Consent and Capacity Board
Commission du consentement et de la capacité

2024 CanLII 21941 (ON CCB)

23-6537-01
23-6537-02

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

AND IN THE MATTER OF
RJ
A PATIENT AT
HAMILTON HEALTH SCIENCES – HAMILTON GENERAL HOSPITAL
HAMILTON, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

RJ was a patient at Hamilton General Hospital, Hamilton, Ontario (“the Hospital”). She was admitted to the Neuro Trauma Intensive Care Unit (NTICU) following a motor vehicle accident in which she suffered serious injuries. At the time of the hearing RJ was in a persistent vegetative state. She was continued on artificial life support in the NTICU. Her medical team was of the opinion that ongoing use of life-support did not confer any medical benefit and was therefore not indicated. The medical team had therefore recommended withdrawal of life sustaining treatments and implementation of palliative care. MJ, RJ’s spouse and substitute decision maker (“SDM”) did not consent to the proposed treatment plan. The Board convened at the request of Dr. Sharma, the health practitioner who had proposed treatment for RJ, to determine whether or not RJ’s SDM had complied with the principles for giving or refusing consent set out in s. 21 the HCCA. The application “Form G” was brought under s. 37(1) of the Health Care Consent Act (“HCCA”).

DATES OF THE HEARING, DECISIONS AND REASONS

The hearing took place on January 10, 2024. The next day the panel released its decisions. On January 23, 2024 counsel for Dr. Sharma, requested written Reasons for Decision (contained in this document), which were released on January 29, 2024

LEGISLATION CONSIDERED

The *Health Care Consent Act*, sections 4, 5, 21, 32, 37 and 37.1

PARTIES

Deemed Form A Application
RJ, the incapable person
Dr. Sunjay Sharma, the health care practitioner

Form G Application
RJ, the incapable person
Dr. Sunjay Sharma, the health care practitioner
MJ, the substitute decision maker for RJ

RJ did not attend the hearing but was represented by counsel, Mr. Russell Browne. Dr. Sharma and MJ attended the hearing.

PANEL

Shashi Raina, senior lawyer and presiding member

APPEARANCES

RJ was represented by counsel, Mr. Russell Browne
Dr. Sharma was represented by counsel Ms. Samantha Hargreaves

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MJ was self-represented.

INTERPRETATION

A Serbian interpreter, arranged by the Board, was present throughout the hearing to provide interpretation to MJ.

PRELIMINARY MATTERS

Attendance at the hearing

The hearing convened in person at Hamilton General Hospital. The Presiding Member, Dr. Sharma, MJ and AJ (RJ's son) were present in person. Counsel Mr. Browne, Ms. Hargreaves, the court reporter, and the interpreter joined by video conference on Zoom.

Proposed Treatment:

Withdrawal of life sustaining treatments, provision of comfort care measures, including palliative and nursing care.

EVIDENCE

The evidence at the hearing consisted of the oral testimony of Dr. Sharma, MJ and AJ, and the following documents entered as exhibits.

1. Physicians document brief comprised of various clinical notes and ethics consultation report (21-page PDF file)

INTRODUCTION

RJ was a 67-year-old woman admitted to the NTICU after a motor vehicle accident (MVA) on December 4, 2023. She was a pedestrian and was struck by a motor vehicle. She suffered extensive and severe injures which included multiple broken bones, including bones in the arms and legs, broken neck, spine and multiple ribs. She had injuries to her liver and important blood

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vessels in the abdomen. RJ suffered several cardiac arrests and received CPR on the way to the hospital. In the emergency department she suffered further cardiac arrests and received aggressive resuscitation, which included opening up of her chest to massage the heart manually. She was successfully revived, but as a result of multiple cardiac arrests she suffered severe anoxic brain injury, in addition to her traumatic brain injury from the MVA.

RJ had several surgical procedures done, including two surgeries of the spine, operations to her right forearm, wrist and right femur. Her belly had to be opened up to treat internal injuries. She developed renal failure requiring dialysis. She was ventilated through an endotracheal tube via orotracheal intubation, on a spontaneous mode of breathing on the ventilator. She was being treated for a urinary tract infection.

