## Request to exclude witnesses from the hearing room

At the beginning of the hearing, Ms. Tourigny asked the panel to issue an order to keep witnesses who had not yet testified out of the hearing room. ML, who was representing herself, was accompanied by her sister, DL. ML confirmed that she intended to call DL as a witness when she presented her evidence. ML asked the panel to allow her to have one of her sisters with her as a support person during the hearing. Ms. Tourigny agreed for DL to remain in the room for the first day of the hearing. Mr. Atnikov did not oppose the request. The panel ordered all the witnesses except DL to stay out of the hearing room until they had testified.

## Exclusion of Dr. D'Egidio as a witness

ML had submitted a motion for an order from the panel to exclude Dr. D'Egidio as a witness for the applicant. ML maintained that, as an expert witness, Dr. D'Egidio was not part of GG's "circle of care." She pointed out that the will say statement provided by the applicant before the hearing stated that Dr. D'Egidio "will discuss G's current medical condition." According to ML, the people in GG's circle of care had no right to share GG's information without his consent or the consent of his decision maker. She contended that the members of the intensive care team at Montfort Hospital (MH) were not part of GG's circle of care, and that under the *Personal Health Information Protection Act*, 2004 (*PHIPA)*, they should not have access to GG's personal information. She also said that Dr. D'Egidio's evidence would be "uninformed, unnecessary and redundant." ML maintained that Dr. D'Egidio's testimony would be redundant because Dr. O'Meara and Dr. Mulligan had the same level of expertise and could offer the same information to the panel.

Ms. Tourigny drew the panel's attention to the document on pages 258 and 259 of Exhibit 1, a memo stating that beginning January 17, 2020, the MH had given [TRANSLATION] "temporary privileges to Dr. D'Egidio as a visiting physician (until February 28, 2020, inclusive) in the department of medicine, intensive care service, with medical treatment rights and admission privileges in the intensive care unit..." Page 267 of Exhibit 1 was an extension of the temporary authorization received on January 17, 2020. It extended Dr. D'Egidio's privileges to April 3, 2020. Ms. Tourigny maintained that those privileges gave Dr. D'Egidio the right to [TRANSLATION] "review the files of all patients," since he was part of the MH team. The consultation report on page 267 showed that Dr. Mulligan had asked him on February 6, 2020 to consult on GG as an intensive care specialist. She stated that his testimony would add to the testimonies of the attending physicians. It was important for the panel to be able to know what a patient could expect in intensive care compared to the medical floor. Mr. Atnikov noted that since Dr. D'Egidio had privileges at MH, his evidence might possibly be biased and could not be presented as the evidence of an independent expert. Lastly, Ms. Tourigny noted that based on its own rules of practice, the Board could receive all evidence relevant to the purpose of the hearing.

The panel agreed that, since Dr. D'Egidio was part of the medical team at MH, he was not subject to the rules for expert witnesses. As stated by Mr. Atnikov, his testimony should not be given the same weight as that of an independent expert because of the presumption of a lack of impartiality. The panel noted that it was at Dr. Mulligan's request that Dr. D'Egidio offered to review and offer his opinion and comments on the proposed treatment plan for GG. His opinion was requested because Dr. D'Egidio had a specialty in the field of intensive care. The panel ruled that Dr. D'Egidio's testimony would be allowed. The panel stated that it was aware of its role as trier of fact. It acknowledged that it would have to be vigilant in its assessment of the importance and weight it could assign to this evidence.

## **Motion to reject the application under subsections 22(1) and 11(2) of the *HCCA***

ML had filed a motion for an order rejecting the Form G application ("the application") submitted by Dr. O'Meara. She alleged that Dr. O'Meara's request was premature and that she had not fulfilled her statutory obligations under the *HCCA.* ML asserted that Dr. O'Meara had not given her the information required under subsections 22(1) and 11(2) of the *HCCA*, for her to be able to make an informed decision about the treatment proposed to her for GG. She proposed that the motion be heard and decided before the hearing could proceed with the Form G application. ML maintained that proceeding in this fashion would allow the panel to [TRANSLATION] "know whether Dr. O'Meara had done her homework;" Ms. Tourigny and Mr. Atnikov agreed that it would be more efficient to hear the evidence for the motion [TRANSLATION] "within the application" to avoid repetitions if it then became necessary to proceed with the Form G application after the motion had been heard. Ms. Tourigny confirmed that the witnesses for the applicant—Dr. O'Meara, Dr. Gratton and Ms. Legault—would be witnesses for the purposes of both the motion and the application.

The panel agreed that it would be more efficient to hear the testimonies of the witnesses in full rather than to try to hear only the evidence on the motion. It would prevent having to have the same people testify twice if the motion was rejected and the panel proceeded with the application. The panel ruled that it would receive evidence for the motion jointly with the evidence for the Form G application.

## The treatment plan

Dr. O'Meara proposed a treatment plan for GG that recommended no further escalation of GG's care. The plan stated that [TRANSLATION] "No dialysis would be provided in case of renal insufficiency... no vasopressors administered: if GG's blood pressure should fall... No CPR or type of ventilation would be provided if his heart or his lungs should fail" and that "Feeding (oral or by PEG tube) would stop if one of the following conditions occurred." The treatment plan also stated that [TRANSLATION] "If one of the above-mentioned conditions occurred, comfort measures would be taken; comfort measures consisting of the administration of drugs to relieve suffering, pain, breathlessness, anxiety, agitation, nausea or any other symptoms." Lastly, the plan stated that [TRANSLATION] "All investigations and (other) interventions would cease." Dr. O'Meara communicated the treatment plan to the substitute decision maker, ML, by letter dated January 20, 2020.

## The Power of Attorney for Personal Care, January 24, 2014

GG signed a Power of Attorney for Personal Care on January 24, 2014 ("the power of attorney"). It gave specific instructions for the attorneys he named in the document. He named ML as his attorney for personal care. If ML was unable to act, he named his children. Paragraph 4 of the power of attorney, entitled "Specific Instructions," included the following instructions:

> [TRANSLATION]
>
> *4.*
>
> *a) I order my attorney to follow and/or take into consideration any general medical directive and/or any specific instruction related to the care of my person and/or living will that I may prepare and sign hereafter.*

> *b) If a time comes when I am no longer able to make decisions about any treatment for myself, I desire the declaration below to be considered as the formal expression of my wishes.*
>
> *c) In the event that a sufficient recovery of my physical and mental capacities is deemed impossible, I, the undersigned, ask that I not be kept alive by artificial and extraordinary methods.*
>
> *d) I ask for the appropriate medication to be given to me to effectively relieve my pain, even if it hastens my death. I ask that you treat these instructions as your moral duty. In this way, I wish to remain responsible until the end and thereby make it easier for you to make decisions on my behalf. These instructions are given to you after careful reflection, voluntarily and while I am of sound mind.*

ML gave the panel a copy of the power of attorney document on April 15, 2020, on the second day of her testimony at the hearing. Dr. O’Meara had not previously received a copy. The copy of the power of attorney was entered as Exhibit 17 in the documents submitted as evidence.

