Consent and Capacity Board | Commission du consentement et de la capacité | Ontario

TO 11 1391

TO 11 1392

IN THE MATTER OF

The *Health Care Consent Act*

AND IN THE MATTER OF

M.D

A PATIENT AT

ST. JOSHEPH'S HEALTH CENTRE

TORONTO, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

M.D. was a patient at the above noted health centre. He was on life support. His attending physician had asked the substitute decision maker (SDM) to consent to an order limiting steps that would be taken in the event of a cardiac event. The SDM did not consent and the physician brought this application to the Board to determine if the SDM had complied with the principles for substite decision making. This application triggered a deemed application to determine whether M.D. was capable with respect to admission to a care facility.

DATE OF THE HEARING

July 22, 2011

PANEL MEMBERS

Mr. Philip Clay, Senior Lawyer Member
Dr. John. Pellettier, Psychiatrist Member
Ms. Beverly, Hodgson Public Member

PARTIES

On the incapacity issue

M..D., the patient
Dr. R. Cirone, the attending physician

On the issue of compliance with the principles of decision making

M.D. the patient
Dr. R. Cirone the attending physician
Mr. W.D. the substitute decision maker

APPEARANCES

Ms. M. Tucker,for the patent
Mr. P. Hawkins, for Dr. Cirone
W.D. acted on his own behalf

RECORD

The record consisted of:

1) Form G under the *Health Care Consent Act*, Application to the Board to Determine Compliance under Subsection 37 (1) of the Act.
2) Deemed Application to Review a Finding of Incapacity under Section 32 (1) of the *Act*.

LEGISLATION CONSIDERED

The *Health Care Consent Act*, sections 4, 21, 32, 37

CASES CONSIDERED

Grover (Re), 2009 CanLII 16577 (ON SC)

EXHIBITS

On Motion to Dismiss

1. Motion to Dismiss filed by W.D. (undated)
2. Letter to Dr. Cirone from W.D. dated June 24, 2011
3. Letter to W.D. from College of Physicians and Surgeons dated July 5, 2011

On the Applicantions

1. Clinical Summary by Drs. Cirone, Vanek and Rogevein July 20, 2011
2. Excerpts from Hospital Records of M.D. including Power of Attorney
3. Response to Summary from W.D.
4. Photograph of right foot of M.D.
5. I.C.U. Nursing Notes from July 1, 2011 to date
6. Article filed by Ms Tucker “Meeting the Clinical Challenge of Care for Jehovah’s Witnesses
7. Medication Administration Record
8. W.D.’s notes on excerpt from medical journal
9. e-medicine health web page July 22, 2011

10. Excerpts from M.D.'s clinical chart submitted by W.D.
11. Graphs prepared by W.D. re; Hemoglobin levels
12. myblood web page submitted by W.D.

PRELIMINARY MOTION

M.D.'s son W.D. was his substitute decision maker as he had been designated his attorney for personal care. W.D. filed a Motion to Dismiss Dr. Cirone's Form G. application. The grounds set out in the motion were that;

1. The Form G Application brought by Dr. Cirone was vexatious and frivolous
2. Dr. Cirone's refusal to consider the use of non-blood alternatives in the treatment of M.D. is currently under the investigation of by The College of Physician's and Surgeons of Ontario.

W.D. gave evidence to support his motion. It became quite clear that he had issues with Dr. Cirone's handling of his father's care and the manner in which he communicated, or did not communicate, with W.D. Those complaints will be addressed by the College's investigation. Dr. Cirone was entitled to bring the Form G application. We found that the merits of that application should not to be determined by way of a preliminary motion but by hearing the evidence on the Application itself.

We dismissed the motion.

THE LAW

The Application was brought by Dr. Cirone under ss. 37 (1) of the *Health Care Consent Act* ("the Act")

The relevant sections of the Act are set out below.

21. (1) **Principles for giving or refusing consent. -** 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.

(2) **Best interests.-** In deciding what the incapable person's best interest 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.

Application to determine compliance with s. 21

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

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 directions 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.

The Application brought by Dr. Cirone under s. 37(1) of the Act resulted in a deemed Application under s. 32(1) of the Act for a review of the attending physician's finding that M.D. is incapable with respect to a treatment.

