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Consent and
Capacity Board

Commission du consentement
et de la capacité

Ontario

2012 CanLII 42098 (ON CCB)

Files No: OT-12-0263

OT-12 0264

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

AND IN THE MATTER OF
GS
A patient at the
OTTAWA HOSPITAL - CIVIC CAMPUS
OTTAWA, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

A hearing of the Consent and Capacity Board (the "Board") was convened at the Ottawa Hospital - Civic Campus (the "Hospital") to consider two matters: a "Form G" application to determine whether or not DF, GS's substitute decision-maker had complied with the principles for substitute decision-making set out in section 37 (1) of the *Health Care Consent Act*, and a deemed "Form A" application under subsection 37.1 to review the capacity of GS to make his own treatment decisions.

DATES OF THE HEARING, DECISIONS AND REASONS

The hearing took place at the Hospital on June 18 and 19, 2012. The panel also met on June 21, 2012 for deliberations. With the consent of all parties the panel released its Decisions on June 22,

2012. On June 25, 2012 counsel for DF requested written Reasons for Decision (contained in this document), which were released on June 29, 2012.

LEGISLATION CONSIDERED

The *Health Care Consent Act*, (HCCA)

PARTIES

GS, the incapable person.
DF, the substitute decision-maker for GS.
Dr. Carl Van Walraven, the health practitioner who proposed the treatment.

DF and Dr. Van Walraven attended the hearing. GS did not attend the hearing.

PANEL MEMBERS

Mr. Paul DeVillers, senior lawyer and presiding member.
Dr. Marvin Silverman, psychiatrist member.
Mr. Pierre Lessard, community member.

APPEARANCES

GS was represented at the hearing by counsel, Mr. Earl Atnikov.
Dr. Van Walraven was represented at the hearing by counsel, Ms. Kirsten Crain.
DF represented herself at the hearing.

PRELIMINARY MATTERS

Appointment of Amicus

Despite the hearing having been twice adjourned for DF to arrange the attendance of Mr. Bruce Marks, her counsel of choice, Mr. Marks informed the panel that DF would be making her own presentation. Since Mr. Marks was present and willing the panel appointed him *amicus curiae* to assist the Board. No party commented or objected to the appointment of Amicus.

THE EVIDENCE

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

1) Dr. Van Walraven
2) Mr. Denis Garven, a patient's advocacy specialist from the Hospital
3) DF
4) DF's three sons, GS"s grandsons
5) Mr. Michael Hackett, Dr. Van Walraven's physician assistant
6) Dr. Andre Pasternac

There were 13 Exhibits:

1) Treatment Plan proposed by Dr Van Walraven dated April 19, 2012.
2) Judgement of the Superior Court of Justice in Montreal date March 1, 2011 ratifying the Power of Attorney dated April 8, 2010.
3) Factum filed by Ms Crain.
4) Letter from Ms. Crain to DF dated February 27, 2012
5) Form G dated April 17, 2012.
6) E-mail Rudz to Hackett date April 12, 2012.
7a) Part 1 of article from New England Journal of Medicine (The Multi-Society Task Force on PVS).
7b) Part 2 of article from New England Journal of Medicine described in 7a).
8) Article from New England Journal of Medicine (Willful Modulation of Brain Activity in Disorders of Consciousness).

9) Summary of evidence from Dr. Pasternac

10) Article from the Lancet (Bedside detection of awareness in the vegetative state: a cohort study).
11) Affidavit sworn by Dr. Pasternac dated April 6, 2011
12) CCB Reasons for Decision dated May 12, 2011.

INTRODUCTION

GS, who was 89 years of age, incurred serious injuries in a car accident in late November of 2010. Among many other injuries GS suffered serious head injuries and spinal cord injuries. These injuries have impaired his cognitive functioning. In the course of his stay in the Hospital GS has endured many infections as well as pneumonias. GS has required tracheotomies and suctioning. He is fed by a percutaneous tube connected to his stomach and urinates via a catheter. Depending on his condition, he has been kept alternatively in the intensive care unit and the trauma unit in the Hospital, and he has been attached to monitors at various times as required in the opinion of his caregivers.

