Consent and Capacity Board   **Commission du consentement et de la capacité**

2013 CanLII 50505 (ON CCB)

LO-13-1782
LO-13-1783

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

AND IN THE MATTER OF
G
A patient at
London Health Sciences Centre – Victoria Site
LONDON, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

We convened as a panel of the Board at London Health Sciences Centre – Victoria Site (Victoria), at the request of Dr. Anderson, a health practitioner. Dr. Anderson brought a **Form G Application** to the Board under section 37 (1) of the *Health Care Consent* Act for a determination as to whether or not the substitute decision maker **J** has complied with the principles for substitute decision-making as they are set out in the *Health Care Consent Act* with respect to proposed treatment for her husband **G**. He had multiple organ system failure and was dependent on mechanical support in the intensive care unit. He could not communicate by speech or by writing.

Dr. Anderson recommended to ***J*** *that she* ***change the course of treatment to ensure comfort at whatever cost, while reducing and eliminating mechanical support, while acknowledging that the patient will pass away in the process.***

An application to the Board under section 37 of the *Health Care Consent Act* is deemed, pursuant to subsections 37.1 of the *Health Care Consent Act* to include an application to the Board under section 32 by G with respect to his capacity to consent to treatment proposed by a health practitioner unless the person's capacity to consent to such treatment has been determined by the Board within the previous six months. The Board considered G's deemed application as no prior determination had been made by the Board within the previous six months.

We found **G** to be incapable with respect to the proposed treatment. We also determined that his wife **J** has not complied with the principles for substitute decision-making set out in the relevant legislation and directed her to grant consent in accordance with the proposed treatment ***by noon on Tuesday July 23, 2013.***

We found as a fact that J deeply loves her husband and partner of 26 years, and is trying desperately to do the best she can for G who is 41 years of age. In spite of her efforts, she did not meet the tests set out in law for substitute decision-makers.

We acknowledge the many family members who attended both days of the hearing. Although they were divided in their view about the doctor's application, they were united in showing respect for J, for the doctor, and for the hearing process. We thank them for their care and concern for G and for J.

Finally, the panel recognizes Dr. Scott Anderson and his medical staff who bore the burden of proof throughout the hearing. The patient's care was complicated by morbid obesity – he weighs approximately 700 pounds. The evidence showed that they explored many treatment options for his multiple organ system failure before making the difficult treatment recommendation which is the subject of this proceeding.

DATES OF THE HEARING, DECISIONS AND REASONS

The hearing commenced on Monday, ***July 15, 2013*** and continued on Thursday, ***July 18, 2013***. The panel released its decisions on ***July 19, 2013***. The doctor requested reasons for decision. These reasons were released on Sunday, ***July 21, 2013***.

LEGISLATION CONSIDERED

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

PANEL MEMBERS

Shirley R. Wales, Presiding Lawyer Member
Patricia Muldowney-Brooks, public member
Joy Wendling, public member

PARTIES

G's Deemed Form A – Treatment Application
G, patient
Dr. Anderson, health practitioner

Dr. Anderson's Form G – Treatment Application concerning G
Dr. Anderson, health practitioner
G, patient
J, G's wife and substitute decision maker "**SDM**".

G did not attend the Hearing. At the request of the doctor, ***the panel visited G in his room*** in the intensive care unit on July 18, 2013. The visit was narrated by the doctor on the record and in the presence of J and all counsel.

Dr. Anderson and J attended the hearing and gave evidence.

APPEARANCES

G was represented at the hearing by counsel, *Ms. Diane Ewer*
Dr. Anderson represented himself at the hearing.
J was represented at the hearing by counsel, *Ms. Jill McCartney* and *Ms. Amy Best* on July 15, 2013, and by *Ms. Paula Lombardi* and *Ms. Amy Best* on July 18, 2013.

PRELIMINARY MATTERS

1. *Naming of the Patient and his Wife and Substitute Decision-Maker by a single initial "G" and "J" to Preserve Confidentiality*

Both the patient and his wife belong to the First Nations people. They are members of different Bands. The use of a single initial to identify them will provide greater confidentiality and protection of the dignity of the patient, given the graphic nature of the medical evidence provided by the health practitioners and the observations by the panel of the patient in his room as narrated for the record by Dr. Anderson.

2. *Adjournment Request on July 15, 2013 brought by counsel for J, the Patient's Wife and SDM*

Ms. Best appeared as counsel for J when the hearing commenced shortly after 1:00 pm on **July 15, 2013**. She reiterated the request for an adjournment, which had been communicated by letter to the Board dated **July 10, 2013** from counsel Ms. Jill McCartney requesting a minimum adjournment of two weeks to confirm her retainer and to fully prepare for the hearing. This letter was entered as **Exhibit Two**.

Counsel first met with J on Friday, **July 12, 2013**. She sent a letter to the Board on that day which was entered as **Exhibit One** confirming her retainer, but renewing her request for an adjournment, this time indicating her earliest availability for **July 17, 2013**.

On **July 15, 2013**, counsel sent her associate Ms. Best to make the motion for adjournment. Ms. Best was asked if she were prepared to represent her client if the panel decided to proceed with the applications on the date scheduled. She indicted that she would do so.

The doctor opposed the request for adjournment. He stated that his patient was suffering, and that any delay would prolong his dying and death process. He cited the efforts of hospital staff commencing in early June 2013 to have J and the patient's family come to terms with the likelihood that G would not survive, and to obtain consent to treatment appropriate to the circumstances. He advised that he was ready to proceed.

Counsel for the patient indicated that she had not received instructions from her client on this matter. She took no position on the request for adjournment.

The panel balanced the right of **J** to be represented by counsel against the doctor's evidence that delay created additional suffering for his patient and that there was no hope of recovery. We also took into account that counsel asked for time to review hospital documentation.

We reminded counsel that the Board had a statutory obligation to convene a hearing within seven days of the filing of the Form G Application: section 75(2) *HCCA*.

> ***Application hearings***
>
> ***Board to fix time and place of hearing***
>
> ***75.*** *(1) When the Board receives an application, it shall promptly fix a time and place for a hearing. 1996, c. 2, Sched. A, s. 75 (1).*
>
> ***Hearing to begin within seven days***
>
> *(2) The hearing shall begin within seven days after the day the Board receives the application, unless the parties agree to a postponement. 1996, c. 2, Sched. A, s. 75 (2).*

We adjourned the proceedings from 2:30 pm until 4:30 pm, allowing a full two hours for patient's counsel to review the hospital records, and the four page document tendered by the doctor which was ultimately introduced as **Exhibit Three**.