Capacity is defined in the legislation. The relevant section reads 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 a 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

The onus is upon the physician with respect to both issues before the Board.. That onus must be discharged upon clear, cogent and compelling evidence.

OVERVIEW

M.D. was an 85 year old man who had been residing in his own home with his son W.D. He had a history of vascular disease and vascular dementia. He was admitted to Sunnybrook Hospital with a diagnosis of right ischemic foot, dehydration and a decreased level of consciousness. He was released on June 1, 2011. Two days late he presented to St. Joseph's hospital and was admitted. After 8 hours or so he was transferred to I.C.U. At the time of the hearing he was on life support

and the critical care doctor's said his prognosis for recovery was "essentially nil'". On June 20 Dr. Cirone had asked W.D. as the attorney for personal care to consent to an order that no C.P.R. be done if his father went into cardiac arrest. W.D. felt that Dr. Cirone was not concerned about his finding better ways to treat M.D. and he refused to agree to the request. The doctor then brought this application. The application triggered a deemed application to review a finding that D.D. was incapable.

THE EVIDENCE

M.D. did not attend the hearing as he was in the intensive care unit on life support. There were two issues before us and they involved different parties. Dr. Cirone gave evidence. He was the medical director of the I.C.U. and had been M.D.'s M.R.P. (most responsible physician) from June 19 to June 23 and had seen him on every shift he worked both before and after that time. He gave evidence on the capacity issue first and then Ms. Tucker cross-examined him on that point.

The evidence was that at the time of the hearing M.D. would open his eyes upon hearing voices but he could not respond in any way to questions or directions. His left leg had some movement but the doctor said it was not purposeful movement. To rule out the possibility of a language barrier a Ukrainian interpreter tried to communicate with him in his native language but to no avail. On cross-examination Dr. Cirone said that it appears that M.D. reacted to pain as he did grimace and make gestures when certain procedure were carried out. He had been on a continuous morphine drip but that was discontinued because it could alter his consciousness. However on July 8 he was assessed both before and after reducing morphine and no difference could be noted in his consciousness.

After hearing the evidence Ms. Tucker was given an opportunity to make submissions on this threshold issue of capacity and she conceded that her client lacked capacity to consent to the proposed treatment. As a result she confirmed that she was unable to obtain instructions from him

Dr. Cirone then moved on to give further evidence on M.D.'s condition and care. He said that there was Power of Attorney in the clinical records. It appointed W.D. as M.D.'s attorney for personal care. It contained the following words under the heading- instructions, conditions and restrictions;

> I direct that no matter what my condition I be given all available medical treatment in accordance with accepted health care standards. However, I direct that no blood transfusions or fractions of blood be given to me under any circumstances. I refuse to predonate and store my blood for later infusion. I may be willing to accept certain medical procedures involving my blood but the details have to be discussed with my attorney.

Dr. Cirone complied with the direction and treated M.D. without the use of a blood transfusion. The willingness of Dr. Cirone to use other methods to treat M.D.'s anemia and to attempt to increase his hemoglobin levels was a source of friction between Dr. Cirone and W.D. It is not the role of this Board to review the quality of care provided to a patient. The evidence was that M.D. had a reasonable quality of life living at home before he went to the Sunnybrook Hospital in May 2011. At Sunnybrook W.D. was asked to consent to the amputation or his father's right foot. He did not consent and the foot became severely infected, became gangrenous and then to use Dr. Vanek's word it "died". Both Dr. Cirone and Dr. Vanek said it was now too late to operate. The blood loss would be too great for a severely anemic patient particularly since a blood transfusion had been ruled out. The simple facts were that after declining the amputation M.D. was released from Sunnybrook on June 1 and went home with medication. His condition worsened rapidly, it appeared that sepsis developed, by June 3 he was in I.C.U. at St. Joseph's. On June 21 his condition worsened further and Dr. Cirone had a brief meeting with W.D. at which time he requested that W.D. consent to an order that no C.P.R. be undertaken if M.D. suffered a cardiac event. This meeting seemed to end an already fractured relationship between Dr. Cirone and W.D. In his evidence W.D. said that the request was not made in a private meeting but in a public area with other health care staff present. He felt pressured and seemed to feel that Dr. Cirone was biased against him and his father because of the restrictions on care imposed by the Power of Attorney. Another meeting was scheduled for June 23. The Hospital Liaison Committee (H.L.C.) for Jehovah's Witnesses attended this meeting. Unfortunately this meeting did not go well and it

resulted in W.D.'s complaint to the College referenced above. In a letter to Dr. Cirone on June 30, Chris Sopiwynk of the H.L.C. expressed,

