Consent and
Capacity Board

Commission du consentement
et de la capacité

Ontario

2013 CanLII 66972 (ON CCB)

TO-13-0763
TO-13-0764

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

AND IN THE MATTER OF
JN
A PATIENT OF
UNIVERSITY HEALTH NETWORK – TORONTO WESTERN HOSPITAL
TORONTO, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

A panel of the Board convened at University Health Network – Toronto Western Hospital ("Toronto Western Hospital") at the request of Dr. Jeffrey Singh, health practitioner. Dr. Singh had brought a Form G Application to the Board under section 37(1) of the *Health Care Consent Act* ("*HCCA*" or the "*Act*") for a determination as to whether or not the substitute decision-maker for JN had complied with section 21 of the *HCCA*, the principles for substitute decision-making, when making a decision about proposed treatment for JN.

An Application to the Board under section 37 of the *HCCA* is deemed, pursuant to section 37.1 of the *Act* to include an application to the Board under section 32 of the *HCCA* by JN with respect to his capacity to consent to the proposed treatment unless the person's capacity to consent to such treatment has been determined by the Board within the previous six months. As no such prior finding had been made, the Board also considered JN's deemed application.

DATES OF THE HEARING, DECISIONS AND REASONS

The hearing commenced on May 23, 2013 and continued on May 28th, June 7th, June 24th, July 26th, August 22nd and August 23rd. On August 24th, the panel released its Decisions. We held that JN was not capable of consenting to the proposed treatment: removal of mechanical ventilation. We also held that MN, the substitute decision-maker, had not complied with the principles of substitute decision making as required by section 21 of the *Health Care Consent Act*. We directed MN to consent to the removal of mechanical ventilation by August 30th at 12p.m.

Reasons for these Decisions, contained in this document, were requested by counsel for Dr. Singh on August 28, 2013. These Reasons were released on September 4th.

LEGISLATION CONSIDERED

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

PANEL MEMBERS

Ms Lora Patton, lawyer member
Ms Ileen Howell, public member
Ms Shirley Ann Dunn, public member

PARTIES & APPEARANCES

Deemed Form A Application

JN, the patient, was represented by Mr. D. Hiltz.
Dr. Singh, the health practitioner, was represented by Ms E. Baron and Ms S. Lake.

Form G Application

JN, the patient, was represented by Mr. D. Hiltz.

MN, JN's substitute decision-maker, was self-represented.

Dr. Singh, the health practitioner, was represented by Ms E. Baron and Ms S. Lake.

PRELIMINARY MATTERS

Adjournments:

This matter was initially scheduled to proceed on May 23, 2013. On that date, the panel adjourned the hearing to ensure that the substitute decision-makers could participate. On May 28th, the hearing resumed but was adjourned at the request of MN, the son of JN, to allow him time to retain counsel. The hearing resumed and evidence was given but not completed on June 7th. On June 24th, the hearing resumed but MN had advised Dr. Singh that he was out of the country due to the illness of his brother; the hearing was adjourned to July 26th. Prior to July 26th, Dr. Singh advised that he was to be out of the country on the return date; the hearing was therefore adjourned, by teleconference to August 23rd. On August 22nd, MN was ill and the hearing was adjourned. On August 23rd, evidence resumed and the hearing concluded.

On August 23rd at close of Dr. Singh's case, MN requested a further adjournment. He stated that he needed time to retain a lawyer. He said that it had been his hope that Dr. Singh would change his mind in the course of the hearing and agree to perform a tracheostomy despite its being refused for several months. He said that it had become clear to him only that day that Dr. Singh's position would not change. Further, MN said that during the hearing's attendance in JN's room, MN had witnessed a change in his father which indicated an improvement in his condition. MN said that JN had appeared to show distress and seemed to cry when the hearing participants were in his room and MN believed that this was a sign of improvement. For both of these reasons, MN said that he felt it necessary to retain a lawyer.

Mr. Hiltz took no position on the adjournment request. Ms Baron was opposed. Ms Baron submitted that the panel had already heard the medical evidence that established that there had been no change in JN's medical condition for several months and none on the day of the hearing. Further, she stated that MN was aware of the purpose and the potential outcome from the hearing from the start and his goal of obtaining a tracheostomy for his father was further evidence that

MN was not making decisions in JN's best interests. She also stated that MN had sufficient time to retain counsel if he wished. Ms Baron submitted that hearings before the Board were to occur quickly and multiple delays had already occurred and a further adjournment was not warranted.