By the time the panel reconvened the hearing at 4:30 pm to hear evidence on the merits of the applications, counsel Ms. Jill McCartney had arrived. She was assisted by Ms. Best in representing her client.

3. Other Preliminary Concerns

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

4. Smudge Ceremony for Commencement of Hearing on July 18, 2013– Request Withdrawn by Counsel for J

The **Order / Endorsement** dated July 16, 2013 contains the following paragraph:

> ***2. The patient's wife and SDM requested that the next hearing begin with a smudge ceremony. The panel looks to <u>the staff at the hospital tasked with the support of aboriginal patients</u> to make the arrangements for this to take place in the first fifteen minutes of the resumption of the hearing in a hearing room large enough to accommodate thirty people.***

Counsel for the patient objected to the ceremony by letter sent to the Board in advance of the resumption of the hearing on July 18, 2013. The request was withdrawn by counsel for the patient's wife and SDM. No ceremony took place in the hearing room.

THE EVIDENCE

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

- Dr. Scott Anderson;
- The patient's father, Mr. C.;
- The patient's sister, Ms. M.;
- **J**, the patient's wife and SDM;
- The patient's employee, Mr. S.; and
- Dr. Mark Tutschka, (senior resident, critical care), called by the doctor in rebuttal evidence.

The **Exhibits** consisted of:

Exhibit One. **Letter** ***dated July 12, 2013*** from counsel Ms. J. McCartney requesting an adjournment of the hearing scheduled for July 15, 2013 to July 17, 2013.

Exhibit Two. **Letter** ***dated July 10, 2013*** from counsel Ms. J. McCartney requesting an adjournment of the hearing scheduled for July 15, 2013 for a minimum period of two weeks.

Exhibit Three. **"CCTC Board Rounds"** ***dated July 2, 2013*** documenting a meeting of medical staff to review the care plan of [patient **G**] – four typed pages

Exhibit Four. Three pages of **hospital records** including a clinical progress record dated ***June 4, 2013***, a "family meeting record" dated ***June 27, 2013***, and a clinical progress note dated ***July 4, 2013***.

Exhibit Five. Print-out of **cell phone text message** provided by the patient's sister which was read into the record on the first day of the hearing by Presiding Member Wales from the **patient's cell phone message** ***dated 2013-05-21 1:18 pm*** (five pages)

INTRODUCTION

G and J were childhood sweethearts. They grew up together, endured the tragic death of their only child from a congenital heart defect, and expected to grow old together. Their twenty-six years living together came to an end on May 25, 2013, when G was admitted to the cardio unit of the hospital for shortness of breath. By May 28, he was transferred to the intensive care unit known as the Critical Care Trauma Centre "CCTC".

He had multiple organ system failure: cardiac, respiratory, neurologic, renal, hematologic and skin. Shortly after transfer to the CCTC, he lost the ability to communicate by speech or by writing. J believed that he responded to her by blinking and by squeezing her hand.

The hospital records filed as **Exhibit 4** confirm that as of **June 4, 2013**,

> *"we have tried to optimize right heart function and associated renal failure. He has multi-organ failure that will likely not resolve. His prognosis is guarded at best. . . the family would like to deliberate . . .*

> *Family meeting – initially with Dr. Kao and then with Dr. Sen to provide further confirmation to family that everything has been tried and that his heart can't recover. They're going to talk themselves about code status, but it's been explained that resuscitation attempt would not solve any of his problems. They understand he's unlikely to survive but are not considering WLS [withdrawal of life support?] at this time.*
>
> *Re: visiting – patient's wife [J] in agreement he would want his immediate family coming to see him, knowing now that he's unlikely to survive.*
>
> *Re: smudging – family know nothing can be lit or on fire in the unit. They plan to smudge outside, capture some of the smoke in a bag and bring it in to release by patient.*

By **July 2, 2013**, G's condition had deteriorated to the point that Dr. Anderson arranged for a special meeting of medical experts documented as the "**CCTC Board Rounds**" to canvass treatment options for G. At page 3 of **Exhibit Three**, the participants include the following information:

> ***Summary of Issues:***
>
> - ***Positive Issues:***
>   - *Some progress has been made addressing some issues:*
>   - *Sepsis appears controlled*
>   - *Marked ventilator asynchrony has improved and support requirement are modest but still significant*
>   - *Fluid removal has become possible*
>   - *There is intermittent evidence of awareness (but suggestive of hemiparesis)*
> - ***Negative Issues:***

> - *Renal failure is expected to be permanent: how will he receive outpatient dialysis?*
> - *Strong probability of left-sided stroke*
> - *He likely has a profound neuropathy, and with morbid obesity +/- stroke, this will severely impair any chance for meaningful rehabilitation*
> - *We have no successful strategy for mobilization, wound care and fecal management*
> - *If he does have problems that have not been diagnosed, we have no way to image and nothing to offer if we do identify a problem (e.g. if he has a urinary abscess, we cannot image him to make the diagnosis and he is not a candidate for surgery or intervention procedures)*
>
> *Overall, we concluded that he has prolonged multiple organ system failure (cardiac, respiratory, neurologic, renal, hematologic, skin) that is either not improving or progressing.*

And at page four:

> ***Action Planned / Responsibilities:***
>
> - *Confirm with surgery that diverting colostomy is not an option*
> - *In absence of any intervention that will reverse his deterioration, there is agreement by those present that withholding or withdrawing of life-support is the most appropriate treatment.*
> - *A family meeting will be held to advise [J] of plan. If required, conflict resolution processes and / or submission to Consent and Capacity Board will be considered*
> - *Ensure that [G's] capacity is documented*
> - *Ensure that the responsibility of a substitute decision-maker has been reviewed again with [J] and the discussion is documented in the clinical record.*
> - *Resume medications for pain and symptom management.*

J, G’s wife and substitute decision-maker refused to consent to the proposed treatment plan. Dr. Anderson’s opinion as G’s health practitioner who proposed the treatment was that J as G’s substitute decision maker had not complied with the principles for substitute decision making when she refused to consent to the treatment plan. Consequently Dr. Anderson brought the **Form G** application to the Board.

