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

16-0402-01
16-0402-02

2016 CanLII 46386 (ON CCB)

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

AND IN THE MATTER OF
SL
A patient at the
OTTAWA HOSPITAL – CIVIC CAMPUS
OTTAWA, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

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

DATES OF THE HEARING, DECISIONS AND REASONS

The hearing took place at the Hospital on May 6, 2016. The Board released its Decisions later that day. On May 10, 2016 counsel for Dr. DH requested written Reasons for Decision (contained in this document), which were released on May 16, 2016.

LEGISLATION CONSIDERED

The *Health Care Consent Act*, (HCCA)

PARTIES

SL, the incapable person.
DH, the SDM for SL.
Dr. Gianni D'Egidio, the health practitioner who proposed the treatment.

SL and DH did not attend the hearing. Dr. D'Egidio attended the hearing.

BOARD MEMBER

Mr. Paul DeVillers, senior lawyer - presiding member.

APPEARANCES

SL was represented at the hearing by counsel, Mr. Peter J. Brown
Dr. D'Egidio, represented himself at the hearing.
DH was represented at the hearing by counsel, Ms. Hana Ahmed Yousuf.

HEARING PREVIOUSLY ADJOURNED

The hearing had been previously set to be heard on May 4, 2016. On that date, counsel for DH informed the Board that she had only been retained that morning and requested an adjournment. Dr. D'Egidio emphasized that there was urgency in having this matter heard from the medical perspective. Counsel for DH requested a longer adjournment because SL's son-in-law needed to attend as a witness and there was a conflict with his work schedule. The matter was adjourned to May 6, 2016 at 9:00 a.m. with the agreement that the Board would hear from the SL's son-in-law at 10:00 a.m. to accommodate his work schedule. Notwithstanding this accommodation the

2016 CanLII 46386 (ON CCB)

witness did not appear at the hearing and left no information with DH's counsel. He could not be reached by telephone at the usual numbers.

Counsel for DH told the Board at 9:00 a.m. that she could not reach DH or any of SL's family. The hearing commenced at 10:00 a.m. After the break for lunch DH's counsel informed the Board that DH was in the hospital but chose not to attend the hearing. Counsel for DH was able to confirm her instructions and continued to represent DH at the hearing.

2016 CanLII 46386 (ON CCB)

THE EVIDENCE

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

1) Dr. D'Egidio
2) Dr. Catherine Gray

There were 20 Exhibits:

1) Form G dated April 26, 2016
2) CCB Summary dated April 28, 2016
3) Family Meeting Summary dated April 25, 2016
4) Progress Note from Family Meeting (3 pages) dated February 4, 2016
5) Note from Dr. Millington (Intensive Care) dated February 13, 2016
6) Note from Dr. Pagliarello (Intensive Care) dated February 10, 2016
7) Note from Dr. Po (Intensive Care) dated April 22, 2016
8) Note from Dr. Rosenburg (Intensive Care) dated February 11, 2016
9) Emergency Report (Nursing Notes 2 pages) dated January 14, 2016
10) Intensive Care Notes (January 15 to March 16, 2016 13 pages)
11) Staff Notes from Dr. Gray dated February 10, 2016
12) I.C.U. Notes dated March 14, 2016
13) Social Work Notes and Dr. D'Egidio Note (2 pages) date April 29, 2016
14) Physio Therapy Note dated April 23, 2016
15) Dr. D'Egidio Note of encounter with SL's daughter dated April 28, 2016
16) Ethics Consultation Record dated April 27, 2016
17) Clinical Nutrition Report (2 pages) dated April 15, 2016

18) Family Meeting Note (Dr. D'Egidio 2pages) dated April 22, 2016
19) Intensive Care Admission Note (4 pages) dated January 14, 2016
20) Photo ulcer wound dated May 3, 2016

2016 CanLII 46386 (ON CCB)

INTRODUCTION

SL was a 92-year-old man who had been in hospital since January 14, 2016. He was admitted to hospital with massive bleeding from his stomach. He was treated in intensive care and after treatment he was transferred to the ward. On February13, 2016 he was readmitted to intensive care with respiratory failure and placed on life support. After a long and difficult liberation from life support he was transferred to the ward again. However, he was left in a physically and cognitively debilitated state.