The panel considered MN's request and denied the adjournment. The panel noted that the hearing had commenced on May 23rd, three months before, and MN had sufficient time to retain counsel. Further, MN had been granted an adjournment on May 28th specifically for the purpose of retaining counsel and he chose not to do so at that time or during the lengthy adjournments that had occurred since. The panel also accepted the medical evidence that there was no change in JN's medical condition on the day of the hearing. As is discussed below, we found that MN was unable or unwilling to accept JN's medical status and prognosis and, understandably, he continued to see improvement though none existed. For these reasons, the adjournment request was denied and the hearing proceeded to its conclusion.

Identification of Parties:

At the outset of this matter, three joint substitute decision-makers had been identified: MN, IN and CN, all children of JN. There was some suggestion that RN, MN's spouse or former spouse, may be the appropriate substitute decision-maker and it was unclear, at the outset of the hearing, whether or not her separation from JN was due to an inability to obtain a VISA to re-enter Canada or due to marriage breakdown. It was ultimately unnecessary for the panel to make a determination about the appropriate substitute decision-maker. On June 7th, it was determined that RN, IN and CN all declined to act as substitute decision-makers for JN. As such, MN was identified as the substitute decision-maker. The other individuals were removed as parties to Dr. Singh's application.

The Proposed Treatment:

Dr. Singh had proposed the removal of mechanical ventilation. This was the only treatment proposed and before the panel.

THE EVIDENCE

The evidence at the hearing consisted of the oral testimony of three witnesses, Dr. J. Singh, MN (the substitute decision-maker) and IN (the daughter of JN and sister of MN). There were 3 Exhibits taken into evidence:

1. Excerpts from the clinical record of JN provided by Dr. Singh;
2. Excerpts from the clinical record of JN provided by counsel to JN; and
3. A CD ROM containing a video of the testimony received at JN’s bedside on August 23, 2013.

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INTRODUCTION

JN was a 60 year old man. Prior to his hospitalization, he suffered from COPD and left ventricular failure; he had stopped working because of his health. JN was an avid musician and was sought after in his community for events. He lived with his youngest son and they were very close; they attended church, socialized and were “best friends.” JN enjoyed spending time with his granddaughter and looked forward to her visits.

On March 26th JN was taken to Toronto Western Hospital by ambulance after he awoke short of breath. After arriving at the hospital, JN suffered cardiac arrest, secondary to severe respiratory distress. Ultimately, JN was resuscitated. JN was placed in a medically induced coma and hypothermia to protect his brain and allow recovery. Over the next several weeks, attempts were made to remove JN’s sedation but when these attempts were made, JN was observed to suffer unrelenting seizures; coma was reinitiated and medication provided to control the seizures.

Once JN’s seizures were controlled, the sedation was removed. JN did not regain consciousness. JN was diagnosed with a severe anoxic brain injury resulting from lack of oxygen to the brain during cardiac arrest and complicated by his pre-existing conditions and the March 26th respiratory distress. The multiple intensive care doctors who cared for JN all agreed that JN would not recover; and even if there was some recovery, JN would not improve beyond a minimally conscious state, dependent for all care and unable to meaningfully engage in his environment. An independent physician came to the same conclusion following his examination and review of the chart on May 8th. These conclusions were based on the lack of any signs of improvement over the several weeks JN had been at Toronto Western Hospital, the type of seizures that JN was experiencing after sedation was reduced and neurological testing. JN's brain injury was described as severe and diffuse, with no higher brain functioning (other than the "short circuiting" that was shown in continuing seizures).

Dr. Singh, JN's attending physician, proposed to JN's children and substitute decision-makers (IN, CN and MN) that mechanical ventilation be discontinued because it offered no benefit to JN and continued to present a number of risks. Consent was refused. When MN was identified as the substitute decision-maker, consent continued to be refused. Dr. Singh made this application to the Board to determine whether the substitute decision-maker had complied with the *HCCA*.

At the time of the June 7th hearing date, JN was unconscious, bed bound and dependent on artificial feeding and all forms of care. JN was receiving support from mechanical ventilation; although JN had the ability to breathe on his own, his neurological status created a risk that he would be unable to maintain an open airway and the ventilation assisted with that and provided increased oxygen. There was no change to JN's status by August 23rd except that JN had developed two small pressure ulcers in the lower back due to his condition.