THE LAW

General

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

Incapacity with Respect to Treatment

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

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

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

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

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

> *"plan of" treatment means a plan that,*
>
> *(a) is developed by one or more health practitioners,*
>
> *(b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and*
>
> *(c) provides for the administration to the person of various treatment or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition; ("plan de traitement")*
>
> *"treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other*
>
> *health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan,*
>
> *but does not include,*
>
> *(a) the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the* <u>*Substitute Decisions Act, 1992*</u> *of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,*
>
> *(b) the assessment or examination of a person to determine the general nature of the person's condition,*
>
> *(c) the taking of a person's health history,*
>
> *(d) the communication of an assessment or diagnosis,*
>
> *(e) the admission of a person to a hospital or other facility,*
>
> *(f) a personal assistance service,*
>
> *(g) a treatment that in the circumstances poses little or no risk of harm to the person,*

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

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

> ***Wishes***
>
> *5. (1) A person may, while capable, express wishes with respect to treatment, admission to a care facility or a personal assistance service. 1996, c. 2, Sched. A, s. 5 (1).*
>
> ***Manner of expression***
>
> *(2) Wishes may be expressed in a power of attorney, in a form prescribed by the regulations, in any other written form, orally or in any other manner. 1996, c. 2, Sched. A, s. 5 (2).*
>
> ***Later wishes prevail***
>
> *(3) Later wishes expressed while capable prevail over earlier wishes. 1996, c. 2, Sched. A, s. 5 (3).*

ANALYSIS

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

The main application before the Board was the **Form G** brought pursuant to the *Health Care Consent Act*. Dr. Anderson applied for a determination as to whether or not J as her husband's substitute decision maker complied with the principles for substitute decision making as set out in the *Health Care Consent Act* with respect to the proposed treatment. Throughout our deliberations, we imposed the onus of proof upon Dr. Anderson. That onus was on a balance of probabilities.

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

The general law relating to capacity to consent to treatment is set out in the *Health Care Consent Act* (HCCA). That legislation also sets out a scheme for identifying substitute decision makers (SDM's) for incapable persons. It also described how SDM's should make decisions and the available options should SDM's not make proper decisions.

The purposes of the *HCCA* are set out at its very beginning. These include providing rules with respect to consenting to treatment, facilitating treatment for incapable persons, enhancing the autonomy of persons for whom treatment is proposed and promoting communication and understanding between health practitioners and their patients.

Furthermore, the *HCCA* in section 2 requires that a health practitioner must determine whether a person is capable to consent to treatment. The *HCCA* also provided that all health practitioners must be members of their respective professional colleges in Ontario. Physicians are included as health practitioners.

As noted earlier the test for capacity is set out in Section 4(1) of the *HCCA* as follows:

> *4. (1) Capacity – 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.*
> *(2) Presumption of capacity – a person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services.*
> *(3) Exception – a person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission or the personal assistance service, as the case may be.*

There is a presumption of treatment capacity on which a person is entitled to rely unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment.

By section 15(1) and (2) capacity can fluctuate and capacity also can vary over time and in relation to the type of treatment. The determination of capacity is therefore issue and time specific. The health practitioner must look at the specific treatment or plan and determine whether the person is capable for the particular treatment.

In the event that a person has been found incapable, a substitute decision maker may give consent to treatment on behalf of the incapable person. Section 16 of the *HCCA* provides that if the incapable person becomes capable, the person's own decision to give or refuse consent to treatment prevails.

Member Michael Newman set out a summary of the jurisprudence relating to this aspect of the analysis in the decision *DD (Re),* 2013 CanLII 18799 (ON CCB):

> *Starson v Swayze (2003) SCC 32 is the leading case in relation to the law on consent to treatment in Ontario. As referred to earlier, Section 4(1) of the HCCA provides a two part test to determine whether a person is capable with respect to a treatment.*
>
> *Justice Major wrote the majority opinion for the Supreme Court in the Starson decision. He commented upon the onus of proof required to displace the statutory presumption of capacity at paragraph 77: "I agree with the Court of Appeal that proof is the civil standard of a balance of probabilities."*
>
> *Chief Justice McLachlin, who wrote the dissent, agreed on this point. At paragraph 13, she wrote, "the person is presumed to be competent and the standard of proof for a finding of incapacity is a balance of probabilities."*
>
> *Justice Major analyzed capacity at paragraph 78 of the Starson decision as follows:*
>
>> *"Capacity involves two criteria. First, a person must be able to understand the information that is relevant to making a treatment decision. This requires the cognitive ability to process, retain and understand the relevant information. Second, a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one. This requires the patient to be able to apply the relevant information to his or her circumstances, and to be able to weigh the foreseeable risks and benefits of a decision or lack thereof.*

Before turning to an analysis of the reviewing judge's decision, two important points regarding this statutory test require comment. First, a patient need not agree with the diagnosis of the attending physician in order to be able to apply the relevant information to her own circumstances. Psychiatry is not an exact science, and "capable but dissident interpretations of information" are to be expected. While a patient need not agree with a particular diagnosis, if it is demonstrated that he has a mental "condition", the patient must be able to recognize the possibility that he is affected by that condition. Professor Weisstub comments on this requirement as follows (at p. 250, note 443):

Condition refers to the broader manifestations of the illness rather than the existence of a discrete diagnosable pathology. The word condition allows the requirement for understanding to focus on the objectively discernible manifestations of the illness rather than the interpretation that is made of these manifestations.

As a result, a patient is not required to describe his mental condition as an "illness", or to otherwise characterize the condition in negative terms. Nor is a patient required to agree with the attending physician's opinion regarding the cause of that condition. Nonetheless, if the patient's condition results in him being unable to recognize that he is affected by its manifestations, he will be unable to apply the relevant information to his circumstances, and unable to appreciate the consequences of his decision.

Secondly, the Act requires a patient to have the ability to appreciate the consequences of a decision. It does not require actual appreciation of those consequences. The distinction is subtle but important… In practice, the determination of capacity should begin with an inquiry into the patient's actual appreciation of the parameters of the decision being made: the nature and purpose of the proposed treatment; the foreseeable benefits and risks of treatment; the alternative courses of action available; and the expected consequences of not having the treatment. If the patient shows an appreciation of these parameters-regardless of whether he weighs or values the information differently that the attending physician and disagrees with the treatment recommendation – he has the ability to appreciate the decision he makes.