His daughter DF is his substitute decision-maker and has been in frequent, if not constant, disagreement with the health practitioners at the Hospital about the treatment required for GS. In fact in May 2011 DF brought an application to the Board for directions pursuant to s. 35(1) of the *HCCA*. The Board declined to give directions and its Reasons for Decision are Exhibit 12 in this hearing.

Dr. Van Walraven as GS's primary treating physician had proposed a Plan of Treatment (Exhibit 1) and DF has declined to consent to this Plan. It was to be noted that the plan did not provide for the removal of any supports at this time but basically called for no heroic measures if there was deterioration in the future. In that sense this is not an end-of-life situation. It was for this reason that Dr. Van Walraven made an application to the Board to find that DF had not complied with the principles of substitute decision-making set out in the *HCCA*. Since the Board had made no finding in that regard within the previous six months, the matter of GS's capacity to consent to treatment needed to be determined before dealing with the question of compliance with the principles of substitute decision-making.

THE LAW

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

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

Capacity to Consent to Treatment

Section 37.1 of the *HCCA* provides that:

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

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

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

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

> 4(1) A person is capable with respect to a treatment, admissions to a care facility, or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance , service, as the case maybe, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

<u>Compliance with the principles of substitute decision-making</u>

Section 37. of the *HCCA* provides that:

> 37. (1) If consent to a treatment is given or refused on an incapable person's behalf by his or her substitute decision-maker, and if the health practitioner who proposed the treatment is of the opinion the substitute decision-maker did not comply with section 21, the health practitioner may apply to the Board for a determination as to whether the substitution decision-maker complied with section 21.
>
> 37. (2) The parties to the application are:
> 1. The health practitioner who proposed the treatment.
> 2. The incapable person.
> 3. The substitute decision-maker.
> 4. Any other person whom the Board specifies.
>
> 37. (3) In determining whether the substitute decision-maker complied with section 21, the Board may substitute its opinion for that of the substitute decision-maker.
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> 37. (4) If the Board determines that the substitute decision-maker did not comply with section 21, it may give him or her directions and, in doing so, shall apply section 21.
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> 37. (5) The Board shall specify the time within which its directions must be complied with.
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> 37. (6) If the substitute decision-maker does not comply with the Board's directions within the time specified by the Board, he or she shall be deemed not to meet the requirements of subsection 20 (2).
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> 37. (6.1) If, under subsection 6, the substitute decision-maker is deemed not to meet the requirements of subsection 20 (2), any subsequent substitute decision-maker shall, subject to (6.2) and (6.3), comply with the directions given by the Board on the

> application within the time specified by the Board.
>
> 37. (6.2) If a subsequent substitute decision-maker knows of a wish expressed by the incapable person with respect to the treatment, the substitute decision-maker may, with leave of the Board apply to the Board for directions under section 35.
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> 37. (6.3) Directions given by the Board under section 35 on a subsequent decision-maker's application brought with leave under subsection (6.2) prevail over inconsistent directions under subsection (4) to the extent of the inconsistency.
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> 37. (7) If the substitute decision-maker who is given directions is the Public Guardian and Trustee, he or she is required to comply with the directions, and subsection (6) does not apply to him or her.

Section 21 of the *HCCA* provides that:

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

iii. reduce the extent to which, or the rate at which, the incapable person's condition of well-being is likely to deteriorate.

2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without treatment.

3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

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

> 20. (2) A person described in subsection (1) may give or refuse consent only if he or she,
> (a) is capable with respect to the treatment;
> (b) is at least 16 years old, unless he or she is the incapable person's parent;
> (c) is not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf;
> (d) is available; and
> (e) is willing to assume the responsibility of giving or refusing consent.

Section 5 of the *HCCA* provides that:

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

<u>Cases reviewed and considered</u>

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

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

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

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

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

Rasouli v Sunnybrook Health Sciences Centre, [2011] ONCA 482
Janzen v Janzen (2002), 44 E.T.R. (2d) 217 (S.C.J.)