THE LAW

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

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

Capacity to Consent to Treatment

Section 37.1 of the *HCCA* provides that:

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

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

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

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

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

Compliance with the principles of substitute decision-making

Section 37. of the *HCCA* provides that:

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

37. (2) The parties to the application are:

1. *The health practitioner who proposed the treatment.*
2. *The incapable person.*
3. *The substitute decision-maker.*
4. *Any other person whom the Board specifies.*

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

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

37. (5) The Board shall specify the time within which its directions must be complied with.

2016 CanLII 46386 (ON CCB)

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

37. (6.1) If, under subsection 6, the substitute decision-maker is deemed not to meet the requirements of subsection 20 (2), any subsequent substitute decision-maker shall, subject to (6.2) and (6.3), comply with the directions given by the Board on the application within the time specified by the Board.

37. (6.2) If a subsequent substitute decision-maker knows of a wish expressed by the incapable person with respect to the treatment, the substitute decision-maker may, with leave of the Board apply to the Board for directions under section 35.

37. (6.3) Directions given by the Board under section 35 on a subsequent decision-maker's application brought with leave under subsection (6.2) prevail over inconsistent directions under subsection (4) to the extent of the inconsistency.

37. (7) If the substitute decision-maker who is given directions is the Public Guardian and Trustee, he or she is required to comply with the directions, and subsection (6) does not apply to him or her.

Section 21 of the HCCA provides that:

21. (1) A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles:

1. *If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.*
2. *If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or it is impossible to comply with the wish, the person shall act in the incapable person's best interest.*

(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;

(b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and

(c) the following factors:

2016 CanLII 46386 (ON CCB)

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

2016 CanLII 46386 (ON CCB)

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

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

Section 5 of the HCCA provides that:

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

Cases reviewed and considered

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

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

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

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

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

Cuthbertson v. Rasouli, 2013 SCC 53.
Janzen v Janzen (2002), 44 E.T.R. (2d) 217 (S.C.J.)
DD (Re), 2013 CanL11 18799 (ON CCB)
SS (Re), 2012 CanL11 85612 (ON CCB)

2016 CanLII 46386 (ON CCB)

VISIT TO BEDSIDE PRIOR TO COMMENCEMENT OF HEARING

Prior to the commencement of the hearing the Board visited SL in his room in the company of counsel and a Cantonese speaking interpreter.

Upon arrival the Board found SL asleep. He had a nasogastric feeding tube (NG tube). He was breathing on his own without assistance but appeared emaciated.

SL awoke easily when spoken to by the interpreter and appeared to provide brief relevant responses to the interpreter in his native language of Cantonese.

When asked if he knew there was a hearing to be held regarding his treatment SL responded: "keep me safe, rescue me". When asked how he felt SL replied that he was "in pain but he wanted to live". SL also told the Board that he was not religious. When asked specifically about the Buddhist religion SL said his wife practiced the Buddhist religion but he never practiced the Buddhist religion, not even as a young man. When asked about his values and beliefs SL replied that he believed in "the natural circle". When asked if he had ever had any discussions about end of life he replied "no".

ANALYSIS

Capacity to Consent to Treatment

What treatment was being proposed?

Dr. D'Egidio explained in his Summary Exhibit 2 that "In my and many other health care providers' opinion SL is dying and we are proposing palliative care. We have exhausted all medical treatment (aggressive and routine) available to us. Further aggressive care would pose more risk than benefit."

2016 CanLII 46386 (ON CCB)

Did the evidence establish that SL was unable to understand the information relevant to making a decision about the treatment in question and unable to appreciate the reasonably foreseeable consequences of the current and proposed treatment?

In his Summary Exhibit 2 and in his oral evidence at the hearing Dr. D'Egidio told the Board that he had assessed SL on April 25, 2016 and made the finding that he was incapable of consenting to his medical treatment. Dr. D'Egidio also noted in Exhibit 2 that SL had been incapable to consent to treatment since admission when he wrote: "Officially (incapable) April 25th but truly Jan. 14th as he was incapacitated by acute illness during the majority of his admission".