However, a patient's failure to demonstrate actual appreciation does not inexorably lead to a conclusion of incapacity. The patient's lack of appreciation may derive from causes that do not undermine his ability to appreciate consequences. For instance, a lack of appreciation may reflect the attending physician's failure to adequately inform the patient of the decision's consequences. Accordingly, it is imperative that the Board inquire into the reasons for the patient's failure to appreciate consequences. A finding of incapacity is justified only if those reasons demonstrate that the patient's mental disorder prevents him from having the ability to appreciate the foreseeable consequences of the decision."

As Justice Day stated in Neto v Klukach [2004] O.J. No. 394 at paragraphs 10-13:

> *"Chief Justice McLaughlin, in her dissenting judgment (but not dissenting on this point) quoted with approval three common indicators of a person's ability to meet the second branch of the test, set out by commentators such as B.F. Hoffman in The Law of Consent to Treatment in Ontario (2nd ed. 1997), at p. 18. One indicator is whether the person is able to acknowledge the fact that the condition for which treatment is recommended may affect him or her. A second indicator is whether the person is able to assess how the proposed treatment and alternatives, including no treatment could affect his or her quality of life. A third indicator is whether the person's choice is substantially based on a delusional belief.*
>
> *In determining capacity, the court in Starson cautioned that capable individuals have the right to take risks and are presumed free to make decisions that are considered unreasonable. The test is not whether the choice by the patient appears reasonable or wise, but whether the patient is capable, within the meaning of the statute, of making the decision. The Board is not to inject its own personal values, judgments, and priorities into the process. As Justice Harris stated in Bartoszek v Ontario (Consent and Capacity Board), [2002] O.J. No. 3800 (S.C.J.) at para 20, "It is mental capacity, not wisdom, that is at issue here. The appellant, Mrs. Bartoszek carries with her, like all citizens, the right to be wrong".*
>
> *In addition, the court in Starson held that the Board must avoid the error of equating the presence of a mental disorder with incapacity. People who have mental disorders are perhaps most at risk of having their personal autonomy overridden by the likely unconscious imposition of value judgments. It is easy to conclude that if a person chooses a course of treatment, which appears to be reasonable and wise, then the person is capable; whereas, if a person chooses treatment that doctors consider to be contrary to the best interests of the patient, or even patently unwise, then the person is incapable. Those with mental illness are perhaps most vulnerable to having their experiences with reactions to medications and personal views regarding treatment options not taken seriously, but instead attributed to the mental illness itself, if contrary to what is considered conventional wisdom.*
>
> *Adjudicators however must take pains to avoid such conclusions. The reasonableness of the patient's wishes, or the patient's best interest, should not be the basis of a judicial finding, as this would treat persons with mental illnesses as person with lesser states. The Court of Appeal in Fleming v Reid 1991 CanLII 2728 (ON CA), (1991), 82 D.L.R. (4th) 298 at 311 stated that:*
>
> > *"Mentally ill persons are not to be stigmatized because of the nature of their illness or disability; nor should they be treated as persons of lesser*

> *status or dignity. Their right to personal autonomy and self-determination is no less significant, and is entitled to no less protection, than that of competent persons suffering from physical ailments."*

Indeed, the court in Fleming held at 312 that:

> *"The common law right to bodily integrity and person autonomy is so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order of protection. This right forms an essential part of an individual's security of the person and must be included in the liberty interests protected by s. 7 [of the Charter]".*

G's Capacity to Consent to Proposed Treatment

Did the evidence establish that G was unable to understand the information relevant to making a decision about the treatment in question?

Dr. Anderson testified G was incapable with respect to treatment including the proposed treatment.

The doctor believed that his patient's inability to set up any form of communication with staff evidenced that G did not have the cognitive ability to understand or process information presented to him that was relevant to his treatment or the consequences of any treatment decisions. In the doctor's opinion G failed both parts of the two part test for treatment capacity. Counsel for the patient did not contest that her client was incapable with respect to the proposed treatment.

We had to remember that there was a presumption G was capable, unless Dr. Anderson had reasonable grounds to believe that G was incapable (section 4(3) *HCCA*). Dr. Anderson had the onus of satisfying the Board on a balance of probabilities that G was incapable.

In terms of the first branch of the test for capacity the Supreme Court of Canada in *Starson* (paragraph 78) says that the ability to understand relevant information required that G had the cognitive ability to process, retain and understand the relevant information. We found there was no evidence G had such cognitive ability. Furthermore, the medical evidence, which we found was challenged or contradicted only by J's report of blinking and hand squeezing, in regards to the issue of G's capacity was clear, cogent and compelling, that G's abilities to understand and appreciate were affected by his multiple organ system failure.

We found G was unable both to communicate and understand that his current medical condition totally impaired his ability to understand information relevant to treatment decisions, in particular the treatment proposed by Dr. Anderson. We found G was not able to understand information that is relevant to making a decision about the treatment proposed by Dr. Anderson. On the basis of this first part of the test, G was not capable with respect to the treatment proposed.

Did the evidence establish that G was unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision about the treatment in question?

In Dr. Anderson's opinion G failed this part of the test for the same reasons he failed the first part of the test for capacity. Dr. Anderson said G's incapacity was a consequence of the effect of his multiple organ system failure. Dr. Anderson said there was no reasonable prospect for G to recover.

Neto v. Klukach, [2004] O.J. No. 394, was a decision of Day, J. of the Ontario Superior Court of Justice dated February 10, 2004. In that decision, which was an appeal of a decision of this Board, the Court explained the second branch of the test for capacity (i.e. the ability to appreciate consequences) in light of *Starson*, as follows:

> *The second branch assesses the ability to evaluate, not just understand, information. The patient must have an ability to appreciate the relevant information as it relates to him or her.*

The evidence we received supported the medical assessments including the opinion of Dr. Anderson that G was incapable with respect to the proposed treatment. G was unable to communicate and therefore lacked the ability to appreciate he was in fact suffering from manifestations of and the devastating consequences of his multiple organ system failure. He was unable to evaluate information concerning the proposed treatment as it related to his own circumstances, a fact which rendered his incapable to make a decision concern his treatment.

The evidence to support a finding of incapacity was clear, cogent and compelling. G had no comprehension about his need for treatment because he was unable to communicate, process, concentrate, focus or evaluate information. G's lack of insight into his condition rendered him unable to appreciate the information relevant to making a decision and appreciate the consequences of a decision or lack of decision. As a result of his inability to recognize he suffered from multiple organ system failure, G also lacked the ability to appreciate the reasonably foreseeable consequences of a treatment decision.