## THE EVIDENCE

The evidence submitted at the hearing was comprised of the verbal testimonies of Dr. O’Meara, Dr. Gratton, Kathryne Legault, Dr. D’Egidio, ML, DL, LL and AS and the following documents, submitted as evidence:

1. Collection of Dr. O’Meara’s documents (1–267 pages)
2. Collection of GG’s documents (1–83 pages)
3. Form G, dated January 22, 2020
4. Nursing notes from March 20 to 26, 2020
5. Excerpt of home care plan by Dr. D’Egidio, April 2, 2019
6. Draft letter from Dr. O’Meara, January 17, 2020
7. GG’s curriculum vitae (no date)
8. Letter from Dr. O’Meara, January 22, 2020
9. Letter from ML to Dr. Mansour, January 22, 2020
10. Notes from Doctors Rousseau and Ayuen, from November 20 to 28, 2019 (1–25 pages)

11. Notes from Doctors Bernier, Nicole, McKay and Brossard from December 1 to 24, 2019
12. Notes from Dr. Chomienne from December 29, 2019 to January 3, 2020 (1–15 pages)
13. Notes from Dr. Chomienne, continuation of 12a (16–31 pages)
14. Form No. 2294716, Ministry of Health and Long-Term Care, January 1, 2020
15. Notes from Dr. Bourgeois, January 18 to 24, 2020 (1–14 pages)
16. Notes from Dr. Bourgeois, continuation of 14a (15–27 pages)
17. Power of attorney for personal care for GG, January 24, 2014
18. Statements from: LL, March 1, 2020; DL, February 12, 2020; DP, February 15, 2020; AS, February 16, 2020; NP, February 20, 2020; HL, February 15, 2020

## INTRODUCTION

GG was a 79-year-old man. He worked as a lawyer for about 53 years. He spoke French and English. At the time of the hearing he could neither feed himself nor move on his own. He was not communicating with his attending team.

GG had been married to ML for 21 years. He had two children from a previous relationship. GG had signed a Power of Attorney for Personal Care on January 24, 2014. He named ML as his attorney for personal care and named his children as substitutes.

In April 2014 GG was diagnosed with dementia. He also suffered from Parkinson’s disease, coronary artery disease and he had pressure sores. He had prostate cancer in 2001. At the time of the hearing GG was suffering from advanced Lewy body dementia. In August 2017 he was seen at the Movement Disorders Clinic. The assessment noted that he was suffering from severe cognitive disorders at that time. He was unable to obey simple instructions and needed help to walk. ML had been GG’s substitute decision maker since about 2017. ML was the person primarily in charge of GG’s care. He was cared for at home by ML with the support of LHIN community care. He was hospitalized at the Civic campus of the Ottawa Hospital in December 2018. He had bleeding in the brain and underwent surgery. He spent four months in hospital. He recovered and returned home. In August 2019 he was admitted to the MH to be treated for pneumonia. Once he recovered, GG returned home. On November 14, 2019 GG was taken to emergency at the MH because he had become unresponsive. Dr. Truong admitted him and provided care for pneumonia (possibly related to aspiration) and hypernatremia. On November 15, 2020 Dr. Truong asked ML to come to the hospital because GG was in critical condition and he wanted to discuss objectives for the care prescribed to GG. ML confirmed that she wanted GG to be intubated and to receive cardiopulmonary resuscitation (CPR) if necessary. On November 25, 2020 Kathryne Legault (SLP) assessed GG. She concluded that GG was unable to swallow well enough to meet his nutritional needs. ML gave her consent for GG to have a nasogastric tube (NGT) inserted. He slowly stabilized. On December 11, GG was given a percutaneous endoscopic gastronomy (PEG) tube in preparation for his return home. On December 24, 2020 GG developed an infection requiring intravenous antibiotics until January 7, 2020. At the beginning of January 2020 the social worker and community agency worked together to determine the level of care that would be required for GG to return home. On January 11 Dr. O'Meara became his attending physician. On January 15 a meeting was held between ML, Dr. O'Meara, Dr. Gratton (palliative care), Janie Cardin (clinical manager), Kathryne Legault (speech language pathologist) and Louise Marleau (dietitian). At that meeting Dr. O'Meara verbally proposed a plan of care for GG that did not include cardiopulmonary resuscitation, intensive care or intubation. ML rejected the proposal. On January 20 Dr. O'Meara sent a letter to ML describing the treatment plan she recommended for GG. The proposed plan did not provide for any further escalation of GG's care. ML rejected the treatment plan proposed by Dr. O'Meara. On January 22 Dr. O'Meara initiated the Form G application to determine whether the decisions of ML, GG's substitute decision maker, concerning the treatment proposed for GG complied with the principles of consent on behalf of an incapable person pursuant to section 21 of the *Health Care Consent Act* (*HCCA*).

## THE LAW

At a Board hearing to review a Form G application the burden of proof falls on the attending physician. He or she must satisfy the Board that the decision maker has not complied with the principles of consent on behalf of an incapable person under the *HCCA*. In the review of the deemed Form A application the burden of proof is on the physician to validate the finding of the person's incapacity to consent to treatment under the *HCCA*. The applicable standard of proof is that of a balance of probabilities. The Board must be certain, based on clear and convincing evidence, that the physician has discharged the said burden of proof. The burden of proof does not rest in any way on the patient or on the patient's decision maker.

The Board must take into consideration all the evidence duly submitted to it. Hearsay may be accepted and received, but the weight granted to it must be carefully considered.

## Capacity with respect to treatment

Under the *HCCA* there is a presumption that everyone is capable with respect to treatment (subsection 4 (2)). In this case this burden of proof falls on Dr. O'Meara.

The criteria required to establish a person's capacity with respect to treatment are listed in subsection 4 (1) of the *HCCA*. It states that:

> *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.*

A person will be deemed incapable of consenting to treatment if he or she does not meet the requirements of either part of this two-part test.

## The plan of treatment

Section 2 of the *HCCA* defines a plan of treatment:

> *"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.*

Section 13 of the *HCCA* states as follows:

*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.*

**<u>Wishes</u>**

Section 5 of the *HCCA* states the following with regard to wishes:

*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).*

**<u>Consent on behalf of another</u>**

Section 21 of the *HCCA* sets out the principles that the person who gives or withholds consent must comply with when that person has to make a decision on behalf of an incapable person for the consent to or refusal of treatment.

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

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

> *2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests. 1996, c. 2, Sched. A, s. 21 (1).*
>
> *(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,*
>
> *(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;*
>
> *(b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and*
>
> *(c) the following factors:*
>
> *1. Whether the treatment is likely to,*
>
> *i. improve the incapable person's condition or 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. 1996, c. 2, Sched. A, s. 21 (2).*

Subsection 22(1) of the *HCCA* stipulates that the substitute decision maker has the right to receive all the information required to be able to provide informed consent. The elements that must be in place for the consent to be informed are described in subsections 11(2) and 11(3) of the *HCCA.*

> *Information*
> *22 (1) Before giving or refusing consent to a treatment on an incapable person's behalf, a substitute decision-maker is entitled to receive all the information required for an informed consent as described in subsection 11 (2). 1996, c. 2, Sched. A, s. 22.*
>
> *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).*

## **Form G Application**

Section 37 of the *HCCA* allows an attending physician to submit an application to the Board if he or she believes that the substitute decision maker is not complying with section 21 of the *HCCA*.