> …our appreciatin for your responsive and compassionate care as well as everything the hospital has been able to do in this difficult situation. Unfortunately, the unexpected belligerent behavior of Walter at the meeting denied us that opportunity and raised the necessity for me to now disassociate the HLC from any of his accusations and criticism of the care provided by you and the hospital. Please be clear that we are NOT in agreement with his actions nor are a party to his accusations.

Given the complaint Dr. Cirone transferred care of M.D. to Dr. Vanek another critical care doctor at the hospital on June 23. With the exception of Dr. Cirone's coverage on the weekend of June 25 and 26 Dr. Vanek has been the M.R.P. since.

Dr. Vanek confirmed Dr. Cirone's diagnosis and prognosis for M.D. He also noted that W.D. was entirely focused on the treatment of anemia with non blood products and taking all steps to increase M.D.'s hemoglobin levels. The doctor's said that W.D. had closed his mind to anything other than the use of non blood products to treat his father's anemia. Briefly stated it was clear from both doctor's evidence, and W.D.'s evidence, that the latter had some knowledge in the area of use of non blood products gleaned both from his church's teaching and from his own research. W.D. made recommendations to the doctor's, asked for tests and sought our second opinions. In his evidence Dr. Vanek expressed some exasperation with the questioning of his medical judgment by a lay person. Ironically while Dr. Vanek was more critical of W.D. in his evidence than Dr. Cirone W.D. was much more satisfied with Dr. Vanek 's care as it appeared to him that Dr. Vanek listened more to his suggestions regarding the treatment of his anemia than Dr. Cirone did.

As we do not review clinical judgment the above noted evidence is set out only to provide some context for the mistrust and poor communication that developed between W.D. and the treatment team. It was in this climate that Dr. Cirone initially asked for the no CPR order on June 21. He was supported in his view by all four of the doctor's on the rotation in I.C.U. plus the chief of staff Dr. Rogvein.

Drs. Cirone and Vanek gave very clear evidence of the current condition of M.D both in the written summary and in oral evidence. On June 3 M.D. presented to the hospital with low blood pressure, a rapid heart rate and a decreased level of consciousness. He had evidence of diarrhea and a very low urine output. His initial bloodwork was “suggestive of bilateral pneumonia”. In I.C.U. he had required oxygen by face mask, fluid and intravenous medication for low blood pressure and urine output. He needed continuous haemodialysis (later changed to intermittent) to flush his poorly functioning kidneys. He had sepsis thought to be caused by his ischemic right foot. On June 19 he had to intubated and placed on life support ventilation. Dr. Rogavein had been his MRP but that responsibility was transferred to Dr. Cirone that day. The summary addressed the efforts to increase red cell production while complying with the health care directive in the Power of Attorney document. Nevertheless the hemoglobin levels continued to fall. The cause of this was said to be “multifactorial’. The doctors evidence was that M.D.’s prognosis for recovery was “essentially nil”.

Both doctor’s expressed concern about the purpose of an invasive and painful “treatment” in the event of a cardiac event. Dr. Cirone said that CPR on a frail patient would break ribs and the bones would rupture the spleen and cause internal bleeding. He said that if there was a full cardiac arrest (as opposed to an irregular beat) the chance of success with CPR was 5-10%. Dr. Vanek said it was pure guesswork but estimated a 5% -30% chance of survival.