Form G Application to Determine Compliance

The legal consequence of G being incapable of making his own treatment decision in relation to the proposed treatment meant that consent may be given or refused on his behalf by a person described in section 20 of the *Health Care Consent Act*.

As noted earlier in a case where substitute decision-maker (SDM) consents to treatment on an incapable person's behalf and the health practitioner is of the opinion that the SDM did not comply with section 21 of the *HCCA*, the health practitioner may apply to the Board. This was the Form G application before the Board in this case.

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

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

(c) the following factors:

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

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

Parties

(2) The parties to the application are:

1. *The health practitioner who proposed the treatment.*
2. *The incapable person.*
3. *The substitute decision-maker.*
4. *Any other person whom the Board specifies. 1996, c. 2, Sched. A, s. 37 (2).*

Power of Board

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

Directions

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

Time for compliance

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

Deemed not authorized

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

Subsequent substitute decision-maker

(6.1) If, under subsection (6), the substitute decision-maker is deemed not to meet the requirements of subsection 20 (2), any subsequent substitute decision-maker shall, subject to

> *subsections (6.2) and (6.3), comply with the directions given by the Board on the application within the time specified by the Board. 2000, c. 9, s. 35.*
>
> ***Application for directions***
> *(6.2) If a subsequent substitute decision-maker knows of a wish expressed by the incapable person with respect to the treatment, the substitute decision-maker may, with leave of the Board, apply to the Board for directions under section 35. 2000, c. 9, s. 35.*
>
> ***Inconsistent directions***
> *(6.3) Directions given by the Board under section 35 on a subsequent substitute decision-maker's application brought with leave under subsection (6.2) prevail over inconsistent directions given under subsection (4) to the extent of the inconsistency. 2000, c. 9, s. 35.*
>
> ***P.G.T.***
> *(7) If the substitute decision-maker who is given directions is the Public Guardian and Trustee, he or she is required to comply with the directions, and subsection (6) does not apply to him or her. 1996, c. 2, Sched. A, s. 37 (7).*
>
> ***Deemed application concerning capacity***
> ***37.1** An application to the Board under section 33, 34, 35, 36 or 37 shall be deemed to include an application to the Board under section 32 with respect to the person's capacity to consent to treatment proposed by a health practitioner unless the person's capacity to consent to such treatment has been determined by the Board within the previous six months. 2000, c. 9, s. 36.*
>
> *In determining whether the SDM complied with s.21, the Board may substitute its opinion for that of the substitute decision-maker. If the Board determines that the SDM did not comply with s.21, it may give him or her directions, applying s.21 (s.37(4)). The Board is required to specify the time within which the direction must be complied with. If the SDM does not comply with the Board's directions within the time specified by the Board(s), he shall be deemed not to meet the requirements of ss.20 (2) (s.37 (6)). If under ss.(6), the SDM is deemed not to meet the requirements of ss.20(2), any subsequent SDM shall, subject to ss.(6.2) and (6.3), comply with the directions given by the Board on the application within the time specified by the Board (s.37(6.1)).*

Member Michael Newman set out a summary of the jurisprudence relating to this aspect of the analysis in the decision *DD (Re),* 2013 CanLII 18799 (ON CCB):

> *Conway v Jacques 2002 CanLII 41558 (ON CA), 2002 CanLII 41558 (ON C.A.), (2002), 59 O.R. (3d) 737, was an appeal from the Consent and Capacity Board in which the Court of Appeal discussed the principles for substitute consent to treatment. The case addressed psychiatric medication rather than end of life decision-making. Justice Sharpe's analysis is on point and binding:*
>
>> *"[30] Ontario's Health Care Consent Act, 1996 is the legislature's response to the successful Charter challenge in Fleming. The Act requires close attention to the patient's wishes by those who make treatment decisions on the patient's behalf. The wishes of the patient are to be considered by the substitute decision-*

maker at two stages under the Act: 1) in acting in accordance with a prior capable wish applicable to the circumstances pursuant to s. 2 *1 (1) 1; and 2) in determining the incapable person's best interests pursuant to* s. 2 *1 (2) where there is no prior capable wish applicable to the circumstances.*

[31] At the first stage, the substitute decision-maker must act in accordance with a wish expressed while capable that is applicable to the circumstances. However, I agree with the appeal judge that prior capable wishes are not to be applied mechanically or literally without regard to relevant changes in circumstances. Even wishes expressed in categorical or absolute terms must be interpreted in light of the circumstances prevailing at the time the wish was expressed. As Robins J.A. held in Fleming at p. 94:

> *In my view, no objection can be taken to procedural requirements designed to determine more accurately the intended effect or scope of an incompetent patient's prior competent wishes or instructions. As the Act now stands, the substitute consent-giver's decision must be governed by wishes which may range from an isolated or casual statement of refusal to reliable and informed instructions based on the patient's knowledge of the effect of the drug on him or her. Furthermore, there may be questions as to the clarity or currency of the wishes, their applicability to the patient's present circumstances, and whether they have been revoked or revised by subsequent wishes or a subsequently accepted treatment program.*

[32] At the second stage, the substitute decision-maker must decide whether or not to consent to treatment on the basis of the best interests test under s. 21 (2). Under s. 21 (2) (b), the substitute decision-maker must take into account "any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under s. 21 (l) 1 ", namely any wishes that are not prior capable wishes applicable to the circumstances. It is only at the second stage that the Act allows for consideration of the decision the patient would have made in light of changed circumstances.

[33] The appeal judge held that the Board failed to consider whether Paul Conway would have consented to the anti-psychotic medication suggested by Dr. Jacques if he had been capable of giving or refusing consent. In my respectful opinion, that is not the test mandated by the Act for determining whether a prior capable wish is applicable to the circumstances. To require the substitute decision-maker or the Board to consider what the incapable person would have decided in light of changed circumstances would replace the two-stage test mandated by the Act with a different test that is not supportable under the language of the Act. Paul Conway's prior capable wish was either applicable to the circumstances or not applicable to the circumstances. ***If a prior capable wish is not applicable to the circumstances, the question for the substitute decision-maker is not what the patient would have decided in light of the change, but rather what is in the best interests of the patient.*** *I would therefore reject the*

> *analysis of the appeal judge and his conclusion that the Board erred in law and failed to make a crucial factual finding". (***emphasis added***)*

M., A. v. Benes, 1999 CanLlI 3807 (ON C.A.), (1999), 46 O.R. (3d) 271 was another Court of Appeal decision on appeal from the Consent and Capacity Board. The case involved psychiatric treatment but also contains general principles applicable to any review by the Board of treatment decisions made by substitute decision-makers.