> *Application to determine compliance with s. 21*
> *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).*
*Section amendments with date in effect (d/m/y)*

## Deemed Form A Application

According to section 37.1, any hearing under subsection 37(1) of the *HCCA* must include a deemed Form A application, in order to review the finding of incapacity with regard to the patient. If it is determined that the person has the capacity to consent to the treatment proposed by the health care practitioner, the Board must reject the Form G application.

> *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.*

## ANALYSIS

### Capacity with respect to treatment

Section 37.1 of the *HCCA* requires the Board to determine whether the person is still incapable of consenting to the proposed treatment at the time of the hearing before reviewing the Form G application, unless the person's capacity to consent to the treatment has been determined by the Board within the previous six months. The panel determined that no review of GG's capacity had taken place within the six months preceding this hearing.

### ***Was the evidence sufficient to establish that GG was incapable of understanding the information related to making a decision concerning the treatment in question?***

Dr. O'Meara testified that she was GG's attending physician from January 11 to 14, 2020. She noted that at the time of the hearing GG was suffering from [TRANSLATION] "very (advanced) dementia. He could not feed himself or move on his own. He was non-verbal. He did not try to communicate." She also testified that there was [TRANSLATION] "no possible interaction" with GG and that "GG's level of awareness did not allow him to receive instructions about his treatment." Lastly, she testified that he was not capable of understanding or assessing the information relevant to making a decision concerning treatment. Mr. Atnikov did not offer any evidence to the contrary. He stated that he had not received instructions from GG about his capacity. ML did not agree that GG did not communicate, but she did not contest the finding of incapacity and did not question the conclusion that he was incapable of consenting to his own treatment.

The evidence supporting Dr. O'Meara's conclusion was clear and convincing that GG was incapable of understanding the information and incapable of assessing the consequences of a decision concerning his treatment. In light of the position adopted by Dr. O'Meara, the panel concluded that GG was not able to understand or assess the information relevant to making a decision about the treatment in question.

## Consent of the substitute decision maker

The legal consequence of the fact that GG is incapable of making his own treatment decisions is that consent could be given or refused on his behalf by a person described in section 20 of the *HCCA*. GG had appointed ML as his attorney for personal care; she was therefore his substitute decision maker.

Before analyzing the evidence to support the Form G application, the panel had to dispose of the issue arising from the motion ML tabled at the beginning of the hearing. This motion asserted that Dr. O'Meara's application was launched without meeting her statutory obligations toward the substitute decision maker under the *HCCA*. ML contended that Dr. O'Meara had not provided her with the information required for her to give informed consent.

### *Did ML receive all the information required to give informed consent pursuant to subsection 11(2) of the HCCA before giving or refusing her consent for treatment on behalf of an incapable person?*

## The *HCCA* criteria for informed consent

Subsection 11(1) lists the elements that must be brought together for <u>consent</u> to treatment. The consent must relate to the treatment, it must be informed, it must be given voluntarily and it must not be obtained through misrepresentation or fraud.

Section 22 of the *HCCA* states that "a substitute decision-maker is entitled to receive all the information required for an informed consent as described in subsection 11 (2)," <u>before giving or refusing consent to a treatment on an incapable person's behalf</u>.

Subsections 11(2) and 11(3) read together indicate that consent to treatment is informed if, before giving it:

1. the person who is giving consent receives the information concerning the matters listed below that a <u>reasonable</u> person, <u>in the same circumstances</u>, would <u>need</u> to make a decision concerning the treatment:
    - the nature of the treatment
    - the expected benefits of the treatment
    - the material risks of the treatment

   - the material side effects of the treatment
   - alternative courses of action
   - the likely consequences of not having the treatment
2. the person <u>receives responses to requests</u> for additional information concerning the questions listed in paragraph 1 above.

ML asserted that Dr. O’Meara did not provide her with information about the nature of the treatment, the risks related to the treatment or the side effects of the treatment.

Ms. Tourigny maintained that ML was an intelligent and educated woman who expressed herself well. The discussions about GG’s care were all in French and/or English. French is ML’s mother tongue and she speaks English well. The doctor argued that the members of GG’s care team had several discussions and meetings with ML about GG’s condition and the care objectives for him. ML received a letter on January 20, 2020 (p. 63, Exhibit 1) describing in detail the plan of care proposed by Dr. O’Meara. The letter also offered ML assistance if she wanted the opinion of another physician and offered to arrange another meeting if ML had concerns about the proposal. The letter asked ML for a response by 3 p.m. on January 22, 2020. The letter informed ML that if she was not in agreement with the plan proposed by Dr. O’Meara, the doctor intended to submit an application to the Board for it to decide [TRANSLATION] “what is in the best interests of GG.” The letter was given to ML by Dr. Bourgeois. ML testified that Dr. Bourgeois went over the letter with her to help her understand what Dr. O’Meara was saying. ML received a second letter on January 22, 2020. That letter included a copy of the provisions of section 21 of the *HCCA.* ML testified that she knew her obligations as a decision maker. She also testified that she had [TRANSLATION] “given her response by way of the letter to Dr. Mansour that was a complaint about Dr. O’Meara.”

Dr. O’Meara testified that when she took charge of GG’s care on January 11, 2020 she noticed that Dr. McKay’s treatment recommendation was in conflict with ML’s actions. She noted that ML continued to feed GG by mouth, which increased the risk that he would choke. She testified that feeding him by mouth ran counter to the purpose of inserting the PEG. The PEG was inserted to prolong GG’s life. The doctor testified that feeding him by mouth increased the risk that GG would suffer from aspiration and pneumonia and have to undergo aggressive interventions such as intubation or CPR. Dr. O'Meara had a discussion about this with ML on January 13, 2020. She noted on page 81 of Exhibit 1: "*when I brought up the fact that our recommendation is for no p.o. intake whatsoever, including thickened fluids, she told me that this was never told to her, that I am wrong. I offered to meet her on Wednesday with the Slp and the dietician, and the clinical manager is organizing this for 11:00 a.m. CCAC will likely attend this meeting as well to discuss services. It is a very brief meeting that I had today, but considering the information I received on hand over, and from the multidisciplinary meeting today, I am concerned that the patient's wife may not be acting in the best interest of this patient by continuing to offer him p.o. fluids, even if thickened, Given his very severe risk of aspiration, and the goals of care to pursue intubation. If this was a question of end of life care, and comfort this would not be an issue. However the risk of her causing a severe aspiration is real, and putting him through aggressive measures such as an ICU stay and intubation would not offer him anything more than prolonged suffering in my opinion.*"

**The meeting of January 15, 2020**

On January 15, 2020 a meeting was held between ML, Dr. O'Meara, Dr. Gratton (palliative care), Janie Cardin (clinical manager), Kathryne Legault (speech language pathologist) and Louise Marleau (dietitian). According to ML, the purpose of this meeting was to plan GG's discharge from the hospital. Dr. O'Meara testified that it was to make sure everyone involved in ML's care [TRANSLATION] "was on the same page." She also testified that [TRANSLATION] "the team was trying to put together a discharge plan for sending him home." The note by Janie Cardin, dated January 13, 2020, stated that the meeting was planned [TRANSLATION] "to address ML's dissatisfaction" with the attending physician and the speech language pathologist. She also noted that the plan for the meeting included the [TRANSLATION] "LHIN, SW and DGQR for discharge planning." Whatever its purpose, it is evident from the notes on pages 73 to 76 of Exhibit 1 that the meeting was heated. After reading the report of this meeting and hearing the testimonies of Dr. O'Meara, Dr. Gratton, Kathryne Legault and ML, the panel felt it had a good idea of what took place at the meeting.