In his Clinical Note Exhibit 3 Dr. D'Egidio referred to his April 25th assessment as follow:

> First, it is very clear to me and SL's family that he is not capable to make his own medical decisions. Based on my assessment today he has an element of dementia which is what I have suspected. He does not know the year, date, or his location (he answers Canada). When asked to give me a sense of his medical condition he simply responds that he is old. Many times the translator explained that he is not making sense and talking about the past in particular communist China He does not recall any of the events last night when he was refusing care (see nursing notes). When asked about his nutrition he states he eats three full meals a day, his RN states that the maximum he took in was 20% of his meals at best. I waited until today to assess his competence because he was far too ill in the past and had too many confounding factors affecting his cognition (sepsis, ARF, and hypernatremia), these conditions have improved but will certainly happen again.

In his Summary Exhibit 2 Dr. D'Egidio indicated that SL's condition was terminal:

> They (SL's family) do not understand that his condition is irreversible and terminal and that we have tried everything available such as life support via a ventilator, antibiotics, artificial feeding and despite this his overall health continues to decline. They believe that further feeding, admission to ICU, and medication will make him regain his strength and cognitive function when only the opposite is true.

In his RACE/Intensive Care Consultation Exhibit 7, given by Dr. Po for the purpose of providing a second opinion for treatment planning, SL's cognitive dysfunction is corroborated when Dr. Po states the following:

> **Impression and Opinion:** SL is a gentlemen of advanced age who just barely survived a complicated ICU admission. There is a possibility of an underlying occult malignancy and suffers from multiple organ dysfunctions namely bone marrow, renal and cognitive. His greatest challenge is now malnutrition and fluid intake which may be reflective of global cognitive dysfunction or depression. He will continue to be at risk of terminal infection in his debilitated and malnourished state.

2016 CanLII 46386 (ON CCB)

The Board noted that there were several references that interpretation was provided for SL when he was being interviewed by various medical professionals. Dr. D'Egidio was asked during his evidence if language was an issue in SL not understanding the information about treatment and he provided the opinion that language played no part in SL's inability to understand the information. This opinion was supported by the fact that SL had family members available throughout his admission to assist if there were any misunderstanding that may have been caused by language difficulties.

Counsel for SL stated that he could not communicate with SL and therefore could not get any instructions from him about his capacity and consequently could not make any submissions on the issue of SL's capacity to consent to treatment.

Counsel for DH questioned Dr. D'Egidio why there had not been any detailed cognition testing and psychiatric department assessments performed. Dr. D'Egidio answered that the cognition tests were not deemed necessary given SL's level of consciousness and that his acute illness would confound the tests. He also told the Board that psychiatric consultations are rarely done in cases of dementia and that a psychiatric assessment would also have been confounded by SL's delirium and acute medical condition.

Counsel for DH submitted that Dr. Gray's report of the family meeting on February 10, 2016 Exhibit 11 left ambiguity about SL's ability to understand the information. The Board found Dr. D'Egidio's evidence based on his capacity assessment of April 25, 2016 as set out in his

Summary Exhibit 2 clear and cogent and that SL's dementia and cognitive dysfunction was well corroborated on the charts by several other physicians.

The Board noted the hearsay evidence that DH and SL's family were not challenging the finding that SL was incapable to consent to his medical treatment. The hearsay evidence provided by Dr. D'Egidio on this point was supported by the fact that there was no contradictory evidence provided at the hearing by DH or the family members.

The Board found that the evidence established that SL was not able to understand the information relevant to making a decision about the treatment in question and was unable to appreciate the foreseeable consequences of the current and proposed treatment. The Board therefore found SL was not capable to consent to treatment.

Compliance with principles of substitute decision-making

In his oral evidence and the Exhibits filed Dr. D'Egidio told the Board that SL had been admitted to the hospital on January 14, 2016 with a bleeding stomach. This is described in Exhibit 19 the Intensive Care / RACE Consultation where it states:

> **History of Presenting Illness:**
> Patient has been unwell, weak and lethargic for 3 months. These symptoms have been worsening since Christmas as per family with minimal PO intake and weight loss. Patient has had persistent diarrhea with black stools which has been more severe the past few days. Earlier today he was feeling too weak and dizzy to go to the bathroom on his own so his wife helped him to the bathroom. He was then found by his wife to have decreased LOC while on the toilet with a large volume of black diarrhea on the floor. He then had an episode of bloody emesis and became unresponsive. EMS was called and patient was brought to hospital. In hospital he was found to have temperature of 31.4 C, Hgb of 46 and to be acidotic with pH of 6.95.