In addition to all the injuries, the most significant was RJ's traumatic brain injury and hypoxic ischemic encephalopathy. RJ had not been observed to move her arms or legs for the duration of her ICU stay. She did not consistently respond to visual confrontation. She did not obey commands when asked to open, close, or blink her eyes, nor when she was asked to stick out her tongue or shake her head.

According to the medical opinions of at least 3 separate intensivists, including a neuro-intensivist and neurosurgeon, RJ was in a persistent vegetative state. She retained some basic reflexes, but she did not perceive or interact with her environment. RJ's care team was unanimous in their opinion that she would not experience any meaningful recovery of consciousness or function.

Despite the best efforts by her care team, RJ's condition was not improving, but was rather deteriorating. Her skin was breaking down, her organs were gradually shutting down and she was in discomfort from multiple sources (broken bones, wounds) and required sedation.

Her brain injuries were considered irreversible and, given the severity of her brain injury, the clinical team was of the opinion that any meaningful survival was not possible for RJ. The team believed that keeping RJ on life support was prolonging her dying process and her suffering, with no possibility of benefit. They recommended withdrawal of life sustaining treatments and

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providing comfort care measures, including palliative medication, nursing care and support for the family.

MJ, RJ’s husband and SDM, did not agree with this recommended care plan. Instead, he wanted to continue with intensive care until she died.

Dr. Sharma brought the Form G application to review if MJ had complied with the principles of substitute decision-making under the HCCA.

THE LAW

General

At a hearing for a Form G application, the onus is on the health practitioner to satisfy the Board that the SDM in question has not complied with the principles of substitute decision-making under the HCCA. For a deemed Form A (treatment) application the onus is on the capacity evaluator to prove that, on the day of the hearing, the person is incapable of making treatment decisions according to the test set out in the HCCA. The standard of proof in all cases is proof on a balance of probabilities. The Board must be satisfied on the basis of cogent and compelling evidence that the health practitioner’s onus has been discharged. There is no onus whatsoever on the existing SDM for the Form G Application or the person who is the subject of the deemed Form A Application. The Board must consider all evidence properly before it. Hearsay evidence may be accepted and considered, but it must be carefully weighed.

Capacity

Under the *HCCA* s. 4(2), a person is presumed to be capable to consent to treatment and the onus to establish otherwise rests with the evaluator. The test for capacity to consent to treatment is set forth in s. 4(1) of the *HCCA*, which states:

> ***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.*

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In other words, a person will be found incapable of consenting if that person fails either part of the two-part test set out in s. 4(1).

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Section 37.1 of the *HCCA* provides for a "deemed application" to review capacity with respect to treatment, whenever a Form G application is brought under s. 37:

> ***37.1 Deemed application concerning capacity.*** *– 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.*

<u>Principles of Substitute Decision-making</u>

Section 21 of the *HCCA* sets out the principles for giving or refusing substitute consent on behalf of an incapable person:

> ***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 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:*

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> *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.*

Section 37 of the *HCCA* allows a health practitioner to apply to the Board if he or she believes that a SDM is not adhering to the principles contained in s. 21:

> ***37(1) Application to determine compliance with s. 21. –*** *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.*
>
> ***(2) Parties.*** *– 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.*
>
> ***(3) Power of Board.*** *– In determining whether the substitute decision-maker complied with section 21, the Board may substitute its opinion for that of the substitute decision-maker.*
>
> ***(4) Directions. –*** *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.*
>
> ***(5) Time for compliance. –*** *The Board shall specify the time within which its directions must be complied with.*
>
> ***(6) Deemed not authorized.*** *– 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).*

> ***37.1 Deemed application concerning capacity.** – 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.*

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ANALYSIS – DEEMED FORM A APPLICATION

Capacity to Consent to Treatment

Before considering whether the SDM complied with the principles of substitute decision making, the panel had to first be satisfied there was clear and compelling evidence that RJ lacked capacity to consent to her own treatment. The panel turned to the test for capacity set out in s. 4(1) of the *HCCA*.

Did the evidence establish that RJ was unable to understand information relevant to making decisions about treatment and/or unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision about treatment?