ML testified that during the meeting she had felt on the defensive when questioned by Dr. O'Meara. Although ML was offended by such questions, the panel found that the answers sought by the team were very important to establishing GG's plan of care. The panel found that during the meeting ML often showed a lack of openness toward the team's proposals. She did not want to discuss [TRANSLATION] "negative things." She did not want to hear Dr. O'Meara's medical impression, saying [TRANSLATION] "No. Too negative." Although she claimed to be realistic about GG's situation, she remained intransigent to their efforts to explain what awaited GG. She categorically refused to discuss the eventual deterioration of GG. ML frustrated their efforts to talk to her about the risks associated with interventions, which she wanted GG to have if a critical event happened. The speech language pathologist and Dr. Gratton tried to talk to her about the risk of aspiration and the risks associated with aggressive interventions like intubation and cardiopulmonary resuscitation. That conversation is recorded on page 75 of Exhibit 1:

[TRANSLATION]
*Would you like to hear my medical opinion?*
*"No. Too negative."*
*"You don't understand. Always too negative. I have to try extra hard to be positive."*
*We just want to prepare you for his eventual deterioration:*
*"No, I don't want to hear about it…"*
*Speech language pathologist asks if ML would like to continue with "comfort feeds" or stop all p.o. intake to minimize the risk of aspiration as much as possible and therefore prolong his life...*
*ML does not answer directly. "I have no proof that it's aspiration pneumonia that he's got."*
*Approach if respiratory decompensation?*
*ML insists on intubation despite the suggestion to avoid intubation and intensive care and instead provide comfort care to the patient in light of his advanced dementia.*
*"I don't care what you think. You think all he's good for is the garbage."*
*Interjection by Dr. Gratton, who explains that the patient is at the end of his life due to advanced dementia. That if he deteriorates to the point where intensive care/intubation is needed, it means he is dying and aggressive interventions will only prolong his death and his suffering.*
*ML does not agree that the patient is at the end of his life.*

During her testimony, ML disputed the account of this discussion. She denied having talked about intubation or CPR. At the end of the meeting, Dr. O'Meara verbally proposed a plan of care that did not include cardiopulmonary resuscitation, intensive care or intubation. During her testimony Dr. O'Meara indicated that those treatments are usually used when the person is going to recover. In the case of GG, they would only serve to prolong his death. After that meeting she withdrew from GG's case. During her testimony she was honest that she had communicated part of the risks to ML, but she did not have the chance to talk to her about the possibility of [TRANSLATION] "broken ribs" if GG had to undergo CPR. She also confirmed that there was [TRANSLATION] "a doctor who did not agree with the application." This doctor asked Dr. O'Meara to not share her opinion of the plan with the panel.

The panel accepted the testimonies of the members of GG's care team as to what happened at the meeting. The panel also found that the notes demonstrated that ML was evasive about the wishes expressed by GG and the content of GG's Power of Attorney for Personal Care.

### Review of the notes

Based on a review of all the evidence, the panel was satisfied that the treatment team had made reasonable and continuous efforts to provide information to ML that was sufficient to enable her to carry out her duties as substitute decision maker. Unfortunately, those efforts were frustrated by ML's general tendency to refuse to accept and consider the information, obtain explanations and engage in significant consultations with the treatment team. It was obvious that ML was only prepared to receive or consider information that was compatible with her predetermined opinions. Evidence of this difficult dynamic can be found in the following annotated excerpts from the clinical notes contained in Exhibit 1.

(Page 135) Note entitled ED Provider Report, dated November 15, 2019. Following GG's admission to MH, Dr. Truong discussed the goals of care for GG with ML: "*I indicated to the wife that the majority of cardiac arrests do not have ROSC(.) In those that do, for her husband specifically it would be extremely rare to hope to return to his baseline now and would (unfortunately) see his actual quality of life severely impaired we then discussed his current quality of life and I asked what would GG want for himself if he was here to tell us today, she responded that she is the POA and that he needs to be intubated and have CPR started if needed she understands that these aggressive interventions are likely to be harmful and not likely not (yield) any benefit but maintains it is what he would have wanted.*"

(Page 131) Note by Dr. Rousseau and Gabrielle Marie Haidar, dated November 19, 2019, states: "*I had a long conversation in regards to the patient Goals of care with his wife. She states that she wants him to be full code, and to have aggressive treatment. She states that 2 weeks ago, he was eating well, whole sandwiches, with many glasses of water and juices per day. She is hopeful that this is an acute illness which can be reverse… Dre Rousseau and I spoke with patient's wife about goals of care- she states that she still wants all treatments to be done. We discussed the possibility of him being intubated in the ICU – difficult to continue this conversation as wife did not want to think negatively…*"

(Page 123) Meeting with Dr. Gratton on November 26, 2019. Dr. Gratton testified that she had a long discussion with ML about GG's terminal situation. She testified that ML understood she was recommending no resuscitation, but did not agree. She testified that ML did not demonstrate much openness for these discussions. She testified that she had explained to her that [TRANSLATION] "if GG had to be resuscitated, he wouldn't come back, he'd still be dying." Lastly, she confirmed to Mr. Atnikov that ML knew the risks associated with continuing to feed GG and accepted them. ML was very displeased that Palliative Care was involved in GG's care. As noted repeatedly, she said there was too much negativity and she needed to stay positive. Dr. Gratton explained to her that her role was to offer support and that she had become involved because "*doctors may have difficulty balancing "being positive" while having a duty to share their concerns, the severity and reality of the situation with her husband."* ML assured her that she was aware of how sick GG was, but said "*his body is not sick."* Dr. Gratton tried to reiterate that advanced dementia is a terminal illness and tried to talk to her about what GG would have wanted. ML told her that GG had granted her power of attorney because of "*her values and her attitude towards life."* Lastly, Dr. Gratton concluded: "*I sense some difficulty in addressing GOC lies in the fact that ML may not fully understand how dementia can progress to become a life-limiting illness. However, she is not receptive to information and teaching at this time."* On December 4, 2019 Dr. Gratton met with ML in the presence of the speech language pathologist (SLP). The SLP stated that she had clearly communicated to ML that GG was at the end of his life. ML refused to discuss or accept the possibility that GG was dying. She repeated many times that we just wanted to throw him out with the "garbage." She reaffirmed that she wanted all possible interventions to prolong his life. Dr. Gratton tried to present alternatives to ML, but she did not want to discuss them. She believed that GG's quality of life was adequate. ML categorically refused to talk about the palliative approach.