ANALYSIS

Capacity to Consent to Treatment

The evidence at the hearing clearly established that GS had been incapable of consenting to treatment since his admission and that he currently has no cognitive function, cannot communicate, and can neither understand information regarding his treatment nor appreciate the reasonably foreseeable consequences of treatment decisions. No evidence to the contrary was led. In response to the panel's inquiry, at the beginning of the hearing, as to whether there were any issues that the parties agreed upon, all parties stated that they had no issue with the fact that GS lacked capacity to consent to treatment.

Compliance with principles of substitute decision-making

As set out in the introduction to these Reasons for Decision, there was a long history of exchanges between DF and the various health practitioners and the Hospital. Part of the evidence that confirmed this was Exhibit 4, a letter sent by the lawyers for the Hospital to DF and DF's reply to the letter which she read into the record during her evidence. This exchange illustrates that there existed a considerable difference of opinion between DF and the professionals at the Hospital over the course of treatment for GS. The evidence revealed that there existed the classic case of disagreement between the family member substitute decision-maker and the health practitioner that the provisions of the *HCCA* were designed to resolve. The panel acknowledged its role was as described in *M(A) v Benes:*

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

Much of the evidence that the panel heard from DF and other witnesses supporting her position was marginally relevant to the question that needed to be determined by the Board. For instance there was a major issue made about the timing and motives for the bringing of the Form G application. DF took issue with the fact that the application was brought by Dr.Van Walraven only three days after he said he discovered the existence of the Enduring Power of Attorney. Her evidence was that it was left with the Hospital shortly after GS was admitted in November 2010. The panel did not consider that anything turned on when Dr. Van Walraven had access to the document. What was important was whether it amounted to a prior capable wish.

In her evidence DF also raised Charter of Rights issues. Counsel for both GS and Dr. Van Walraven raised objections that they had not been provided with notice of constitutional challenges. The panel found that without such notice the Board does not have authority to deal with the constitutionality of the *HCCA* and it is even questionable what authority it would have with the proper notice. In the Benes case the court did comment on the issue as follows:

> For all these reasons, in our view, s. 37(3) does not infringe the liberty or security interests of an incapable person under s. 7 of the Charter. The Board is entitled to review an S.D.M.'s assessment of an incapable person's best interests to ensure that the S.D.M.`s decision is correct.

Was the Enduring Power of Attorney a Prior Capable Wish

The panel needed to review the Power of Attorney dated April 8, 2010 (Exhibit #2) and the

evidence surrounding its execution to determine if it contained a prior capable wish pursuant to section 21(1)1.

The wording of article 4.3 the Power of Attorney clearly states that GS did not wish for his life to be prolonged in certain circumstances:

> 4.3 To carefully consider that it is my specific wish and desire that I do not want my life to be prolonged and I do not want life-sustaining treatment to be provided or continued:
>
> a) If I am in an irreversible coma or persistent vegetative state, or
>
> b) If I am terminally ill and the application of life sustaining procedures would serve only to artificially delay the moment of my death; or
>
> c) under any circumstances where the burden of the treatment outweigh the expected benefits. I want my Attorneys to consider the relief of suffering and the quality as well as the extent of the possible extension of my life in making decisions concerning life-sustaining treatment.

The panel found that the wording in the Power of Attorney indicated a clear wish of what GS would want in particular circumstances. Before considering whether those circumstances existed the panel had to deal with another issue. The reason for this was that DF challenged the Power of Attorney on the basis that GS would never have knowingly signed this document if he had fully understood its true meaning in these circumstances. She stated that GS was a man who intended to live a long life and would never agree to a treatment plan that did not call for all measures possible to sustain life. She described him as a fighter who had survived the holocaust in Europe and two heart surgeries. She also told the panel of a discussion she had had with GS shortly prior to the car accident wherein he stated that he was pleased with his recovery from hip surgery. He used words to the effect that he would not be satisfied to live to 100 years of age because he did not want to limit his possibilities for a longer life.