THE LAW

In these applications, the onus is always on the health practitioner at a Board hearing to prove his or her case. The standard of proof on any application under the *HCCA* is proof on a balance of probabilities. The Board must consider all evidence properly before it. Hearsay evidence may be accepted and considered, but it must be carefully weighed. In order for the Board to find in favour of the health practitioner, it must hear clear, cogent and compelling evidence in support of the case.

Capacity to Consent to Proposed Treatment

Under the *HCCA*, a person is presumed to be capable to consent to treatment (Section 4(2)) and the onus to establish otherwise, in this case, rested with Dr. Singh.

The test for capacity to consent to treatment and admission to a care facility is set forth in s. 4(1) of the *HCCA*, which states:

> 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.

Obligations of Substitute Decision-Making

The *HCCA* identifies the principles that a substitute decision-maker must apply when making a decision about a proposed treatment. Those principles are outlined in Section 21:

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

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

In the event that a health practitioner believes that a substitute decision-maker did not comply with Section 21, he or she may apply to the Board for a determination. Section 37 addresses issues related to such an application:

> 37. (1) If consent to a treatment is given or refused on an incapable person's behalf by his or her substitute decision-maker, and if the health practitioner who proposed the treatment is of the opinion that the substitute decision-maker did not comply with section 21, the health practitioner may apply to the Board for a determination as to whether the substitute decision-maker complied with section 21.
>
> **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.
>
> **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.
>
> **Directions**
> (4) If the Board determines that the substitute decision-maker did not comply with section 21, it may give him or her direction and, in doing so, shall apply section 21.
>
> **Time for compliance**
> (5) The Board shall specify the time within which its directions must be complied with.

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).

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.

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.

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.

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.

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 capacity 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.

JN'S CAPACITY TO CONSENT TO THE PROPOSED TREATMENT

Did the evidence establish that JN was unable to understand the information relevant to the treatment decision? Did the evidence establish that JN was unable to appreciate the reasonably foreseeable consequences of making a decision about the proposed treatment?

It was Dr. Singh's evidence that JN lacked the ability to understand the information relevant to making a decision about the proposed treatment and the ability to appreciate the reasonably foreseeable consequences of a decision about treatment. Although there was some disagreement about JN's medical condition, no one disagreed that JN lacked the ability to consent to the treatment.

Dr. Singh's evidence was that because of his brain injury, JN was unable to understand or process language. Attempts had been made to communicate with JN with visual and verbal cues (for example, requests to open his eyes, move his hand, move his toes) and there had been no response from JN. There was no evidence of higher brain functioning in the testing completed. Further, Dr. Singh indicated that infliction of painful or noxious stimuli resulted in no cognitive response. It was his opinion that JN's brain injury had resulted in a lack of cognitive function. He stated that the six intensive care specialists who had provided care to JN since his admission were in agreement that JN was not capable of consenting to the proposed treatment.

Dr. Singh's evidence was clear and cogent. The panel found as a fact that JN was unable to cognitively process any information about the proposed treatment. As such, he lacked the ability to understand that information for the purposes of making a decision about the treatment and lacked the ability to appreciate the reasonably foreseeable consequences of a decision.

APPLICATION TO DETERMINE COMPLIANCE WITH THE *HCCA*

1. *Did MN apply JN's known capable wishes about his treatment when making decisions about the proposed plan of treatment?*

There was no evidence that JN had expressed prior capable wishes that were applicable to his current circumstances and the proposed treatment. The panel found that there were no such wishes.

As a result, MN was required to apply section 21(2) of the *HCCA* when making decisions about JN's treatment.

2. *Did MN consider JN's values and beliefs that he knew JN held when capable and believed he would still act upon if capable (s.21(2)(a)) and JN's wishes that he had expressed about treatment that were not prior capable wishes (s.21(2)(b))?*

There was conflicting evidence about JN's values and beliefs relevant to his care and the current treatment decision. The clinical notes revealed that, at times, IN and CN appeared to agree that removal of mechanical ventilation would be in keeping with their father's values and beliefs (see Exhibit 1, page 74 where Dr. Goligher recorded a discussion with IN in which she related that MN had expressed that their father would not want to continue living "like this"; Exhibit 1, page 75 where Dr. Goligher noted that that IN and CN "are now in agreement that we should withdraw life support"; and Exhibit 1, page 106 where Dr. Hawryluck recorded that IN and CN agreed that "they do not believe their father would want to live chronically dependent"). However, the notes also indicate that IN and MN had said a number of times that they would never "unplug" the machines because of their religious values.

