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

HA 11 3583

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IN THE MATTER OF

The *Health Care Consent Act*

AND IN THE MATTER OF

S.R.

A PATIENT AT

TRILLIUM HEALTH CENTRE-MISSISSAUGA

MISSISSAUGA, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

S.R 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 for palliative care only. 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 substitute decision making. This application triggered a deemed application to determine whether S.R. was capable with respect to treatment.

DATE OF THE HEARING

November 18, 2011

PANEL MEMBERS

Mr. Philip Clay, Senior Lawyer Member
Dr. John Pellettier, Psychiatrist Member
Ms. Constance McKnight, Public Member

PARTIES

On the incapacity issue

S.R., the patient
Dr. N. Altman, attending physician when application brought (represented by Dr. A. Murthy, medical director of the intensive care unit (ICU)).

On the issue of compliance with the principles of decision making

S.R. the patient
Dr. N. Altman, attending physician when application brought (represented by Dr. A. Murthy medical director of the intensive care unit (ICU)).
Ms. T.R. the substitute decision maker

APPEARANCES

Mr. T. McIvor, for the patient
Mr. M. Handleman, for Dr. A. Murthy
T.R. acted on her 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

Janzen v. Janzen (2002), 44 E.T.R. 217 (S.C.J.)
Re Conry, (1985) NJ 321

EXHIBITS

1. Clinical Summary by Dr. N. Altman November 10, 2011
2. Excerpts from Hospital Notes October 29-November 9, 2011
3. Notes of Ashleigh Devane R.N. November 17, 2011

THE LAW

The Application was brought by Dr. Altman 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. Altman 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.

EVIDENCE ON THE TREATMENT CAPACITY ISSUE

S.R. was a 49 year old man who had lived at home with his mother prior to his hospitalization. He had many medical problems including seizures probably related to alcohol withdrawal after excessive use, esophagitis, celiac disease, a syndrome of inappropriate ADH secretion, chronic malnutrition and previous femoral fractures. He did not attend the hearing as he was in the intensive care unit on life support.

As noted above the SDM compliance issue raised a threshold issue of capacity. If a patient has capacity to make his own decisions then an SDM was not required and the SDM application

becomes moot. We ruled that we would hear evidence and receive submissions on the capacity issue first. If we found the patient to be incapable then the evidence heard could then applied to the compliance issue (together with other evidence) so that we could not be receiving the same evidence twice.

Dr. Murthy gave evidence. He was the medical director of the I.C.U. and had been S.R.'s attending physician the day before the hearing. He explained that the ICU physicians worked in rotations. He had been the attending physician for a few days in July. S.R. was admitted to the hospital on July 19 and onto ICU three days later. He recalled that while S.R. was more alert at that time he was still very confused on admission. He said the patient had never had what might be described as a normal level of consciousness during his entire stay in ICU. When he was the attending doctor in July he had an opportunity to meet with the family and to discuss with them the grave condition of S.R.

Dr. Murthy said that there were other ICU doctors who had cared for S.R. and Dr. Altman had been the physician who was caring for him when a family meeting was held on November 8. The next day Dr. Altman, supported by the rest of the ICU medical team, made the application that resulted in this deemed capacity hearing. Dr. Altman was not available to attend this hearing so Dr. Murthy was the one to attend and give evidence based upon Dr. Altaman's clinical summary and his own observations.

Dr. Murthy described briefly the patient's condition. He was totally bedridden and was connected to a ventilator by a tracheostomy. He was unable to speak. The doctor said it appeared that S.R. could recognize him. S.R. did open his eyes when he heard voices and he did nod his head. The patient did grimace when being moved or treated. This led the doctors and nurses to conclude that he felt pain. The doctor said that while there were intermittent nods and while his eyes usually opened when he heard sounds the team was unable to find any meaningful response to any questions or commands.

The first formal test of capacity was required on August 4 when a tracheotomy was required. S.R. was unable to respond to respond to questions and could not communicate. He was found to

be incapable and the consent of his mother was obtained as SDM. In response to cross-examination the doctor conceded that the incapacity finding was not charted at that time but it was also not questioned. It was clear from the evidence and their attendance at the hearing that S.R.'s mother and siblings had been very involved in his admission and subsequent care and had spoken with his doctors on a number of occasions..