Dr. Sharma testified, and it was confirmed by the documentary evidence (Exhibit 1) that RJ was in a persistent vegetative state because of a traumatic brain injury suffered in a serious motor vehicle accident (MVA). Dr. Sharma said that RJ had suffered a traumatic injury because of the initial hit in the MVA. He said the neurons broke apart due to the impact and when brain cells break, they can't regenerate. The damage was permanent. On top of the traumatic brain injury RJ had suffered anoxic brain injury due to the cardiac arrest. Dr. Sharma gave evidence that the degree of brain damage was very severe and affected areas that control cognitive functioning. Dr. Sharma said RJ was unable to communicate with her external environment and would never be able to do so.

Dr. Sharma's evidence was corroborated by the opinion of Dr. Paul Engels contained in his consultation report dated December 29, 2023 (Exhibit 1, page 12), wherein Dr. Engels had noted that RJ's neurological exam was consistent with that of a catastrophic brain injury. He had noted that RJ did not consistently respond to visual confrontation. She did not respond to any

commands like open, close, or blink eyes, or stick out her tongue or shake her head. His opinion of her prognosis was that she would never regain interaction with her environment and would progress to a formal vegetative state without chance of recovery if she was continued on life-support.

Dr. Sharma gave evidence that because of her catastrophic brain injury, RJ was unable to understand or process any information, including information relevant to making a decision about the proposed treatment. Consequently, she was unable to apply the information to her circumstances and therefore unable to appreciate the reasonably foreseeable consequences of a treatment decision.

All the NTICU medical experts were consistent in their opinions that RJ was unable to interact with the external environment. The evidence was clear, cogent, and compelling that RJ was unable to understand any information.

I therefore found as a fact that RJ was unable to cognitively process any information about the proposed treatment. As such, she 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. RJ was therefore incapable of consenting to the proposed treatment.

ANALYSIS –FORM G APPLICATION

A Form G application under the HCCA enables the Board to determine whether a SDM is acting in accordance with the principles of giving or refusing consent enshrined in s. 21. If the Board determines that the SDM has not followed such principles, it may substitute its own opinion for that of the SDM and direct the SDM to comply with s. 21. Here follows an analysis of whether MJ's refusal to consent to Dr. Sharma's proposed treatment plan was in compliance with the principles of substitute decision-making, which consist of two branches: first, whether RJ expressed a prior capable wish applicable to the circumstances (which would be a paramount consideration), and second, what kind of decision would be in RJ's best interests.

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It is important to underscore a fundamental difference between a capable person making treatment decisions on his or her own behalf, and a SDM making decisions on behalf of an incapable person. In the first instance, it is accepted principle that a capable person has the right to make foolish or selfish decisions – this is an inviolable attribute of individual liberty and personal autonomy protected by our laws. Nobody has the right to interfere with a capable person's treatment decisions, whether or not those decisions are judged by others to be in the person's best interests. In other words, a capable person is the final arbiter of his or her own best interests.

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In contrast, a SDM does not have the right to make unwise decisions on behalf of an incapable person; a SDM must make decisions in accordance with the principles of consent set out in the HCCA, i.e. the incapable person's prior capable wish or best interests. This removes a fair amount of discretion on the part of the SDM to judge what is best for the incapable person. The SDM is not the final arbiter of the incapable person's best interests. If the SDM strays from the HCCA principles, the Board is empowered to intervene and compel the SDM to comply with those principles, in accordance with Board's perception of the person's best interests, as revealed by the evidence.

Prior Capable Wish

Did MJ act in accordance with a wish expressed by RJ while she was capable that was applicable to the circumstances?

There was no evidence that RJ had expressed prior capable wishes that were applicable to her current circumstances and the proposed treatment. AJ in his testimony acknowledged that his mother never mentioned a specific wish for a situation like this.

I therefore found that there was no prior capable wish applicable to RJ's circumstances.

MJ was therefore required to apply section 21(2) of the HCCA when making decisions about RJ's treatment. My analysis accordingly turned to the consideration of RJ's best interests according to the principles set out in the HCCA.