Dr. Cirone had asked W.D. for an order for no CPR and no re-intubation. He set out in the summary the wording that he sought which appeared from the evidence to expand on what he had asked for directly in the ill fated meetings with W.D. It reads as follows;

> …(M.D.)… not receive CPR. This would include no chest compressions, do defibrillation or cardioversion and no external or transvenous pacemakers. In the event that… (M.D.)…was to be extubated and discontinued from mechanical ventilation, he would not have an endotracheal tube reinserted and mechanical ventilation re-instituted. All other therapy as outlined by his expressed prior capable wishes.

Dr. Cirone was asked by W.D. about the treatment of other ongoing or new medical conditions and he confirmed that with the exception of the treatment specifically referred to above that M.D. would receive all medical care available. With respect to extubation he conceded that sometimes it occurs accidently and if even in that event it was the plan not to re-intubate. He addressed the pain associated with intubation and his view that it would be for no purpose. With respect to pain the doctor's conceded that in his altered level of consciousness it was difficult to know what pain M.D. felt but he did show by grimaces that he felt some pain with care and treatment.

Both Dr. Cirone and Dr. Vanek said that CPR and re-intubation of a patient in M.D.'s medical condition was not within "acceptable health standards" and they stated that their colleagues in the I.C.U. team felt the same way. They said that they respected the right of M.D. to set out his wishes in his Power of Attorney document. They said that they had complied with those wishes in not using blood products and in trying various treatments to attempt to help M.D. recover even though it had seemed to be a hopeless effort for some time. Their view was that if the patient's heart stopped beating properly or if he had to be extubated that acceptable health standards would mandate not putting M.D. through the pain of chest compression or intubation for no purpose as he would not recover anyway.

W.D. filed documents and gave oral evidence. As it has been noted that he was hostile in the June 23 meeting it must be said that he kept a calm demeanour throughout his evidence. W.D. was clearly focused on the manner of treatment issues. He was determined to prove that non blood alternatives could be used to increase his father's hemoglobin levels and he even went to the extent of creating a graph from information provided by the hospital that showed a spike in hemoglobin levels after iron injections. W.D. felt that there was a "slight chance" of improvement if the hemoglobin levels were increased. He could not accept the doctor's prognosis that there was no chance of recovery. His position was that if there was any chance of recovery he felt obligated to follow his father's wish to have something done. He admitted that there were limitations to what medical science could do and that at some point further treatment is hopeless. He admitted telling the doctor's that "he would not want treatment if there was no hope of recovery". He said that if the situation was totally hopeless there was no point in prolonging suffering. He just did not feel that his father was at that point yet. He said he had never discussed with his father just where the

"threshold" would be. W.D. acknowledged that life support itself is very intrusive. He thought that his father's directive was clear. It said "no matter what my medical condition I be given all available medical treatment in accordance with accepted health care standards". He noted that his father had almost died on July 8 but the doctor's had affixed an external pacemaker and this had saved his life. He was concerned that the withdrawal of treatment now sought would mean that even a relatively non invasive treatment such as an external pace maker would not be used. He thought that any lay person such as his father, would see CPR as part of what is offered to patients in Canadian hospitals and that it would therefore be within "acceptable health standards". He noted that a variety of things could cause the heart to malfunction and he wanted doctor's to keep the heart functioning while they tried other treatments to help him recover.

ANALYSIS

THE INCAPACITY ISSUE

The evidence clearly supported a finding that M.D. was incapable with respect to the proposed treatment or withdrawal of treatment that Dr. Cirone proposed as outlined above. Ms. Tucker on behalf of M.D. conceded this point.

THE COMPLIANCE WITH DECISION MAKING PRINCIPLES ISSUE

Section 21 of the Act sets out the principles that a substitute decision maker must follow. We examined the evidence and considered the submissions

Prior capable wish

It was conceded by all parties that M.D. had made a valid Power of Attorney that set out his wishes. These were then wishes made when M.D. was capable. Pursuant to s. 21 (1) 1 of the Act the W.D. as the SDM was required to follow his father's expressed wish. As noted above W.D. had said that

the meaning of the directive was clear and that CPR and intubation were treatments that were within acceptable medical standards and that he was bound to insist that his father be given this treatment “no matter what his medical condition’

In submission Mr. Hawkins essentially said that the matter was not that simple. He said there were two matters to be considered.