> *"[42] An S.D.M. does not stand in the shoes of an incapable person at least on questions of consent to treatment. The S.D.M. is important but only as part of a statutory regime which, by its terms, tries to respect an incapable person's well-being and dignity where that person's consent or refusal to treatment cannot be established.*
>
> *[45] Values, beliefs and non-binding wishes are not the only elements of the best interests test. The likely effect of the proposed treatment is a key element as well. The S.D.M. is not likely to have special knowledge about the possible effects of medical treatment and thus, as a general rule, must rely on the expertise of the treating health practitioner.*
>
> *[46] A case will come before the Board only when the health practitioner disagrees with the S.D.M.'s application of the best interests test under s.21 (2). The Board will then have before it two parties who disagree about the application of s.21: the S.D.M., who may have better knowledge than the health practitioner about the incapable person's values, beliefs and non-binding wishes; and the health practitioner, who is the expert on the likely medical outcomes of the proposed treatment. The disagreement between the S.D.M. and the health practitioner potentially creates tension and the Act recognizes this by providing for a neutral expert board to resolve the disagreement. Indeed, after hearing submissions from all parties, the Board is likely better placed than either the S.D.M. or the health practitioner to decide what is in the incapable person's best interests. Thus, the Board should not be required to accord any deference to the S.D.M.'s decision."*

In the Benes decision the Court of Appeal held that the Board did not have to defer to a decision of an SDM just because it was made in "good faith and was reasonable." The Board had the right to review a decision by the SDM in the absence of prior expressed wishes by the incapable person. The SDM refused treatment against the recommendation of the incapable person's physician and the physician then applied pursuant to s.37 for a review of the decision. The Board found that the SDM had not complied with s.21 of the HCCA and ordered that she consent to the recommended treatment. The SDM appealed arguing that s.37 was unconstitutional because it violated the incapable person's rights under s.7 of the Charter. For other reasons, the court held that the section was unconstitutional. The finding was appealed to the Court of Appeal by the Attorney General of Ontario. The SDM argued that as long as the SDM's decision was made in good faith and was reasonable, the CCB should defer to that decision. However, the

> *Court of Appeal disagreed with this argument stating that the standard of "good faith and reasonableness" did not adequately protect the* Charter *interests of the incapable person.*
>
> *The court made this decision based on the following reasons: the SDM is not always chosen by the incapable person (sometimes authority is conferred by statute) so the SDM might not always know the incapable person's beliefs, values, and non-binding wishes any better than the Board; the "best interests" test involves more than looking at the values, beliefs, and non-binding wishes of the incapable person (the effects of proposed treatment must be considered and this may be best dealt with by a medical expert – the job of the CCB is to resolve tension between the SDM and the medical expert); the HCCA does not require an SDM to follow particular procedural guidelines in making a decision under s.21 but the Board must follow procedural guidelines. The CCB was able to substitute its decision to authorize treatment for the SDM's decision to refuse treatment, even though the SDM was acting in good faith.*

Here, the Board found that J was a person who gives or refuses consent on behalf of G, an incapable person. J was obliged to follow the principles set out in section 21 of the *Health Care Consent Act*.

Did J apply G's known previously expressed wishes applicable to G's circumstances about his treatment?

Why did J not consent to the proposed treatment for her husband? She relied on the conversation with her husband shortly before he was transferred from the cardiac unit to the intensive care unit. He urged her to "fight for him" after he was transferred to the new unit, "to grow a backbone".

Such directions are consistent with discussions she had with him around the time of the death of their daughter some ten years before, that they would "fight for each other" if sick in hospital. This was also in accord with the evidence of Mr. S., G's employee, who related a discussion with G predicated on a mutual friend's circumstances, about his desire for J "to fight for him" if he were in a life-threatening situation in hospital.

J reported that the doctors had underestimated the time their daughter would survive with her heart defect. In a similar fashion, she expressed the view that the doctors could be wrong about her husband's condition, just as they were wrong about her daughter. J continued to hope in the possibility that her husband would recover from his illnesses and return home.

J at times denied even the possibility that her husband was suffering in his current state. The doctor testified that he had ulcers over his body, some of which measured twelve inches by twelve inches, and which were infected. These ulcers were shown to the panel on the visit to G's room, as was his fecal incontinence which produced a steady stream of infection preventing the repair of his skin. His blood stream was also infected. He was completely dependent on the ventilator to breathe and on dialysis for kidney function. His skin was decomposing.

Surgery was ruled out because the surgeon would have to negotiate through two feet of fat to reach the organs. The only equipment large enough to produce images of his body were at the University of Guelph school of veterinary science. He was not transported there because of the other factors ruling out surgery.

The doctor testified that G had suffered three cardiac events in the last month which would have caused heart attacks but for the close supervision of medical staff who administered drugs to counteract the cardiac event. The doctor noted that because of G's approximately 700 pound weight, it was hard to accurately calculate appropriate doses of medication.

During the hearing, J confirmed that she had not been aware of the severity of her husband's symptoms. For example, she declared that she had not been aware of the ulcers, or that they were infected, or G's absolute dependence on machines to live. The doctor testified that J had been informed on numerous occasions over a period of weeks about the severity of her husband's multiple organ system failures. This was documented in the hospital records entered as **Exhibit Four**.

The panel accepts the doctor's evidence, but also understands that the hearing may have been the first time that J truly took in the information which had been presented to her at multiple meetings with hospital staff. Her desire to honour her husband's wishes, to "fight for him" rendered her incapable to accept information at odds with her fervent belief that he would live.

We found that her previous experience with her daughter gave her the confidence to reject the opinions of the medical experts. They had been wrong once before, so why not now?

By the time J attended the hearing, she spoke in terms of her husband choosing to die, if it was his time as designated by the Creator, while on life support machines. Once again, she relied on her prior experience, this time of her mother who passed away in hospital while on oxygen. J seemed unwilling or unable to take in the reality that her mother's circumstances varied dramatically from that of her husband.

Neither J's daughter or mother had multiple organ system failure and were alive solely due to mechanical support. Therefore, any wish which G expressed in either context did not apply in his current circumstances.