There had been other intrusive procedures throughout the admission that had required consent and the treating physicians at no time felt that S.R. had regained capacity. Dr. Head, a psychiatrist, met with S.R. on November 14. He found him to be incapable with respect to a treatment at that time. An incapacity finding was formally noted on the patient's chart on the day of the hearing.

Mr. McIvor called no evidence on the incapacity issue.

DECISION ON THE TREATMENT CAPACITY ISSUE

The evidence was overwhelming that S.R. failed both branches of the treatment capacity test set out in the *H.C.C.A.*

S.R. was unable to understand the information relevant to a treatment decision or lack of decision. While there was some evidence that he could respond to some stimuli the evidence was clear over an extended period of time that he was completely unable to communicate even in the most rudimentary way. He could not even nod or blink his eyes in a way that demonstrated comprehension. The evidence also supported the conclusion that S.R. was unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

We agreed with Mr. McIvor that it would have been good practice for the physician making an incapacity finding to note that on the patient's chart at the time. However on the facts of this matter no issue was taken at the time when a substitute decision maker was sought as it was clearly apparent to the treatment team and to the family that S.R. lacked capacity. The notation of

that fact in November did not mean that the patient was capable until then, it simply meant that his lack of capacity had not been formally noted earlier.

EVIDENCE ON THE SDM COMPLIANCE ISSUE

Dr. Murthy provided the three exhibits referred to above and then gave oral evidence to clarify and explain the first two exhibits. Ms. Devane was the nurse for S.R. during the shift the day before the hearing and she gave oral evidence to support her notes which were in the third exhibit. The patient's mother who was his SDM chose not to give evidence or call witnesses.

Mr. Handleman took the doctor carefully through the clinical summary and all of the medical terms referred to therein were explained in plain language. The patient's day to day life, during his 112 days in the ICU, were starkly set out for the Board.

S.R. was admitted to the hospital on July 19. By July 22 he was intubated and transferred to the ICU where he had a tracheostomy hooked to a ventilator for breathing. He was fed by a tube in his stomach. The clinical summary refers to "a long complicated course in" ICU. Among other things he has had aspiration pneumonia, his fingers and toes were necrotic (blackened and dead) as a result of the high dose pressors during a period of septic shock. He had had many fevers caused by infections. He had ulcers all over his body which were treated with bandages. However over time the skin on his back and groin area had oozed so much liquid that it had torn away and could not be dressed. He required turning in his bed every two hours and his facial grimaces indicated that this caused him pain. He had frequent diarrhea which caused pain to his raw skin and presented a constant risk of further infection. Throughout the doctor's evidence it became apparent that many of the treatments for one problem created another problem.

The doctor said in his view it was very unlikely that S.R. would ever leave the ICU. To do so he would need to be off ventilation which he had not been since his admission. Even then the absolute best that could be hoped for would be a transfer to the complex continuing care ward of the hospital. The doctor thought it likely that even in that event S.R. would soon be back in ICU.

He said Dr. Altman had expressed his view to him that there was zero chance that S.R. could leave the ICU.

In response to the Board's questions the doctor said that if they continued to pursue the aggressive treatment of all medical conditions that S.R. would die in hospital. If they withdrew life support he would die much more quickly.

Ms. Devane's notes of her twelve hour shift the day before the hearing graphically set out the reality of S.R.'s painful existence in the ICU. He was completely helpless. The doctor's orders were to withdraw pain medication in the morning so that they could assess S.R.'s capabilities. It was apparent to her from S.R.'s gestures and grimaces that he felt more pain then. His heart rate increased when she was turning him or treating his ulcers and this was also an indication that he felt pain. She had to change his bed pad every two hours as it was wet and soiled. He showed pain during his frequent bowel movements and more pain when she tried to clean him. Ms. Devane said S.R.'s eyes could open when he heard voices but he could not follow her movements. He did tear up when experiencing pain. He showed no emotion other than pain. His condition had been very similar for the entire 112 days he had been in ICU.

ANALYSIS

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

We found that there was no specific prior capable wish expressed applicable to the end of life circumstances that the patient faced at the time of the hearing. As the patient was only 49 years old and incapable with respect to treatment almost from the time of his hospitalization that was not surprising.

Best interests

Pursuant to the provisions of s.21(1) the lack of a prior capable wish lead us into the consideration of the patient's best interests as that term is defined in s. 21 (2) of the legislation.

Values and beliefs

We examined the evidence in relation to the values and beliefs that the patient held when capable and that he would still act upon if capable. There was evidence from family members that bore on this point.