In submissions, MN expressed that the clinical records that referenced conversations in which family members had expressed that JN would not want to live in his current condition or that family members were consenting to the removal of mechanical ventilation were inaccurate. He relied on IN’s testimony that she had never spoken to a doctor about her father’s wishes or what should happen next in his treatment. Ms Baron submitted that the position taken by the family before the legal process was underway was most telling about JN’s true values and beliefs; she asked that the panel place weight on the information contained in the clinical records because the physicians who recorded the family’s statements were doing so in the ordinary course of their work, because they were bound by ethical principles, because multiple physicians had recorded these statements, and because the physicians had also recorded statements that were contrary to the position that they were advocating.

The panel accepted that the clinical notes reflected the statements made by the family, as they were understood by the physicians for all of the reasons noted by Ms Baron. We considered the stress placed on the family because of this situation and IN’s understandable confusion about to whom one may be speaking and what was said when calling a hospital from another country, over a period of several months in a time of stress. We also determined that JN’s values and beliefs expressed by IN and CN were not contradicted by their position that they would never turn off the machines; rather, we concluded that IN and CN accurately had reflected that JN would “not want to continue to live this way” but they were struggling with the decision in light of their own understanding of his medical condition and because of what they hoped would happen: that JN would recover.

JN also testified about his father’s values and beliefs. JN said that if he were able to ask his father what he wanted, JN would want to fight for his life. He testified that JN had faced a difficult situation with his own mother and that JN had decided to consent to a tracheostomy to extend her life, even though his mother was 84 at the time and, because of her age, she had less of a chance to recover than JN did now. When asked whether his father would want to continue with mechanical ventilation or have it removed, MN stated that his father would want a tracheostomy; after repeated questioning and an explanation that a tracheostomy was not an option, MN eventually stated that JN would want to continue mechanical ventilation. He said this was the case even if his father would never be able to talk again and even if his father were in pain.

MN also testified that he had witnessed his father opening his eyes; something that he said the doctors had told him would never happen. He said that on Sundays, his father would open his eyes and appeared happy when he entered the room, which he believed indicated that his father was pleased that he was still going to church as they had done together previously. MN said that he wanted his father to have a tracheostomy to remove the tubes from his throat so that JN could talk. He believed that if a tracheostomy was performed, his father, after some time to recover his strength, would be able to speak. MN said that even if JN was confined to a wheelchair, he would be able to speak to JN or at least see him. MN also testified that JN would not find that his current life, dependent on all aspects of care, was undignified; he said that JN had seen his own mother and others in a similar situation. MN repeatedly said that his father would fight for his life and would hope that MN would fight for him.

In considering MN's testimony, the panel noted MN's fixation on a tracheostomy and his belief that JN would be able to speak again if the supportive breathing tubes were placed in his throat, rather than his mouth. Although MN eventually, in response to repeated questions, said that his father would want to live and would want to fight for his life, even if there was no chance of recovery, it was clear to the panel that MN believed that his father would recover, at least to the point of being able to speak, even if confined to a wheelchair. When speaking of the tracheostomy, MN said that it would give his father another chance and that if, ultimately, his father did not recover, he (MN) would then be prepared for his death.

The panel completely understood MN's desire to continue to believe that his father would recover. He was obviously very close to his father and shared the day-to-day experiences with him. MN was clearly devastated by his father's illness. However, the panel determined that MN's testimony was highly influenced by his belief that JN would recover and that MN was saying what he thought was necessary to ensure that the mechanical ventilation remained which would, in his mind, allow the recovery to occur; this was despite the overwhelming evidence to the contrary, all of which had been explained to MN multiple times by multiple different physicians at Toronto Western Hospital. We did not put weight on MN's testimony about JN's values and beliefs for this reason.