Dr. Gratton testified that, in order to make sure she has properly understood the person with whom she is talking, she repeats the person's words and has the person confirm that this was indeed what was meant. That is what she did with ML. She testified that ML understood but disagreed. She testified that the severity of GG's advanced dementia was 7 based on a scale of 1 to 7. Lastly, Dr. Gratton noted: "*I do not think she will ever accept a palliative approach to care, or that pt can't be fed (will never accept comfort feeds alone).*"

(Pages 125 to 127) Notes on the meeting with Dr. Ayuen on November 26, 2019. Dr. Ayuen testified that ML was angry that the nurses were not feeding GG. She was also angry when they asked the palliative care team to speak with her. Dr. Ayuen tried to explain to her: *"we are feeding for comfort which means he is at risk for aspiration, but despite this, at the behest of the family, we can give some food (knowing it is not enough to meet nutritional requirements and that there is always a risk of aspiration, ie. Food going into the lungs Instead of the stomach)… I also reviewed that it was my understanding that Louise, the dietician, and Kathrine, the SLP spoke with her yesterday about feeds/swallowing and that the decision on wife's part was no NGT and "feeding for comfort."*

Dr. Ayuen noted that ML became [TRANSLATION] "very angry" when health professionals other than the attending physicians talked to her. She was also surprised that ML denied having spoken to the speech language pathologist. ML also claimed that the speech language pathologist was not qualified to make recommendations because she did not [TRANSLATION] "know all the details of the case." Dr. Ayuen told her that the doctors trusted the expertise of all allied health professionals such as the speech language pathologist and the dietitian.

Dr. Ayuen suggested that a family meeting would be useful to make sure everyone had the same information; it would give ML the opportunity to ask questions and clarify issues. ML was strongly opposed to the idea. She believed that only doctors should talk with her. Dr. Ayuen told her dementia is a "big deal diagnosis." She also confirmed that once a patient has dysphagia it is irreversible. ML did not agree. She believed that GG simply needed to practise swallowing and that he would improve if the nurses took the time to feed him. She reproached Dr. Ayuen for "just letting the patient die."

(Page 188) Kathryne Legault noted the following on November 26, 2019: "*Ongoing severe impairment in swallowing function, with no change in high risk of aspiration. Pt's wife states satisfaction that pt has a cup of Ensure in his stomach, prefer "positive" comments to "negative" ones. Therefore limited ability to establish realistic goals at this time. Pt's wife states same plan remains (to offer mildly thick liquids based on pt's ability to participate) She did accept a booklet on dysphagia in dementia… pt's wife denying pt had been experiencing dysphagia*." And on page 199 on December 3, 2019: "*GG continues to present with swallowing function that is consistent with someone who is dying from his degenerative conditions. Gently reviewed this with ML however she is insistent that… "if we make him practice swallowing he will get better." These expectations remain disconnected from observations made on a nearly daily basis for the last two weeks*." In her testimony Kathryne Legault confirmed that the reason why she let ML administer juice and Ensure to GG was because ML [TRANSLATION] "insisted on it." She had stopped sending them to his room but ML insisted [TRANSLATION] "they send them so she could make GG (practice)." Ms. Legault testified that she had tried to balance the risks to the patient against ML's insistence on feeding him. In her testimony ML stated that [TRANSLATION] "the doctor never informed me that it was contraindicated to give my husband juice and Ensure."

(Page 208) On December 11, 2019 Annick Coté noted: "*We talked about PEG tube and how it will not prolong life nor improve QOL… Wife still hopes that pt. will be able to resume eating and drinking by mouth. Her expectations appear somewhat unrealistic."* And on p. 210: "*Wife's expectations are not realistic (wanting exercises and having pt eat PO)."*

(Page 216) On December 17, 2019 the speech language pathologist expressed this concern related to planning GG's return home: "*As noted previously, pt's wife's goals are not realistic and she may request more aggressive PO trials in community*."

(Page 103) On December 22, 2019 Dr. McKay had a long discussion with ML about GG's diagnosis and trajectory. She noted that ML was not open to the possibility that GG was at the end of his life because of his dementia. She was adamant that GG receive all treatments, even if they could cause him [TRANSLATION] “more discomfort.”

(Pages 251 and 252) The panel acknowledged all of ML’s efforts to assert GG’s rights. The panel was also aware that ML showed no openness for discussions that she perceived to be negative in nature. While she wanted GG to return home, at the meeting on December 31, 2019 with the occupational therapist responsible for planning GG’s discharge from the hospital, ML refused to accept the recommendations that they tried to communicate to her. “*Both OT and PT (Vivian Germain) meet with ML... ML expressed that my request to discuss this in person was not acceptable, and that it should have been done via phone… Writer recommended that additional chairs and rug be removed from the room to allow the use of the mechanical lift. ML elevated her tone of voice and expressed that I was not being objective, and that I had no right to request that… Physiotherapist also explained same, and added that those recommendations are in our scope of practice and that the same recommendations are also provided to other clients. ML told both OT and Pt that she did not believe us and wanted to see proof (other reports). She expressed that we were crossing the line… Throughout our discussion ML elevated her tone of voice and expressed her miscontent… Recommendations provided to client’s wife. Unfortunetly, ML refused the copy of the recommandations.”*

(Page 98) On January 3, 2019 Dr. Chomienne summarized ML’s instructions regarding GG’s care. She noted that ML, [TRANSLATION] “3. With respect to her husband’s condition, understands that the disease may be progressing, but says that everything has clearly deteriorated because of the LHIN’s incompetence. 4. Regarding the do-not-resuscitate order: (ML) understands (that) (if) her husband is found dead—without vital signs—during rounds, there will be no resuscitation (no CPR, no intubation); however, if his situation deteriorates to the point where he needs BIPAP or intubation, yes she would want that.”

(Page 153) The note by Janie Cardin on January 13 states: [TRANSLATION] “With (reference) to the fact that ML continues to administer fluids p.o. to her husband, it was pointed out that, following discussions in my presence and that of various doctors including Dr. Ayuen, and with the SLP’s expertise, we expressed concern on numerous occasions over many weeks about the oral feeding because of GG’s condition. ML indicated that she does not see things in the same way and so I am reinforcing the importance of the multi meeting on Wednesday.”

(Page 59) On January 21, 2020 Dr. Nicole spoke to ML about her instructions for GG’s care. She told ML that the doctors did not agree with her plan because [TRANSLATION] “it would not bring GG back to his current level of functioning and would cause him pain.” According to Dr. Nicole, it was clear ML felt that [TRANSLATION] “stopping treatments was equivalent to attempted murder.” She told ML that [TRANSLATION] “we definitely cannot provide MAID for GG.”

**Case law**

The decision in *NS (Re),* 2017 CanLII 86486 (ON CCB), p. 10, which was cited by Ms. Tourigny and ML, lays out the burden of proof that falls on the applicant: “*The onus however is on the applicant to demonstrate what that information is and that it was conveyed and delivered to the person*.” ML also cited page 14 of *NS*. She asserted that she had not previously been informed of the terrible repercussions that she learned about at the hearing. “*These vague and limited references to the consequences of continuing with mechanical ventilation are in sharp contrast to the numerous consequences outlined in ex. 3 and explained in detail at the hearing in Dr. Healey’s evidence in chief. They do not in my opinion satisfy the precondition to the Form G application of providing the information to obtain informed consent as contemplated by the legislation. Further and more fulsome explanations may have been given but there is no evidence of same.”* She also submitted that [TRANSLATION] “it’s not up to the person to go looking for information, it’s the doctor who is supposed to give it.”