Firstly was the wish clear and unambiguous? If it was then it had to be followed. However he noted that all available treatment was qualified by the statement “in accordance with acceptable health standards” He emphasized the doctor’s statements that CPR and re-intubation of a patient in M.D.’s medical condition was not within acceptable medical standards.

Secondly if the wish was not unambiguous then the best interests test in s.21 (2) had to be followed. He said that the evidence showed that it was not in M.D.’s best interest as that term is defined in the legislation for him to be given chest compressions or re-intubated.

Was the wish clear?

Mr. Hawkins submitted that the wish was not clear. He said that the directive taken as a whole was made to ensure that M.D. Jehovah’s Witness beliefs about no blood transfusions or blood products was respected. He noted that the Power of Attorney was signed at the offices of the Jehovah’s Witnesses and was witnessed by elders. The specific wording was designed to ensure that “accepted health standards” were not applied when it came to the use of transfusions and the whole document was intended for that purpose.

Ms. Tucker submitted that M.D. did consider the very grave medical condition that he found himself in. She noted that the plain meaning of the words “no matter what my condition” could not be ignored. She also argued that as a devout Jehovah’s Witness M.D. would share his faith’s views on the sanctity of life and he would be prepared to accept some pain to preserve his life. She referenced the article set out in Exhibit #6. Mr. Hawkins noted in reply submissions that there was no evidence that his faith gave M.D. any views on the extent to which he would be prepared to

suffer pain in order to stay alive in any medical state. In fact the evidence was that W.D. and M.D. did not discuss the specific details of what M.D. would want done if on life support.

We found that the words “no matter what my condition” must have been inserted for a reason. By including those words there was a purpose to the directive other than to avoid blood transfusions. M.D. could have simply said he wanted no blood transfusions and left it at that. He did not. We found that M.D. must have turned his mind to a grave medical condition and that he expressly wanted all available treatment in accordance with acceptable health standards. We agreed with Mr. Hawkins that there was no evidence that M.D.’s faith meant that he had a particular view on accepting pain to preserve life.

Acceptable health standards

We found that this matter really turned on the issue of what M.D. meant when he used the words “acceptable health standards”. Mr. Hawkins submitted that the only evidence that we had on the meaning of that phrase was the medical evidence of the doctors. Both Dr. Cirone and Dr. Vanek said that it was not within acceptable health standards to give CPR or re-intubation to a patient when there is no hope of recovery. We found that such an interpretation of those words might make sense from a purely clinical perspective. Given the doctor’s prognosis we understood why they might be troubled by causing pain to a man they saw near the end of the dying process. However the words were not written by a physician. We found that the purpose of including these words in addition to the specific no blood wish was so that M.D.’s designated attorney would interpret them and make a decision as to what they meant. To hold otherwise is to negate the purpose of making the Power of Attorney. If M.D. was content to let his son make health decisions without any guidance he did not need to say “no matter what my condition” . If those words were not included this would leave his son with unfettered discretion as to what to do- other than on the blood transfusion issue. In the particular circumstances of this matter W.D. had his own personal views as to the doctor’s care, and his father’s condition, that conflicted with the doctors. He did not trust them. He clearly wanted to wait longer to see if his father improved. An SDM is required to follow the patient’s wish if expressed and not to impose his own views as to the decision to be made or not made. While W.D. gave evidence that he and his father had not specifically discussed

details of potential end of life circumstances he felt confident that his father would also want him to refuse the doctor's recommendations.

W.D. said that he interpreted "acceptable health standards" to mean the kinds of treatments that are available in Canadian hospitals. He said that CPR and intubation and other forms of life support are available to patients generally and his father would have expected them to be available to him.

We found that the words "acceptable health standards" had to be given some meaning as they were clearly used to qualify the balance of the sentence. We agreed with the interpretation taken by W.D. that they meant the kind of care that is routinely available in Canadian hospitals. This means that they would not include radical alternative care that might be tried in some circumstances in some other settings.