Further, the panel drew no conclusions from MN's testimony about JN's mother's illness and JN's actions as reflections of JN's values and beliefs; JN's mother had been hospitalized decades before and we found that JN was unlikely to remember the specifics of her condition or the motivations behind his father's actions. We found that MN's testimony was not reflective of his father's values and beliefs, in particular of his values and beliefs that would be relevant to his current medical condition.

The panel determined that we were unable to draw any conclusions about JN's values and beliefs from the evidence before us. Although there was some evidence that JN would not want to continue to live in his current condition, based on the statements from IN, CN and MN as recorded in the clinical records, that evidence was not clear and cogent as it lacked any specificity and the panel was unable to make a determination on this point.

3. ***Did MN consider whether the proposed treatment plan was likely to improve JN's condition or well-being, prevent it from deteriorating or reduce the rate at which it was likely to deteriorate (s.21(2)(c)(1))? And did MN consider whether JN'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(2-4))?***

Dr. Singh testified that JN was dying as a result of his anoxic brain injury. The injury was diffuse and severe and left JN without higher brain functioning. As a result, JN did not have the ability to process any information about his environment or his body and could not, on his own, maintain an open airway (by coughing and clearing mucous), shift his weight to prevent bed sores, or feel pain. All of the evidence before the panel was that JN would never regain consciousness; if he did, which was very unlikely, recovery would not be beyond a minimally conscious state. This was confirmed by the notes of multiple intensive care specialists, neurologists and an independent physician (see, for example, the clinical note of Dr. Steel, an independent critical care specialist, Exhibit 1, pages 97-100).

Dr. Singh testified that JN was likely to succumb to his brain injury in three ways: he would be unable to maintain an open airway, he would experience a pulmonary complication like pneumonia, or he would experience another complication. These likely outcomes were the same whether or not the mechanical ventilation was removed. He said that the proposal to remove mechanical ventilation had been made because there were increased risks with this continued treatment. Ventilation increased the risks of infection because of its very nature (it created an environment in the body that promoted infections and pneumonia). There were also risks of damage to throat and, although less likely, fistula. With mechanical ventilation, JN required suctioning to clear his airway (as often as hourly) and had required replacement of the tubing in his throat to clear thick secretions four times over the last several months.

Dr. Singh stated that mechanical ventilation offered no benefits to JN. He said that JN’s anoxic brain injury was severe and diffuse. He explained that the respiratory distress that had caused JN’s cardiac arrest had diminished the oxygen and increased the carbon dioxide in JN’s blood causing the blood to become acidic and causing damage to the organs, including the brain, before the cardiac arrest. JN had been in cardiac arrest for more than ten minutes and CPR offered limited oxygen to the brain during that time. Dr. Singh stated that the portions of the brain responsible for consciousness, memory and thought were most susceptible to oxygen deprivation because they required significant levels of both oxygen and glucose to function and survive. The brain stem, responsible for basic functions like heart and lung functioning, required much less oxygen and more easily survived, as was the case with JN’s injury. Dr. Singh provided evidence that MN was made aware of all of this information, multiple times and by multiple physicians at Toronto Western Hospital.

Dr. Singh stated that aggressive attempts to care for JN had not resulted in any signs of recovery over the five months that he had been hospitalized; if recovery were likely, signs would have been apparent in the several days after the cardiac arrest. In addition to the lack of recovery, JN's neurological testing showed no motor or cortical response to pain or noxious stimuli; such would not be the case if the brain were functioning. The presence of seizures was also a poor prognostic sign; Dr. Singh stated that the seizures were a demonstration that the only higher brain function was this "short-circuiting" that led to the seizures.

Dr. Singh's evidence was supported by multiple physicians who records are found in the clinical chart (see, for example, Dr. Wilcox's April 1st note, Exhibit 1, pages 24-27; Dr. Lazaru's April 5th note, Exhibit 1, page 115; Dr. Tai's note April 24th, Exhibit 1, pages 70-71; and Dr. Goligher's April 26th note, Exhibit 1, page 74). Dr. Steel, an independent critical care specialist, not involved in JN's care, reassessed JN on May 8th and determined that JN was "slowly going to die" of his brain injury; he recommend the removal of mechanical ventilation to allow a "more natural death" (Exhibit 1, page 100).