The panel agreed with ML that the issue of what information should be shared and also the proof that the said information had been communicated fell on Dr. O’Meara. The panel found, however, that the decision in *NS* was not applicable to the situation before the panel. That case was different because it rested on the finding that the substitute decision maker in *NS* was open to receiving information. On page 10 of *NS*, the panel noted: “*I find we have a substitute decision-maker who is readily available to receive the information, at most times with her own translator or a Punjabi nurse available to interpret.”*

The notes attest to the fact that ML was very devoted to GG. She testified that she was at his bedside almost every day. Her presence at the hospital kept her in constant communication with the care team. She kept herself informed about everything that was happening with GG’s treatment. There was no doubt that ML was a tireless defender of GG’s rights.

Based on its review of the evidence, the panel acknowledged that ML was in a very difficult situation. She loved her husband and did not want to see him die. The panel found ML to be an intelligent and educated woman. She had studied law and worked as a lawyer before retiring to take care of GG full time. She demonstrated great understanding and insight at the hearing. There was no reason to believe that she had not been able to understand the information provided to her. Despite this, ML was continually evasive about the conversations that had taken place with the care team and the instructions they communicated to her. Her unshakable belief that she was defending GG’s right to continue living is admirable. Unfortunately, her love for GG decreased her ability to act objectively, which is essential when making decisions for another person under the *HCCA*.

The panel therefore concluded that ML was not prepared to receive or consider all of the information provided by the treatment team. Information that ML deemed incompatible with her beliefs or position fell on deaf ears, or she categorically refused allow the information to be communicated to her. ML fell into a persistent pattern of obstructive behaviours that made communication between her and treatment team members extremely difficult, and sometimes even impossible.

Lastly, ML claimed that Dr. O’Meara had tried to transfer her responsibility for providing information under section 11 of the *HCCA* to the other doctors. She argued that only Dr. O’Meara was in a position to transmit information under the *HCCA*. The panel found no merit in this argument. The care team at the MH was precisely that, a team. The panel did not find any statutory obligation requiring that only Dr. O’Meara communicate information under the *HCCA* to ML.

## The application to determine substitute decision maker compliance with regard to treatment

A Form G Application under the *HCCA* requires that the Board determine whether the substitute decision maker acted in compliance with the principles set out in section 21 of the *HCCA* when giving or refusing consent for treatment for an incapable person. If the Board determines that the substitute decision maker did not respect these principles, it can substitute its opinion for that of the substitute decision maker and order the substitute decision maker to comply with section 21. What follows is an analysis of the issue of whether ML's refusal to consent to the treatment plan for GG proposed by Dr. O'Meara complied with the principles governing decision-making for an incapable person. Section 21 sets out a two-part test: first, did the incapable person express a wish applicable to the circumstances while capable (which would be an essential consideration), and second, if the first part of the test is not satisfied, is the substitute decision maker's decision in the incapable person's best interests.

It is important to stress that there is a fundamental difference between a person capable of making decisions on his or her own behalf and a substitute decision maker making decisions on the incapable person's behalf. First of all, it is common knowledge that a capable person has, at all times, the right to make stupid decisions—this is an inviolate principle of individual freedom and personal autonomy, which is protected by our laws. No person has the right to interfere in the treatment decisions made by a competent person, even if those decisions are deemed by others not to be in the person's best interests. In other words, a capable person is the sole judge of his or her own interests. However, a substitute decision maker does not have the right to make imprudent or unreasonable decisions on an incapable person's behalf, and the substitute decision maker must make decisions in compliance with the principles of consent set out in the *HCCA*:

- in accordance with the desire applicable to the circumstances that was expressed by the incapable person while capable, or
- in the incapable person's best interests as judged objectively.

This removes a large part of the substitute decision maker's discretionary power in deciding what is best for the incapable person. The substitute decision maker is not the only judge of the incapable person's best interests. If the substitute decision maker strays from the principles set out in the *HCCA*, the Board has the right to intervene and compel the substitute decision maker to comply with these principles, in accordance with the Board's objective perception of what is in the person's best interests as demonstrated by the evidence.

In the majority decision in *Cuthbertson v. Rasouli* 2013 SCC 53, the Supreme Court of Canada provided a succinct interpretation of the substitute decision maker's obligation to make objective decisions that are in the incapable person's best interests:

> [88] The substitute decision-maker is not at liberty to ignore any of the factors within the best interests analysis, or substitute her own view as to what is in the best interests of the patient. She must take an objective view of the matter, having regard to all the factors set out, and decide accordingly. This is clear from the mandatory wording of the opening portion of s. 21(2): the decision-maker "shall take into consideration" the listed factors. The need for an objective inquiry based on the listed factors is reinforced by s. 37, which allows the decision of the substitute decision-maker to be challenged by the attending physician and set aside by the Board, if the decision-maker did not comply with s. 21. The intent of the statute is to obtain a decision that, viewed objectively, is in the best interests of the incapable person.

## **Prior expressed wishes**

Subsection 21(1) of the *HCCA* requires that the substitute decision maker respect the wishes expressed by the incapable person while capable if it is determined that these wishes apply in the circumstances. This is sometimes called "advance directives." If the evidence shows the existence of an applicable wish, it is not necessary to consider the incapable person's best interests.

### ***Did GG express a wish applicable to the current circumstances while capable?***

The Board's role in a Form G Application is to determine whether the substitute decision maker has complied with the *HCCA* rules governing decision-making for an incapable person. The applicant is asking the panel to conclude that GG had previously expressed a wish that is applicable to the current circumstances. When a Form G Application is reviewed, the burden of proof falls on the doctor, who in this case was Dr. O'Meara. The applicable standard of proof is that of a balance of probabilities. The Board must be satisfied, based on clear and convincing evidence, that the doctor discharged his or her burden of proof and that GG expressed a prior wish while capable that was clear and applicable to the current circumstances. There is a presumption that the contents of a power of attorney are known and have been approved. This presumption can be rebutted.

In *Barbulov v. Cirone* (2009) 2209 CanLII 15889 (ONSC), the Court described the factors that must be considered when determining if a Power of Attorney for Personal Care contains a prior wish. The panel applied these factors, which are as follows:

> *40 Where the CCB is asked, on an application under section 37 of the HCCA, to determine whether a substitute decision-maker has complied with the principles for giving or refusing consent under section 21 of that Act, the Board must first inquire whether the substitute decision-maker knows of a prior capable wish expressed by the now incapable person.*
>
> *41 Section 21(1)1 of the HCCA requires a person who gives or refuses consent to a treatment on an incapable person's behalf to do so in accordance with a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, if the substitute decision-maker knows of such a wish. A power of attorney for personal care may express a person's wish regarding the treatment to which he would or would not consent in certain circumstances. Section 5(2) of the Act provides that wishes may be expressed in a power of attorney, in a form prescribed by the regulations, and any other written form, orally or in any other manner. Later wishes expressed while capable prevail over earlier wishes: HCCA, s. 5(3).*
>
> *42 The Substitute Decisions Act, 1992, S.O. 1992, c. 30, contains the requirements for a valid power of attorney for personal care. Section 46 (1) provides that a person may give a written power of attorney for personal care, authorizing the person, or persons, named as attorneys to make, on the grantor's behalf, decisions concerning the grantor's personal care. The power of attorney may contain instructions with respect to the decisions the attorney is authorized to make: SDA, s. 46(7).*
>
> *43 Such a power of attorney need not be in any particular form: SDA, s. 46(8). The Act provides that a power of attorney for personal care is valid if, at the time it was executed, the grantor was capable of giving it, even if the grantor was incapable of personal care: SDA, 47(2).[1] The Act also imposes a requirement that the power of attorney for personal care be executed in the presence of, and signed by, two witnesses, although a court may declare effective a power of attorney that has not met this formality, if the court is satisfied that it is in the grantor's interest to do so: SDA, s. 48(1) and (4).*
>
> *44 In the present case there is no doubt that the 1995 POA met the requirements of the SDA, with respect to the capacity of Mr. Barbulov to give a power of attorney for personal care and the formalities of the creation of the document. However, the inquiry into whether a power of attorney expresses a*