As Justice Sharpe said at paragraph 31 in *Conway* v. *Jacques,* cited above:

> *However, I agree with the appeal judge that prior capable wishes are not to be applied mechanically or literally without regard to relevant changes in circumstances. Even wishes expressed in categorical or absolute terms must be interpreted in light of the circumstances prevailing at the time the wish was expressed.*

The comments attributable to G were not precise and lacked particularity. In light of Justice Sharpe's comments in paragraph 31 of the *Conway* decision the Board found that there were no prior capable wishes applicable to G's current circumstances. There were no clear, precise, statements attributable to G of his having considering the possibility of the multiple organ system failure he suffered and the reliance on mechanical support to live.

We found no evidence G had his current circumstances in mind when he made any comments. Holding that any of his statements were applicable to his devastating current circumstances would be too mechanical or literal application of his words with complete disregard for changes in his circumstances.

We therefore found that J did not know of a wish applicable to the circumstances that G expressed while capable and after attaining sixteen years of age. J was obliged to act in G's best interests as defined in section 21 (2) of the *Health Care Consent Act*. That meant that in deciding what G's best interests are, G as the person who gives or refuses consent on his behalf shall take into consideration the factors set out in S. 21(2).

Best Interests

The absence of previously expressed capable wishes applicable to G's circumstances as at the hearing meant we had to determine consent based upon G's best interests, in light of Justice Sharpe's observations in this regard at paragraph 33 in *Conway v Jacques*.

Did J consider G's values and beliefs that she knew he held when capable and believed he would still act upon if capable (s21(2) (a)) and G's wishes that he had expressed about treatment that were not prior capable wishes (S21(2) (b)?

J expressed the desire to have a particular spiritual healer visit her husband. The doctor testified, and the panel accepts that the documentary evidence in **Exhibit Four** confirms that multiple attempts were made over several weeks by staff to facilitate the visit. From J's testimony on July 18, the panel concluded that it would be possible for J to complete these arrangements for her husband by the time given for compliance with the Board's directive by noon, Tuesday July 23, 2013.

Again, the panel finds that J's seeming reluctance to make these arrangements in a timely fashion relates to her shock and emotional paralysis caused by the rapid downward spiral of her husband's medical condition after admission, and her hope beyond any reasonable evidence-based expectation that he would recover and return home.

J's counsel argued that not to allow for this visit from the spiritual healer would be a violation of religious rights under section 15 of the *Canadian Charter of Rights and Freedoms* which states:

> *15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular,*

without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

The panel accommodated J's wish when setting the time for compliance, while balancing it against the doctor's evidence that delay would only increase the patient's suffering. The panel took into account that J testified that her husband took pain medication from time to time, and interpreted that as an indication of G's values and beliefs. In other words, he took medication to alleviate pain as the situation arose.

The Board found that on a balance of probabilities that G's values and beliefs were such that he would not have wanted to linger in the event of multiple organ system failure and that from the perspective of dignity he would have preferred to die in his sleep, and not be maintained by mechanical or other interventions such as the ventilator in his current condition.

Did J consider whether the proposed treatment plan was likely to improve G's condition or well-being, prevent it from deteriorating or reduce the rate of which it was likely to deteriorate (s21(2) c (1) (i-iii))? And did J consider whether G's condition was likely to improve, remain the same or deteriorate without the treatment; whether the benefit outweighed the risk of harm; and whether a less restrictive or less intrusive treatment would be as beneficial (s.21(2) (2-4))?

Dr. Anderson's oral and documentary evidence was clear that none of the specialists were of the view that G would recover. Dr. Anderson set the chance of recovery at less than 0.001%. Only five per cent of patients in intensive care units remain for more than 14 days. As of July 18, G had been a patient in the ICU for over 50 days.

G was completely dependent on mechanical support to breathe, and for dialysis. He had ulcers on 15% of his skin. It took up to ten people to turn him in the bed to prevent bedsores and to facilitate the use of the ventilator and the dialysis machine.

J had a different perspective. She believed her husband to be a fighter, and capable of recovering. Her evidence was in terms of her hope of what might happen if G had treatment by a spiritual healer. The medical evidence, which the panel found to be clear, cogent and compelling, indicated that more than enough time had passed to conclude that G would not improve.

In Dr. Anderson's opinion, the benefits G would expect to obtain from the proposed treatment outweighed the risk of harm to him. Dr. Anderson testified that staff considered the current course of treatment to be a form of torture for G. The doctor assured the panel that his patient was suffering while on the life support machines. He recommended the proposed course of treatment as a way to allow his patient to lessen his pain and to die in dignity.

Dr. Anderson testified that G would likely pass away within a short time of removal of the life support machines. His death would alleviate G's pain and suffering and improve G's well-being in the doctor's opinion. The proposed treatment included pain medication to balance any pain, suffering, and discomfort.

Member Michael Newman dealt with similar issues in the decision *DD (Re)*, 2013 CanLII 18799 (ON CCB):

> *Nothing in the evidence suggested that, in the circumstances here, DD would want to be subject to unnecessary medical interventions. In Scardone v. Hawryluck (2004), CanLII 34326 (ON S.C.), the court held that "best interests" should be interpreted broadly to include issues of dignity and quality of life. All of the evidence made plain to the Board that DD had a very poor quality of life and his situation would not improve. DD was subjected to daily indignities through invasive medical procedures that were required to keep him alive without increasing the likelihood that he would recover any awareness or consciousness.*
>
> *While PD said she considered the proposed treatment plan in light of these factors, she was influenced by her own needs and desires, her religious beliefs and hope, and was unable to interpret the legislation without emotional attachment to her husband. The legislation requires that a panel of the Board substitute its own judgement for that of a substitute decision-maker if, after hearing all of the evidence from all parties, the panel determines that the decision is not the correct one with respect to DD's best interests. (Scardoni, supra; M(A) v. Benes 1999 CanLII 3807 (ON CA), (1999), 46 O.R. (3d) 271 (C.A.)).*

The question for the Board, was whether it was in DD's best interests to be kept alive by the current treatment plan of prolonging or extending his life with on-going interventions, and the likely risk of infections and pain, without hope of recovery according to the clear medical evidence? In other words in determining the S.21(2) (c) considerations including DD's well-being in this case we had to consider the invasiveness of the interventions required to extend DD's life, and that these would not, according to the medical evidence improve DD's current condition, resulting from his massive stroke.