DF also told the panel that she was with GS when he signed the Power of Attorney and despite his poor English (he emigrated from Romania and worked as an engineer in Montreal using mostly French) he commented on article 4.3. DF stated that GS only agreed to sign the Power of Attorney after being assured by the lawyer that the clause was a standard clause included to protect DF from having to make a hard decision in those circumstances. He was told that she would have the final say. On cross examination DF and her three sons all stated that they had had no direct discussions with GS regarding his understanding of article 4.3 in the context of pain and suffering or loss of quality of life.

The panel found that the Power of Attorney did constitute a applicable prior capable wish. Whatever his difficulties were with the English language, GS recognized the possibility for the circumstances in which he finds himself and agreed to sign the Power of Attorney on the explanation it gave his daughter the possibility of relief from making a hard decision. The fact that she was unwilling to make that decision did not alter the fact that is was his wish.

The panel therefore turned its attention to GS's current medical condition. Dr. Van Walraven described GS as being in a persistent vegetative state because he cannot react to his environment, is unable to speak or follow commands and is unable to react when threatened with motion in his direction. Dr. Van Walraven stated that there was zero percent chance that GS would ever make a truely meaningful recovery.

Evidence to the contrary came from DF, her three sons and Dr. Pasternac. All of these witnesses said that although GS could not communicate verbally they were convinced that he recognized them when they visited and showed signs of happiness by facial expressions. DF stated the GS did not react this way with the doctors and nurses because she surmised that he thought they were trying to kill him so he would look away from them.

Dr. Pasternac was a witness who had been GS's cardiologist in Montreal and had treated him for 15 years before the car accident in November 2010. He is not licensed to practice medicine in Ontario and is not a specialist in internal medicine or in trauma care. He stated that he had not done a complete examination of GS and based his observations from a brief review of the charts and his visit with GS. He stated that GS recognized him and was happy to see him. He stated that GS looked away when he lost interest and was sad. Dr. Pasternac, however, qualified his opinion as to the awareness of GS on more than one occasion as subjective observations.

On the balance of probabilities the panel accepted Dr. Van Walraven`s evidence over that of the other witnesses who believed GS was capable of cognitive activity. Dr. Van Walraven is a qualified internal medicine specialist who had the benefit of examining the complete charts and consulting with other medical practitioners dealing with GS during his lengthy stay at the Hospital. The evidence of the family was understandably emotional and was in the view of the panel influenced by their desire to see their loved one well again. Dr. Pasternac also stated that he had an emotional attachment to his former patient. On cross examination he admitted that he had recanted evidence he gave in the CCB hearing in May of 2011 because he did not like the tone of the cross examination. He was now recanting his previous recantation and this, in the view of the panel affected the credibility of his evidence. Issue was taken during the hearing that a Board order on an adjournment of this matter had not been followed because Dr. Pasternac was not permitted to examine GS when he arrived unannounced for that purpose. The panel accepted the explanation given that there was a Hospital protocol that had not been followed to pre-arrange examinations of Hospital patients by medical practitioners without privileges at the Hospital.

The panel determined that DF had not complied with the principles of substitute decision-making in the *HCCA*, in that she failed to apply an applicable prior capable wish as required. We directed DF to consent to the Treatment Plan proposed by DR. Van Walraven on this basis. Nevertheless, for completeness the panel went on to consider how a decision should be made in the event that there was no applicable prior capable wish; in other words, what result would be required in an application of GS's best interests pursuant to section 21(2) of the *HCCA*.