*person's wishes with respect to treatment, within the meaning of s. 5 of the HCCA, is not limited to questions of capacity and formalities. The intended effect or scope of a wish must be determined: Fleming v. Reid (1991), 4 O.R. (3d) 74 (Ont. C.A.), at p. 94; Conway v. Jacques (2002), 59 O.R. (3d) 737 (Ont. C.A.), at para. 31. To do so the CCB must determine whether the contents of a power of attorney for personal care express the wishes of the incapable person. Fundamental to this inquiry is the need for the Board to satisfy itself, on all the evidence, that the person who made the power of attorney for personal care understood and approved of the contents of the document he or she was signing so that it can be said the document expresses the wishes of that person with respect to treatment.*

*45 Counsel for the respondent referred me to the decision of the CCB in A. (G.), Re [2007 CarswellOnt 5075 (Ont. Cons. & Capacity Bd.)], 2007 CanLII 32891 in which the Board held that if a party wanted to assert that the person who signed a power of attorney for personal care did not know its contents, that party would have to adduce evidence to establish that point. I would not put the matter quite that way. I think the proper approach should draw upon principles applicable to the proof of wills: Feeney's Canadian Law of Wills, Fourth Edition, at §3.1. Where a person seeks to rely upon a power of attorney for personal care as the expression of a prior capable wish of an incapable person, that person must demonstrate that the grantor not only possessed the requisite capacity to make the power of attorney, but also knew and approved of the contents of the document. As in the case of wills, a presumption operates that the contents of a power of attorney were known and approved if the document had been read over to the grantor, or if the contents were otherwise brought to his or her attention. This presumption, of course, can be overborne by evidence of circumstances that the grantor did not know or approve of the contents, with the result that the person advancing the power of attorney would need to satisfy the tribunal or court of the grantor's knowledge and approval of contents.*

*46 In A. (G.), Re the Board went on to state, at page 14 of its reasons:*

*While, in law, it is occasionally possible for a person to escape contractual responsibility on the basis that he or she did not know what they were signing, courts have always been cautious about letting that happen. People are presumed to be responsible for their actions and know to what they've agreed.*
*In my respectful view, that puts the matter too high, and conflates powers of attorney for personal care with commercial contracts when, in fact, they are different types of documents. By signing a commercial contract one person makes promises to another, which the latter can call the other to perform. Courts, indeed, are reluctant to release a person from such written promises simply on the person's assertion that he did not really understand the bargain he was making.*

*47 Powers of attorney for personal care are a different creature. The grantor is not making a bargain with the grantee. Rather, the grantor is selecting a person to act in his stead and is expressing, through the document, the nature of the care he wishes to receive in the event that certain circumstances arise. Under a power*

> *of attorney for personal care the grantee does not receive any benefit enforceable against the grantor, as does the promisee under a commercial contract. Instead, the grantee is requested to perform a duty for the grantor and, if he accepts the grant, the grantee must comply with the expressed wishes of the grantor.*
>
> *48 So, where the CCB is faced with a power of attorney for personal care, it should not approach the inquiry under section 21(1)1 of the HCCA on the basis of whether the grantor is trying to "escape contractual responsibility"; to do so would be an error. Instead, the inquiry must always remain focused on the task mandated by the statute - does this document express the capable wishes of the person with respect to treatment in particular circumstances? To conclude that the document does, the CCB must be satisfied on the evidence that the grantor understood what he was doing through the document - i.e. he knew and approved of its contents and effects. If he or she did not, then I do not see how one could say that the power of attorney for personal care expressed the wishes of the person with respect to treatment, as required by section 5 of the HCCA.*

Section 5 of the *HCCA* stipulates that a wish concerning treatment may be expressed in writing or orally. GG signed a will and a Power of Attorney for Property as well as a Power of Attorney for Personal Care on January 24, 2014. ML testified that GG had his will and powers of attorney drawn up after a meeting with his doctors, Dr. Lemay and Dr. Cameron. His doctors had advised him to [TRANSLATION] "put his affairs in order" because he was starting to have memory problems.

The power of attorney includes the following clause:

> [TRANSLATION]
>
> *4.*
>
> *a) I order my attorney to follow and/or take into consideration any general medical directive and/or any specific instruction related to the care of my person and/or living will that I may prepare and sign hereafter.*
>
> *b) If a time comes when I am no longer able to make decisions about any treatment for myself, I desire the declaration below to be considered as the formal expression of my wishes.*
>
> *c) In the event that a sufficient recovery of my physical and mental capacities is deemed impossible, I, the undersigned, ask that I not be kept alive by artificial and extraordinary methods.*

> *d) I ask for the appropriate medication to be given to me to effectively relieve my pain, even if it hastens my death. I ask that you treat these instructions as your moral duty. In this way, I wish to remain responsible until the end and thereby make it easier for you to make decisions on my behalf. These instructions are given to you after careful reflection, voluntarily and while I am of sound mind.*

***Based on its examination of all the evidence, is the panel satisfied that the power of attorney is valid?***

The power of attorney was drawn up and witnessed by Josée Roy, lawyer. Her assistant acted as second witness. The power of attorney designates ML as attorney and, alternatively, his children. The signing formalities for the power of attorney were followed.

GG had the capacity to sign the power of attorney. GG was diagnosed with dementia in April 2014. He became incapable of making decisions about his treatment in 2017. There was no evidence that GG did not have the required capacity when he signed his will and powers of attorney. ML testified that he was still working in March 2014. DL testified that following GG's diagnosis in April 2014, although he was not the [TRANSLATION] "great philosopher he once was, he was still able to research his disease and conceptualize the problems linked to dementia." DL testified that she believed GG was able to do research because he talked about the stages of his disease and made jokes about where he was at.

The panel was satisfied that GG was aware of what he was signing when he signed the power of attorney. GG had worked for 53 years as a lawyer. GG's curriculum vitae (Exhibit 7) notes that he practised in the field of succession law. At the end of his career and up until his retirement, he presided over hearings for an administrative tribunal. ML and her sister DL described him as a very intelligent man [TRANSLATION] "who wanted to know everything." In response to a question from Mr. Atnikov, ML testified that GG "*would never have put a document before a client without having them read it first*." The panel was satisfied that GG, himself a lawyer, was aware of the importance of the documents he signed on January 24, 2014. They had been drawn up following a conversation with his doctors about the importance of putting his affairs in order. According to ML, GG read the dictionary to relax and never would have let a client sign a document without first making sure the client had gone over it. ML testified that she was not in the room when the power of attorney was signed. She testified, however, that she could see him [TRANSLATION] “through the glass” and that GG did not read it. The circumstances as described by ML would not have enabled her to arrive at the conclusions that she communicated to the panel. The panel was satisfied that there was sufficient evidence that the power of attorney was valid and that GG was aware of its contents and, in particular, paragraph 4.