As the Court of Appeal set out (paragraph 45) in Benes values, beliefs and non-binding wishes are not the only elements of the best interests test. The likely effect of the proposed treatment is a key element as well.

What impact would withdrawal of ventilator support as set out in the current plan, have upon DD's "condition or well-being?" That term is used in paragraph 21(2) (c) 2 of the Act, "Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment".

Scardoni v. Hawryluck, 2004 CanLII 34326 (ON SC), 2004 CanLII 34326 (ON S.C.), (2004), 69 O.R. (3d) 700 was another appeal from the Consent and Capacity Board. Justice Cullity made these observations about the Board's interpretation of the phrase, "well-being".

> *"[45] A question of statutory interpretation that was more directly in issue in the appeal concerned the meaning of the word "well-being" in section 21 (2) (c) of the Act. The interpretation accepted by the Board was central to its finding that further treatment in the intensive care unit was not in Mrs. Holland's best interests. At page 20 of its Reasons for Decision, the Board stated:*
>
> > *"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".*
>
> *[46] This interpretation was challenged by Ms Chan who submitted that matters that are to be considered relevant to the well-being of a patient were intended to be confined to those relating to her health. In her submission, the Board erred in law in taking into consideration evidence with respect to Mrs. Holland's quality of life and, particularly, that of the discomfort and indignity she had experienced in undergoing treatment in the intensive care unit and would experience again if she was returned there.*
>
> *[47] The phrase "quality of life" is used in other sections of the Act in connection with decisions with respect to an incapable person's best interests. It does not*

> *appear in the section relating to consent to treatment. Whether or not the considerations on which the Board relied are aptly encapsulated by the phrase, I am satisfied that the Board's interpretation of the reference to the "well-being" of a patient is to be preferred to the more narrow definition that Ms Chan urged me to accept.*
>
> *[48] The interpretation accepted by the Board is supported by dictionary definitions of wellbeing that refer to a person's state of happiness, contentment and prosperity as well as good health: see for example, the New Oxford Shorter Dictionary; Random House Unabridged Dictionary; and Nelson's Canadian Dictionary of the English language. Generally, the dictionaries treat the term as synonymous with "welfare". Similarly, in IR.C. v. BaGeley, [1955] A.C. 572 (H.L.), at page 616, Lord Somervell of Harrow referred to a person's "wellbeing" as meaning "a happy or contented state".*
>
> *[49] Finally, in Janzen v. Janzen (2002), 44 E T. R. 217 (SC.J.) in which the interpretation of section 21 (2) of the Act was considered in the context of competing applications for appointment as an incapable person's guardian of the person, Aitken J 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 as pneumonia or kidney or heart failure; but according to the medical evidence it would not improve Mr. Jansen's (sic) 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."*
>
> *[50] I accept that interpretation and find no error of law in the Board's conclusion on the meaning of "well-being" in the Act."*

Justice Cullity approved of that approach, though he reversed the Board's decision on other grounds. In the case before us we found "condition" refers to a person's overall health which can involve many factors. We also found that "well-being" has a broad meaning to an incapable person's overall situation and quality of life.

In our view DD's well-being included consideration of his dignity and quality in life. The ongoing current plan was more detrimental than beneficial in terms of well-being. Put another way the treatment provisions of the current plan were not in DD's best interests. PD based much part of her objection to the proposed treatment on hope. We questioned the efficacy of treatment decisions by a substitute decision maker for others

> *based on hope, and not experienced medical opinions, when the legal requirement is best interests.*
>
> *We found that the evidence supported a finding that DD will remain non-communicative, with severe brain damage and completely dependent for his care needs. Furthermore, we agreed with the clear, cogent, and compelling medical evidence that the proposed palliative treatment plan was in DD's best interests, including being consistent with DD's values and beliefs.*
>
> *We knew from the medical evidence about the impact of withdrawing ventilator support upon G's condition was that he would likely die within days. Did well-being to DD's life simply mean quantity of life and not quality of life? Everyone eventually dies. So the risk was not whether DD died, but when and how he died and what transpired in the interim. These are some of the factors that must be considered in determining well-being.*
>
> *The withdrawal of ventilator support and provision of palliative care was less intrusive than the ventilator and other supports and the likely infections. These were important factors to consider. To the extent that "well-being" included considerations of DD's dignity and potential for improvement in the quality of his life, we believed the withdrawal of ventilator support was more beneficial. The Board found therefore, that PD has not complied with s. 21 of the Health Care Consent Act as she did not support the recommended treatment plan.*

The panel believed on a balance of probabilities that our decision was supported by the clear, cogent and compelling evidence. In addition, we were of the view that G's best interests would be served by following the treatment plan proposed by Dr. Anderson.

J was clearly motivated by her deep love and devotion to her husband and was acting in good faith. However, her inability to move beyond her husband's instructions "to fight for him", and her focus on the unfortunate experiences of her daughter and mother, left her unable to evaluate what was in G's best interests and to act to improve his overall well-being.

As Justice Aitken in Janzen, cited in the *Scardoni* decision above said:

> *Treatment in the form of a ventilator, medications and periodic heroic interventions as required might improve other medical conditions suffered by Mr. Janzen, such as pneumonia or kidney or heart failure; but according to the medical evidence it would not improve Mr. Jansen's (sic) 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.*

Dr. Anderson’s proposed treatment for G consisted of:

> ***changing the course of treatment to ensure comfort at whatever cost, while reducing and eliminating mechanical support, while acknowledging that the patient will pass away in the process.***

We find that this proposed course of treatment considered G’s well-being. We also found that withdrawal of the ventilator support and comfort care would be the best way to respect the factors set out in paragraph 21(2)(c) of the *HCCA* which define best interests. We found that G’s well-being and dignity were respected with the proposed plan.

RESULT

We confirmed Dr. Anderson's finding that G was incapable of giving or refusing consent to the proposed treatment which consisted of:

> ***changing the course of treatment to ensure comfort at whatever cost, while reducing and eliminating mechanical support, while acknowledging that the patient will pass away in the process.***

We also determined that J the substitute decision maker has not complied with the principles for substitute decision making set out in the *Health Care Consent Act*. The Board directed J to consent to the proposed treatment plan **by noon on Tuesday, July 23, 2013.**

Dated: July 21, 2013

Shirley R. Wales
Presiding Lawyer Member