We understood that the doctor's considered medical opinion was that there was essentially no chance of recovery. W.D. could not accept that yet. His father had been discharged from a hospital with medication on June 1. He was not in a persistent vegetative state but had in the words of the doctors an "altered state of consciousness." He did react to stimuli although in the doctor's opinion not in a responsive way. The issue of the degree to which he felt pain was instructive. The doctor's thought that he did feel pain and that was a reason for not reviving him if he had a cardiac arrest. W.D. agreed that there was pain as his father did grimace when moved or treated but he saw that as evidence that his father still had a functioning brain and was therefore not like a person who was said to be brain dead but whose heart just kept beating. W.D. stated that he was concerned about the pain his father was suffering even though he advocated for keeping him alive on life support and reviving him if his heart did give out.

Ultimately our decision rested on the fact that M.D. made a decision when capable to let his son make decisions. We found that meant that his son, not the doctor's, should interpret what he really meant by "acceptable health standards."

Was wish applicable to circumstances?

Mr. Hawkins argued that there was no evidence that M.D. turned his mind to the issue of CPR or intubation when he gave his health direction. He referred us to cases for assistance on the issue of whether a capable wish was applicable in the circumstances.

In *Grover* the patient was in a vegetative state after a third stroke to her brain stem. Mrs. Grover had made a health directive that called for a code 4 which included "…to resuscitate me if my heart stops beating or I cease to breathe and put me on life support systems if necessary to prolong my life…"

Mr. Justice Hockin considered whether the wish was applicable to the circumstances and in so doing referred to the decision of Sharpe J who said in *Conway v. Jacques,*

> However, I agree with the appeal judge that prior capable wishes are not to be applied mechanically or literally without regard to relevant change 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.

Ultimately in *Grover* Hockin J. upheld the decision of the CCB to direct that life support be removed because when the wish was made Mrs Grover did not take into account the nature and extent of the medical result to her from an event as devastating as her third stroke turned out to be.

The *Grover* case can be distinguished from this matter based upon the factual differences. In *Grover* the patient was in a vegetative state after a stroke. It was not possible on the facts disclosed in the decision to know the extent to which the altered consciousness of M.D. differed from the mental state of Mrs. Grover. However in *Grover* after this brain stem stroke, the third suffered by the patient, neither the SDM nor the other siblings believed that there was any possibility of recovery. The SDM., in that matter simply said that her mother would want to live 'because of the way she was" . This statement was found by Hockin J. to be "extremely vague." In the matter before us W.D. believed that there was a chance of recovery, albeit slight. He believed that his father would want him to take steps to keep him alive until it was clear that there was no hope. He

recognized that there were limits to even a direction that appeared to be expressed in fairly absolute terms.

Summary

Given the context of this hearing we want to note that we found that W.D. had obsessed about the non blood alternatives and in the weeks leading up to this hearing and had spent time and energy assigning fault to medical professionals especially Dr. Cirone. W.D. has his legal options with respect to the prior care of his father. He has complained that he has been ignored and pressured by the treating physicians. Certainly the communication of the treatment plan was not done in the way it should have been done. We make no findings of fault in that regard-it is simply a fact. We hoped that after this hearing W.D. felt that he was heard and his role as the chosen decision maker had been respected. We did not mean to convey by our decision that we disagreed with the doctor's prognosis or that all decisions had now been made. The *Act* provides for principles for substitute decision making because the SDM role is not an easy one. It requires the SDM to constantly be vigilant as to whether he or she is acting in accordance with prior capable wishes and those wishes are still applicable to the circumstances. In his evidence W.D. stated that he did not see the directive in the Power of Attorney to be absolute. He knew that there was a point at which he may have to re-evaluate his decisions in light of changed circumstances such as ongoing pain with no hope of recovery. We hope that W.D. appreciates the ongoing responsibility that he has in this regard.

RESULT

We found that M.D. was incapable with respect to the following treatment decision;

That M.D. not receive CPR. This would include no chest compressions, do defibrillation or cardioversion and no external or transvenous pacemakers. In the event that M.D. was to be extubated and discontinued from mechanical ventilation, he would not have an endotracheal tube reinserted and mechanical ventilation re-instituted

We found that W.D. has complied with the principles for substitute decision making as set out in the legislation.

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Philip Clay
Senior Lawyer Member
Reasons requested July 25, 2011
Reasons released July 28, 2011