### *Based on an examination of all the evidence, is the panel satisfied that GG did not express a more recent wish while capable?*

DL testified that she spoke to GG about his wishes in 2003 when he was diagnosed with prostate cancer and possibly in 2009 when she lost her husband. She testified that she did not speak to him about his wishes when he was suffering from dementia. She admitted that she had not seen the power of attorney. The only information he conveyed to her regarding power of attorney was [TRANSLATION] “that he knew that ML was going to respect his wishes.” She testified that GG was aware his disease was terminal. DL testified that she did not know if his wishes had changed since their conversations.

LL, ML’s sister, has been a nurse practitioner for 21 years. It is noted in Exhibit 16 that it was LL [TRANSLATION] “who noticed the first symptoms of GG’s disease” in the summer of 2013. She testified that in 2014 GG was not yet at the point where he could not research his disease; [TRANSLATION] “He wasn’t at that stage yet.” She was certain that GG had researched his disease and knew what to expect. She testified that she had not seen GG’s power of attorney and did not know the details contained in it.

ML and DL testified that GG wanted to live [TRANSLATION] “until his last breath.” DL testified that GG was a Christian who respected life. For her, this meant that he [TRANSLATION] “wanted to live as long as possible but believed it was God’s right to decide when it was time to go.”

The review of the evidence did not reveal any prior wish that would supersede the power of attorney. The only other wish expressed through DL and ML was general and not limited to the present circumstances. The panel concluded that ML, perhaps involuntarily, attributed to GG certain beliefs and values which she held personally but did not necessarily apply to the circumstances. According to DL, he [TRANSLATION] “loved God” but only went to Church

[TRANSLATION] "at Christmas and Easter." In this case the details of GG's faith remain vague and, although he was Christian, it seems that he lived his life in an independent way and did not strictly follow any religious doctrine.

The panel found that the meaning of the directive in paragraph 4 is clear. The evidence provided by ML for her interpretation of the wishes that she believed GG had expressed did not align with GG's signing a power of attorney that asked [TRANSLATION] "that I not be kept alive by artificial and extraordinary methods." The panel did not find it possible to attribute the meaning that the substitute decision maker was trying to give the wish to [TRANSLATION] "live until his last breath" to the situation in which GG now found himself. Following his diagnosis in April 2014, GG did not become incapable of consenting to treatment until 2017. This was an educated man who researched his disease and who, according to his family, [TRANSLATION] "knew what was awaiting him." Notwithstanding this knowledge, he did not try to change or revoke his Power of Attorney for Personal Care even though it clearly stated that he did not want [TRANSLATION] "to be kept alive by artificial and extraordinary methods."

Given all of the available evidence, the panel concluded that paragraph 4 of the power of attorney was a wish expressed while GG was capable and that it was applicable to the circumstances, in accordance with subsection 21(1) of the *HCCA*. The panel also accepted the clear and convincing evidence of GG's care team regarding GG's state of health and prognosis, as outlined in the voluminous notes in the medical record. The panel accepted Dr. O'Meara's testimony that GG's illness was in the terminal stage and that interventions such as those described in the letter of January 20, 2020 would only prolong the death process and that GG would die whether [TRANSLATION] "artificial methods" like intubation were used or not. This evidence was supported by the testimonies of Dr. Gratton and Dr. D'Egidio. The panel also concluded that the treatment plan proposed by Dr. O'Meara was clear and unambiguous. Dr. O'Meara and the entire treatment team had agreed that there were no reasonable expectations as to GG's recovery or a substantial improvement in his quality of life. The treatment plan was consistent with GG's specific directives in paragraph 4 of his Power of Attorney.

**Best interests**

It is also understood that, when no prior wishes apply to the circumstances, the law requires that a substitute decision maker make decisions that are in the incapable person's best interests, in accordance with the factors set out in subsection 21(2) of the *HCCA*. The panel therefore analyzed the best interests listed in subsection 21(2) of the *HCCA*. When the substitute decision maker makes a decision about a proposed treatment, she must examine the values and beliefs that GG had while capable and that she believes he would still act on if capable (subsection 21(2)(a) of the *HCCA*) as well as the medical factors set out in subsection 21(2)(c) of the *HCCA*.

The panel found that the medical factors were clear and uncontroversial. GG suffered from advanced dementia from which he would not recover. All of the evidence indicated that GG would continue on the same course until he died, completely dependent on others in all aspects of daily life. GG's attending physicians, as well as Dr. D'Egidio, an intensive care specialist, agreed with the prognosis for GG. The many notes clearly documenting this and submitted as evidence before the Board attest to this fact. Dr. O'Meara, Dr. Gratton, Dr. D'Egidio and the speech language pathologist Kathryne Legault all testified that the treatment plan proposed in the letter of January 20, 2020 was, in their opinion, in GG's best interests.

The reasons for Dr. O'Meara's treatment plan were clear, convincing and compatible with the medical considerations set out in subsection 21(2)(c) of the *HCCA*: GG's condition would not improve if he were treated in intensive care and GG would not benefit from such treatments. GG's "well-being," interpreted in a general way to include quality of life, dignity and pain, would only be undermined. The evidence did not reveal a viable alternative to the proposed treatment plan.

The panel was unable to conclude, based on a balance of probabilities, that GG would have wanted escalated treatment given his current state and prognosis. GG had expressed his wishes in the power of attorney signed on January 24, 2014. As mentioned previously, between April 4 and 2017, GG did not try to change or revoke his Power of Attorney for Personal Care, which clearly states that he did not want [TRANSLATION] "to be kept alive by artificial and extraordinary methods.” This indicated to the panel that GG’s real wish, even though he had become incapable, was to have no interventions that would serve only to prolong his death.

Lastly, and as we stated earlier in these reasons, the panel studied GG’s religious and cultural beliefs carefully. We found that, although the evidence revealed that GG was a man [TRANSLATION] “who lived his faith,” and although there was general evidence about his family beliefs and values, there was no evidence of the way in which GG would personally interpret his religion and his beliefs in his current situation. The evidence did not lead the panel to conclude what decision GG would have made had he been able to make one. The panel found that the proposed treatment plan was in GG’s best interests. The panel found that GG’s substitute decision maker had not fulfilled her obligations under the *HCCA*. She had not wanted to—or was not able to—examine the incontestable evidence of GG’s state and prognosis, or to take it into account when called upon to accept or refuse the proposed treatment plan.

## RESULT

For the foregoing reasons, the Board unanimously confirmed the finding of GG’s incapacity with respect to the treatment proposed by Dr. O’Meara in the letter of January 20, 2010.

The Board also unanimously determined that the substitute decision maker did not comply with the substitute decision-making principles set out in the *HCCA*, and it orders the substitute decision maker to respect the treatment plan proposed by May 15, 2020. If the substitute decision maker does not comply with the Board’s directions within the deadline imposed by the Board, she will be presumed to have not satisfied the requirements with which the substitute decision maker must comply under subsection 20(2) of the *HCCA*.

Date: May 11, 2020

Brigitte Pilon, lawyer – Presiding Member