Values and Beliefs

DF, her three sons and Dr. Pasternac were all adamant that GS held values and beliefs contrary to giving up on life. They described him as a disciplined man with a strict health regime and a fighting spirit. They described him as being religiously observant in his Jewish faith, which they pointed out would necessarily mean he would be against any measures in a Treatment Plan that would limit measures taken to preserve life. No evidence about the tenets of the Jewish faith was given to the panel. It was simply stated as a given that it would not support Dr. Van Walraven's Treatment Plan. The panel questioned whether DF's belief that the proposed Treatment Plan was tantamount to certain death influenced her view about what GS's reaction to the plan would be if he were capable. Because Dr. Van Walraven did not know GS when he was capable, he could offer no evidence on his values and beliefs.

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

There was no evidence submitted to the panel of any identified wishes apart from the Power of Attorney which has been addressed above.

Well-being

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

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

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

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

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

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

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

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

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

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

Dr. Van Walraven`s evidence was that GS had a zero percent chance of making a truly meaningful recovery. GS was in stable condition and being monitored by nursing staff twenty four hours a day. He stated it was no longer necessary to conduct as many lab tests and exploratory tests as previously when GS's condition was less stable. He stated that GS`s baseline status was poor, and it could not be made better. If GS's baseline could not be improved the panel could not see how his quality of life or well-being could be made to improve.

On the other hand DF`s evidence did not deal with the issue of well-being. Her focus was almost entirely on treatment to preserve GS`s life. The panel found it entirely understandable that she would advocate strongly on behalf of her father. However, we found that this desire on her part to try to preserve GS`s life did not allow for any consideration for these other medical issues. In her final submissions DF made statements to the effect that GS was a problem to the hospital and to Dr. Van Walraven. She argued that the proposed Treatment Plan was a way to save costs and to get rid of a problem by transferring GS to a long term care facility. She also referred to the situation as murder disguised as euthanasia. She stated that we value life in Canada and have no death penalty.

<u>Expected benefits to treatment outweigh risk of harm</u>

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

Also, as previously stated, Dr. Van Walraven told the panel that GS`s baseline was poor and could not be improved. He also stated that many of the heroic measures and further testing which are both being eliminated in his proposed Treatment Plan but were being advocated by DF would result in pain and discomfort to GS. Therefore it followed that, given that there could be no benefits, the benefits could not outweigh the risk of harm.

In her evidence, DF did not refer to the risk of any harm from the treatment she advocated and seemed to be focused of the preservation of life aspect to her proposed treatment. She also referred to certain cases of “awakenings” where patients had come out of prolonged comas. The panel did not feel that the evidence in this case supported the likelihood of similar events in GS’s case.

Less restrictive and less intrusive treatment

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

The panel considered this to be the crux of the disagreement between DF and Dr. Van Walraven.

The Treatment Plan proposed by Dr. Van Walraven proposed less restrictive and less intrusive treatment and DF would not consent to it and gave no appearance of even considering it.

Conclusion

The panel found that GS was not capable to consent to treatment.

The panel also found that the enduring Power of Attorney (Exhibit 2) constituted an applicable prior capable wish under section 21(1)1. In the alternative, after considering all of the provisions of section 21(2), the panel found on the balance of probabilities that the Treatment Plan proposed by Dr. Van Walraven (Exhibit 1) was in the best interests of GS. Nothing in the evidence suggested that, in these circumstances, GS would want to be subject to unnecessary medical interventions. In the *Scardoni* the court held that “best interests” should be interpreted broadly to include issues of dignity and quality of life. All of the evidence made plain that GS had a very poor quality of life and the situation would not improve. GS was subjected to daily indignities through invasive medical procedures without increasing the likelihood that he would recover any awareness or consciousness.

The finding under section 21(2) was as a result of weighing the evidence of Dr. Van Walraven on the issues set out in section 21(2)(c) against the evidence of DF with respect to values and beliefs set out in section 21(2)(a). The panel found Dr. Van Walraven`s evidence cogent and compelling and therefore more persuasive.

RESULT

For the foregoing reasons, the panel unanimously found GS not capable with respect to treatment. The panel also found that DF had not complied with the principles of substitute decision-making in the Act and directed her to consent to the five part Treatment Plan (Exhibit 1) by July 6, 2012.

Dated: June 29, 2012

Paul DeVillers
Presiding Member