Exhibit 7 as was previously noted is an Intensive Care/ RACE Consultation note by Dr. Po which provides a summary of the SL's treatment in the hospital:

> **HPI: (please refer to Medicine admission note March 18, 2016 for Course in Hospital):**
>
> Based of the progress notes for the last two weeks.

2016 CanLII 46386 (ON CCB)

-Admitted to Hospital Jan 14, 2016 with UGI bleed into ICU, recovered and transferred to ward shortly after
-Re-admitted to ICU Feb 13 with pneumonia. Complicated with pleural effusions, fluid overload, CHF, AKI, deconditioning and prolonged ventilator wean
-Transferred out of ICU on Mar 21st, with tracheostomy. Decannulated Mar 30th
-Medical admission complicated with on going poor oral intake requiring supplemental NG feeds plus recurrent febrile episode, bacteremias, gouts, hypernatremia
-Improved swallowing noted by SLP on Apr 6th. But patient refusing oral intake, ongoing NG supplementation
-Lytic chest lesions with hypergammaglobulinemia. No further workup
-New gram negative bacteremia Apr 22, 2016: being treated with PiP-Tazo
-Patient is Cantonese speaking, able to interact in a limited fashion with family verbally, spends majority of time in wheel chair, moves all four limbs, no neurological deficits. Has truncal stability. Becomes uncooperative when family away. Pulls at IV, monitors, NG tubes
-Able to swallow. Has not aspirated but refuses to eat, refuses po intake. Currently being fed by family
-Persistent normocytic anemia, hypernatremia, renal insufficiency, malnutrition. Hypoalbuminemia

Dr. D'Egidio in his Summary Exhibit 2 summarized the medical evidence a follows:

1. He (SL) has advanced dementia/cognitive impairment that cause him to refuse to eat adequately – we have been artificially feeding which requires restraints and provides discomfort. He is not responding to this treatment and this is not compatible with life.

2. He is unable to absorb nutrition despite 8 weeks of artificial therapy – this is not compatible with life.

3. Due to his nutritional status, weakness, and possible underlying cancer his immune system is weakened and he has recurrent life threatening infections treated with 10 courses of 9 antibiotics and this will continue to happen. Any further care such as CPR, ECU, life support would only cause more harm through more physical and cognitive decline, discomfort, and merely delay the dying process. His current infections are not compatible with life.

4. Due to his nutritional status and gut failure/bleeding he has received 23 blood transfusions and is in a transfusion dependent state – this is not compatible with life.

5. He is not developing pressure ulcers from his lack of mobility, poor

2016 CanLII 46386 (ON CCB)

> nutritional status, and poor immune system, these will worsen despite our best care.

2016 CanLII 46386 (ON CCB)

Did the evidence establish that there existed a Prior Capable Wish?

The Board found that the evidence did not establish that there existed a prior capable wish.

There was no evidence of a Power of Attorney or Living Will nor was there any evidence that there had been any discussions between SL and DH or any of his family members dealing with the eventuality of him being in a life support situation.

Best Interests

Having found that no prior capable wish existed in the Board then needed to decide, as provided in subsection 21 (1) (2) of the HCCA, whether DH as substitute decision maker was acting in SL's best interests.

The evidence at the hearing revealed that a disagreement existed between the family member substitute decision maker and the health practitioner concerning what treatment was in SL's best interests This is what the provisions of the *HCCA* were designed to resolve. The Board acknowledged its role was as described in *M(A) v Benes:*

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

Values and Beliefs

The only evidence before the Board concerning SL's values and beliefs was what he told the Board when the Board attended upon him in his room. That was that he was not a religious person and that he believed in the "natural circle" of life. Dr. D'Egidio responded to this by telling the Board that accepting his recommended palliative treatment plan was not inconsistent with this belief. He stated that in his medical opinion SL, having had all possible treatment, had completed the circle of life. Dr. D'Egidio believed that with palliative treatment SL could die pain free and with dignity.

Since DH and the rest of the family did not attend the hearing there was no opportunity to determine if SL had ever expressed any other relevant values and beliefs while still capable.

The Board did have Dr. D'Egidio's evidence that DH's and the family's reasons for not consenting to his palliative care treatment plan was their mistaken understanding of the medical situation. They believed that SL's condition would improve with further aggressive measures which would strengthen him.

There was no evidence before the Board to suggest that DH was withholding consent to the palliative care treatment plan based on SL's values and beliefs.