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Best Interests

In the absence of a clearly expressed prior capable wish applicable to the circumstances, the analysis turns to the incapable person's best interests. The factors to consider in determining an incapable person's best interests are set out in HCCA s. 21(2). These factors are weighed according to the strength of the evidence; the legislation does not establish a hierarchy among the various factors. The role of the SDM is to weigh all the factors and make a decision that is objectively in the best interests of the incapable person, not a decision based on what the SDM wants for the incapable person. This interpretation was noted by the Supreme Court's majority decision in *Cuthbertson v. Rasouli* 2013 SCC 53 (CanLii):

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

The role of the Board was to determine whether MJ's decision to refuse consent to the proposed treatment was in RJ's best interests, according to the following factors.

What were the values and beliefs that MJ knew RJ held while she was capable and believed RJ would still act on if capable?

There was no clear evidence about RJ's values and beliefs relevant to her care and the current treatment decision. The family was interpreting her values and beliefs based on her religious beliefs and past experiences. As per the Ethics Consultation report (Exhibit 1, page 3) the family had reported to the care team that RJ was a devoted mother and wife who sacrificed her own comfort for the well-being of her family. While the family understood her current condition, they

believed that RJ would want to live as long as possible in order to be with her family. According to the family, RJ was a devout practicing Orthodox Christian, and her religious belief was that life was precious and something to be grateful for. They believed that according to their religion suffering was an experience that brought people closer to God. MJ had told the care team that deciding to withdraw treatment would be going against their religious belief.

It was noted in the Ethics Consultation report as follows: *"The SDM and family share an understanding that she may die soon but explain that withdrawing treatment would be the same as "playing God" and "killing the patient" They do not want the responsibility of making this decision."*

The family had also reported a situation where RJ's sister was admitted to the ICU in Serbia, and RJ had fought for her sister to be kept alive by all means. Based on her perceived religious beliefs and how she handled her sister's experience in the ICU, the family believed that RJ would want to continue to receive treatment as long as it kept her alive, even if it caused her discomfort.

AJ testified at the hearing. He said his mother never mentioned a specific wish for a situation like this. He said the family was Orthodox Christians and his mother attended church and followed lent. He said their religion supported life, and it would be against their religion to give consent to remove life support. He said based on her religious belief, he believed that RJ would have wanted to live. He further said that pain and suffering, if she was experiencing it, would be considered purification of soul according to their religious beliefs. He also said that his mother had expressed to him that she wanted to see her granddaughter grow up and get married.

AJ also talked about the incident concerning RJ's sister, where RJ reportedly advocated for her getting all the treatment possible. Based on this incident also AJ said he believed that his mother would have wanted to live. I was not persuaded that RJ's actions in the case of her sister were in any way a reflection of her values and beliefs. No details were available about this incident. All AJ said was that his aunt had accidentally consumed poison in Serbia, and that RJ ensured that her sister got all the treatment, although the sister eventually died. There was no evidence about RJ's sister's condition and what decisions were required to be made by her family. Had there

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been any evidence that RJ's sister was in a similar situation as RJ (on life support with absolutely no chance of recovery) and RJ had advocated for continuation of her sister's life sustaining treatment, that would have been more reflective of RJ's values and beliefs about end-of-life situations. In the absence of such evidence, I found the incident was not reflective of RJ's values and beliefs, in particular of her values and beliefs that would be relevant to her current medical condition.

In her closing submissions Ms. Hargreaves submitted that there was no hierarchy to the factors set out in section 21(2) of the HCCA. She said all factors had to be considered equally in determining the best interests of the incapable person. She said the values and beliefs of the incapable person did not sit at a higher level. She further submitted that MJ was placing disproportionate emphasis on the values and beliefs of RJ without properly considering her medical condition, which she said weighed more heavily in favour of the proposed treatment.

Based on the evidence presented, I was unable to draw any conclusions about RJ's values and beliefs. The evidence I had was that RJ being a devout Christian who would have wanted to live based on her religious beliefs. However, the question was not simply whether RJ would have wanted to live, the question was whether she would have wanted to live in a vegetative state on life support in face of overwhelming evidence that there was no chance of recovery and the life sustaining treatment was not going to be of any benefit, and that prolonging life was causing pain and suffering. AJ's statement that his mother never mentioned a specific wish for a situation like this, suggested that the family never discussed end-of-life situations. Therefore, it could not be concluded that RJ would have strictly adhered to the religious belief to preserve life no matter what the circumstance.