Dr. Singh's evidence was challenged on cross examination. He was asked about multiple references in the clinical charts about JN opening his eyes and, in particular, about two notes. On May 18th, nursing staff recorded that "Pt opens eyes spontaneously and at times to voice" and later that JN "does awake to noise and looks @ direction of noise @ times" (Exhibit 2, page 13). On May 20th, staff recorded that "Pt continues to be @ baseline neurological status appears awake but __?" (Exhibit 2, page 15). Dr. Singh stated that assessing a patient who was in a minimally conscious state was a difficult process, even for experienced intensive care nurses. He testified that what the nurses were observing were reflex responses originating in the brain stem; JN was not "seeing" or "hearing" in such a way that he could process that sight or sounds because there was no higher brain functioning which would allow him to interpret those senses but the primitive brain responded in a simple way to the stimuli.

Dr. Singh's evidence was not contradicted by any medical evidence. His evidence was clear and cogent. Based on his evidence, the panel was convinced that mechanical ventilation provided no benefit to JN: he was going to succumb to his anoxic brain injury with or without the ventilation. Given the absence of any benefit to JN of the ventilation, the risks of the treatment were heightened, particularly the risk of infection due to the breathing support tubing.

It was argued in submissions that JN was going to die with or without mechanical ventilation and that there was no harm to JN in continuing the ventilation and allowing his life to be prolonged. The panel disagreed with this submission. We agreed that removal of the mechanical ventilation would likely result in JN's eventual death as he would be unable to maintain a clear airway long-term. However, it was also likely that JN would experience a fatal infection as a direct result of the continued mechanical ventilation. We accepted Dr. Singh's evidence that it was impossible to predict when or how a fatal event may occur and we accepted that such an event was likely to occur, regardless of the proposed removal of mechanical ventilation.

The panel was invited by Ms Baron to interpret the factors in Subsection 21(2)(c) narrowly, and to weigh the benefits and risks of treatment in terms of the specific medical impact of the ventilator. Considering those aspects of best interest narrowly, we agreed that the ongoing use of mechanical ventilation was not likely to improve JN's condition or prevent it from deteriorating or reduce the rate of deterioration. We concluded that there were no benefits to JN in continuing the ventilation and in light of that finding, the existence of risks associated with its use caused us to find in favour of the removal of mechanical ventilation. Some of the risks were small: for example, if JN's throat was injured as a result of the ventilation, he was unlikely to feel any pain and would not know that his ability to speak was impaired. However, the risk of fistula, although a slight risk and the constant risk of a fatal pneumonia were significant given there was no benefit to balance against these risks.

The panel went on to consider the factors in subsection 21(2)(c) more broadly. In addition to the narrow interpretation of JN's medical issues above, we also considered JN's "well-being" broadly to include his dignity at the end of his life. In *Scardoni v Hawryluck* (Ont. Crt of Justice, February 5, 2004), the court discussed the interpretation of "well-being" in the context of section 21(2)(c) of the *HCCA*. That court approved the definition used by the Board in its Decision:

> 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 the person's illnesses and physical situation. "Well-being" includes considerations such as the person's dignity and levels of pain.

We adopted the same definition. Although MN had testified that JN would not find his current dependence for all aspects of care undignified, the panel placed no weight on this evidence, as explained above. Although JN appeared not to experience pain, he was subject to continuous interventions to prevent his body from deterioration – a deterioration that was inevitable (including interventions directed at maintaining the mechanical ventilation: JN was subjected to regular suctioning of his airway and the replacement of breathing support tubes down his throat). None of these things would benefit JN and all were assaults on his dignity as he moved towards his death.

The panel found that in the absence of any identifiable and relevant values and beliefs that were held by JN that would indicate how he would want to make decisions about the proposed treatment, MN was required to weigh the factors outlined in subsection 21(2)(c) when making a decision about the proposed treatment. We found that he had not done so. MN's desire to believe that his father would recover was preventing him from accepting JN's current medical condition and applying the factors relevant to the proposed treatment in light of that medical condition. We held that the mechanical ventilation offered no benefit to JN and that it carried risks and a negative impact on his well-being.

RESULT

We held, unanimously, that JN was not capable of consenting to the proposed treatment. We were also unanimous in our decision that MN, the substitute decision-maker, had not complied with the principles for substitute decision making set out in the *HCCA* and ordered that MN consent to the removal of mechanical ventilation by August 30th, 2013.

Dated: September 4, 2013

Lora Patton
Presiding Member