SL told the Board that he was in pain but he wished to live. Dr. D'Egidio told the Board that adopting his palliative care plan did not mean that SL would not live as long as under the present aggressive treatment plan. He said that the aggressive treatment interventions could, in fact in addition to being uncomfortable and painful, accelerated death because of SL's already compromised condition. He made reference to a New England Journal of Medicine study done with cancer patients. He noted that this study revealed that patients transferred to palliative care live longer and better that those who remain on aggressive treatment.

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

2016 CanLII 46386 (ON CCB)

There was no evidence presented to the Board to suggest that SL had ever expressed any wishes regarding treatment. Therefore, the Board did not need to consider if there were prior expressed wishes that were not required to be followed under paragraph e of subsection (1) concerning his treatment decisions that needed to be taken into consideration in deciding what was in his best interests

2016 CanLII 46386 (ON CCB)

Well-being

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

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

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

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

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

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

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

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

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

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

Dr. D'Egidio's evidence was that SL had no chance of making a truly meaningful recovery. This evidence was corroborated by Dr. Po in Exhibit 7, by Dr. Rosenberg in Exhibit 8 and by Dr. Gray in her oral evidence. According to the evidence SL was in an extremely compromised medical condition. The evidence was that despite all of the efforts to feed SL he continued to lose weight, going from weighting 62 Kg to 39 Kg from February 19 to April 13. As pointed out in Dr. D'Egidio's evidence this poor nutritional state made SL susceptible to a compromised immune system and susceptible to life threatening infections.

Dr. D'Egidio proposed a plan of treatment that was focused on palliative care and would improve his well being. Although it could shorten his life, it would ensure that he was kept comfortable and would improve his quality of life and respect his dignity. Dr. D'Egidio told the Board that SL felt pain and was uncomfortable when the numerous life preserving procedures were being performed. This was supported by the evidence that SL needed to be restrained to stop him from pulling at his IV and feeding tube. The Board found that SL was in pain under the present aggressive plan of treatment. This was what SL told the Board.

2016 CanLII 46386 (ON CCB)

The Board considered it entirely understandable that DH and the family would advocate strongly on behalf of their loved one. However, the Board found that the desire to preserve SL's life did not allow for any consideration by DH and the family of the cogent and compelling medical evidence.

2016 CanLII 46386 (ON CCB)

If SL's medical condition could not be improved the Board could not see how his quality of life or well-being could be made to improve.

Expected benefits to treatment outweigh risk of harm

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

Also, as previously stated, Dr. D'Egidio's corroborated evidence was that SL`s medical condition could not be improved. He stated that many of the treatment measures which were being eliminated in his proposed treatment plan but were being advocated by DH and the family members would result in pain and discomfort to SL and possibly accelerate his death. Dr. D'Egidio evidence was that the benefit of dying pain free and with dignity outweighed the risk of harm. The Board agreed.

Less restrictive and less intrusive treatment

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

The Board considered this to be the crux of the disagreement between DH and the family members and Dr. D'Egidio and the medical team. Dr. D'Egidio's evidence was that there was no less restrictive and less intrusive treatment that could be beneficial to SL because there was no chance of his medical condition improving. He was therefore proposing a treatment plan that would no longer require aggressive interventions that were painful and cause discomfort and

were a risk to cause his death. His proposed treatment plan allowed SL to pass with respect and dignity.

Conclusion

The Board found that SL was not capable to consent to treatment.

The Board also found after considering all of the provisions of section 21 of the HCCA that on the balance of probabilities the treatment plan proposed by Dr. D'Egidio was in the best interests of SL. In the *Scardoni* case the court held that "best interests" should be interpreted broadly to include issues of dignity and quality of life. All of the medical evidence made plain that SL had a very poor quality of life and the situation would not improve. SL was subjected to daily indignities through invasive medical procedures without increasing the likelihood that his medical condition would improve.

RESULT

For the foregoing reasons, the Board found SL not capable with respect to treatment. The Board also found that DH had not complied with the principles of substitute decision making in the Act and directed her to consent to the treatment plan proposed by Dr. D'Egidio by May 10, 2016. The treatment plan included withdrawal of aggressive measures such as intensive care and artificial feeding and commencement of palliative care.

Dated: May 16, 2016

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Paul DeVillers

Senior Lawyer-Presiding Member

2016 CanLII 46386 (ON CCB)