I found that MJ's decision not to consent to the proposed treatment had more to do with his own belief system than with RJ's values and beliefs. I found MJ struggled with the idea of consenting to removal of life support. In his testimony he said, *"I certainly can't accept taking her off life support – it doesn't accord with my religious belief and that of my family"*.

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Even if I accepted the evidence that based on her religious beliefs, RJ would have wanted to live no matter what her condition, this factor was just one factor to be considered in determining her best interests. It had to be weighed against the medical considerations, which in the instant case warranted significant weight given the complexities and seriousness of injuries.

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The Supreme Court of Canada noted in Rasouli at paragraph 96:

> *"As I see it, this review of s. 21(2) reveals that although a patient's beliefs and prior expressed wishes are mandatory considerations, there is no doubt that the medical implications of a proposed treatment will bear significant weight in the analysis."*

I agreed with Ms. Hargreaves' submissions that MJ was placing disproportionate emphasis on values and beliefs and not properly considering the medical factors which he was required to do in order to make a treatment decision in RJ's best interests. While I completely understood MJ's and the rest of family's desire to continue life sustaining treatment for RJ believing that RJ would recover and be able to interact with them again, such belief was completely unrealistic given the overwhelming medical evidence to the contrary, all of which had been explained to MJ and AJ multiple times by multiple different physicians attending to the care of RJ.

I found that in RJ's case the medical implications deserved significant weight, and for the reasons set out below, I found that the medical evidence weighed in favour of the proposed treatment.

What were the wishes expressed by RJ with respect to the proposed treatment plan that were not prior capable wishes applicable to the circumstances?

There was no evidence about RJ's wishes expressed relevant to this criterion of best interests.

Was Dr. Sharma's proposed treatment likely to improve RJ's condition or well-being? Was the proposed treatment likely to prevent RJ's condition or well-being from deteriorating? Was the proposed treatment likely to reduce the extent to which, or rate at which, RJ's condition or well-being would deteriorate? Without the proposed treatment was RJ's condition or well-being likely to improve, remain the same or deteriorate?

Dr. Sharma gave evidence that RJ was in a persistent vegetative state due to extensive and irreversible brain damage. He said RJ would never achieve a higher functioning beyond a vegetative state and would not be able to interact with her external environment. He said RJ did not and would not have the cognitive ability to be aware of the external environment. He said his opinion was based on clinical examination, MRI scans that demonstrated the nature of injures, EEG (a test that measures electrical activity in the brain) and extensive clinical experience of the team involved in her care.

Dr. Sharma said, despite best efforts from the care team to improve RJ's health, her condition was not improving, and her status continued to worsen. She was in discomfort from multiple sources, like broken bones and multiple wounds. The prognosis for RJ was very poor. Dr. Sharma said the natural course identified for RJ was a predictable trajectory towards death. The clinical team believed that intensive care was prolonging her dying process and her suffering, with no possibility of benefit.

Dr. Sharma's evidence was corroborated by the evidence of other NTICU physicians, including a detailed formal second opinion of Dr. Paul Engels dated December 29, 2023 (Exhibit 1, page 12), Dr. Skitch's consultation dated December 26, 2023 (Exhibit 1, page 10), and Dr. Sne's consultation dated January 6, 2024 (Exhibit 1, page 15)

Dr. Sharma said, given RJ's status, the care team had recommended withdrawing life- sustaining treatments and providing comfort care measures, including palliative medication, nursing care and support for the family. He said the care team believed continuing life-sustaining treatment was not the indicated standard of care as it would not improve RJ's underlying medical condition or prevent her condition from worsening and would only prolong her suffering and dying.

Dr. Sharma said artificially prolonging her life at the cost of her dignity and comfort was affecting RJ's well-being. He said all medical interventions to keep her alive were very uncomfortable and would not influence her underlying brain injury.

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Dr. Sharma said the care team had observed that RJ experienced discomfort in response to nursing care and stimuli thus requiring sedation. He said he had demonstrated to the family how RJ was experiencing discomfort (Exhibit 1, page 11 – consultation note of Dr. Sharma dated December 29, 2023). He said in addition to physical suffering, the team was concerned about other forms of suffering, such as loss of dignity, quality of life and the capacity to interact with her family, which was the most important thing in RJ's life. The team had no expectation of recovery and was of the opinion that RJ was certain to die in the ICU. As such the team proposed to shift the standard of care to comfort-focused care and withdrawal of life sustaining treatments in order to offer RJ a peaceful and dignified dying process.

AJ, on behalf of MJ, asked questions of Dr. Sharma. He asked Dr. Sharma if was fully convinced that it was not too early to give up on RJ. Dr. Sharma said that he was fully convinced that there was no possibility of any improvement. He said the damage in the arrears of brain that RJ had, was irreversible. He said he and other members of the care team were *"very confident"* in their assessment, and they had no doubt that the damage was irreversible, and RJ would not recover.

When asked if had experience with patients who had similar injuries and were given a chance, Dr. Sharma said he had seen patients who were kept alive longer but never seen anyone recover. He said literature from countries where life support was not withdrawn suggested that prolonging life did not result in any improvement.

MJ in his closing submissions said that Dr. Sharma was drawing conclusions based on medical evidence. He said, *"medical evidence was not going to tell us how the brain would behave unless RJ was given more time"*. The family was hopeful that continuing life sustaining treatment would give RJ a chance of improvement. While the family's position was understandable, this matter had to be decided based on objective medical evidence. Doing otherwise would be simply speculative. Continuing RJ on life support with the hope that one day some miracle would happen, and she would recover from her catastrophic brain injury was wishful thinking to say the least.

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The medical evidence overwhelmingly suggested that RJ had no chance of recovery and that she was in discomfort and the intrusive measures were indignity to her body. Besides her neurological condition, RJ had multiple medical complications that required interventions but couldn't be done because of the poor clinical state. The evidence was clear that if RJ was kept alive on life support, she would eventually die because of her multiple medical complications. Dr. Sharma said the death in such circumstances would be much more painful.

Dr. Sharma said continuing life-sustaining treatment would not improve her condition or well-being, it would not prevent her condition or well-being from deteriorating or reduce her rate of deterioration. He said continuing life-sustaining therapy did not meet the standard of care and was not in RJ's best interest. The entire care team was unanimous in their opinion that continuing life-sustaining treatment was causing more harm than benefit to RJ.

I accepted Dr. Sharma's evidence that continuing with life sustaining treatment was not likely to improve RJ's condition or prevent it from deteriorating or reduce the rate of deterioration. I found, based on the overall evidence, that there were no benefits to RJ in continuing the life sustaining interventions.

Did the benefit RJ was expected to obtain from the proposed treatment outweigh the risk of harm to her?

Dr. Sharma said the proposed treatment would alleviate RJ's suffering from the injury that she would never recover from. He said implementing the proposed treatment would result in RJ passing away without suffering. He said even with continued life sustaining treatment, RJ would still die, albeit in a much more painful way. I accepted Dr. Sharma's evidence that the benefits of the proposed treatment outweighed the risks of harm and therefore found in favour of proposed treatment.

Was there a less restrictive or less intrusive treatment that would be as beneficial to RJ as the proposed treatment?

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Dr. Sharma said there was no less intrusive way to prolong RJ's life. He said if the team tried to prolong her life by keeping the life sustaining measure in place, it would cause suffering to RJ with no corresponding benefit.

I accepted Dr. Sharma's professional opinion that the proposed treatment was the least restrictive or least intrusive treatment that would be beneficial to RJ.

<u>Conclusion Regarding Best Interests</u>

In summary, I carefully weighed the above factors in deciding that MJ had made treatment decisions not in accordance with RJ's best interests.

RESULT

For the foregoing reasons, I found that RJ was not capable of consenting to the proposed treatment. I also held that MJ had not complied with the principles for giving or refusing consent set out in the HCCA, and ordered MJ to consent to the proposed treatment plan by January 22, 2024.

Dated: January 29, 2024

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Shashi Raina, presiding Member

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