Dr. Murthy had been one of the treating physicians when S.R. first came in to the ICU on July 22. He said he had a conversation with the family at that time. He was referring to the some or all of the family members who attended the hearing being the mother, the brother, and two sisters. They said that S.R. was close with his family as he lived with his mother and saw his siblings frequently. He was said to be intelligent and independent. They said he would not want to be in hospital. They conceded that S.R. did not take care of himself. He had medical problems caused by, or worsened by, poor nutrition and alcohol binges. With respect to his discussions directly with the patient's mother about her son's views that might be applicable to his current condition Dr. Murthy said that two weeks prior to the hearing he had asked T.R. to sit down with the treatment team but she had declined the opportunity.

The doctor filed a progress note from a social worker as part of Exhibit #2 which referred to a family meeting in which Dr. Friedrichs, another physician in the ICU rotation, had been involved. The mother, brother and one sister were involved. The patient's condition had deteriorated. When asked whether the patient would want to have aggressive treatment given the very poor prognosis, the brother and sister were very quick to report that S.R. would not want that. The ranking SDM was the mother though. The notes of that meeting were that T.R. struggled with the belief and hope that her son "will show us to be wrong" as he was "a good son" and she was "praying for him every day."

Another family meeting was held on the evening of November 8 with Dr. Altman present. The social work note the next day indicated that the family said that the patient would not want to continue active treatment. However the next day a message was left that they wished to continue it. It was at that time that Dr. Altman decided to apply to the Board.

From the statements made by the siblings in the July, October and November meetings we were able to conclude that the patient's values and beliefs as expressed to his siblings were that he would not want to be bedridden in hospital on life support. The patient had made it clear to them that he wanted to be independent.

It was quite clear from the evidence of the doctor, and the position taken by her at the hearing that the patient's mother, as SDM, did not dispute the statements of her other children made to the treatment team as to S.R.'s values and beliefs. It was also clear from her position at the hearing and her brief submission that she did not really contest the overwhelming medical evidence of the futility of continued treatment. It was apparent that she could just not allow herself to abandon all hope for her son's recovery and she could not be the one who made a decision that would result in his death. It should be noted that notwithstanding their statements to the ICU doctors prior to the hearing S.R.'s siblings effectively took the position at the hearing that this was T.R's decision to make. T.R. did not want to ask questions of the doctors but at her request her son V.R. did ask a few questions on her behalf. No issue was taken by way of questions with the statements attributed to the siblings as to S.R.'s values and beliefs. The only submission made for the family was V.R.'s emotional plea to the Board to keep her son alive.

Incapable wishes

We then considered s. 21 (2) (b) whether there was the expression of a wish that was not required to be followed. The only evidence on point was the evidence of the doctor as to what the siblings said after their brother was in hospital in late July. They believe that he tried to tell them through gestures that he did not want to stay in hospital.

Condition or well-being

We considered all of the provisions of s. 21 (2) (c) at the same time. The evidence left no doubt in our minds that the patient's medical condition would not improve materially. The treatment history had been that there had been alleviation of some medical symptoms. For example there were infections that were successfully treated. The doctor said that the need to elevate blood pressure to the vital organs lead directly to necrosis of the extremities. The overall condition of the patient had deteriorated and would continue to deteriorate no matter how aggressive the treatment became.

We then looked at the word "well-being" which connotes something more subjective than a strict medical condition. In *Janzen v. Janzen* Aitken J. stated;

> Treatment in the form of a ventilator, medications, and periodic heroic interventions as required might improve other medical conditions suffered.... but it would not improve Mr. Jansen's (sic) quality of life. I consider the concept of "well-being" a very broad concept which encompasses many considerations, including quality of life. Many of the interventions contemplated as being necessary to prolong Mr. Janzen's life involve procedures that could be painful or uncomfortable for Mr. Janzen...

There was no doubt that the procedures and interventions in S.R.'s care were very painful for him as he expressed pain in his facial expression notwithstanding the heavy doses of pain medication that he was on.

We also accepted the view that well-being comprises a consideration of the indignity to the body caused by aggressive, yet ultimately futile interventions. In *Re Conry* the court held;

> The medical and nursing treatment of individuals in extremis and suffering from these conditions (persistent vegetative state) entails the constant and extensive handling and manipulation of the body. At some point, such a course of treatment upon the insensate patient is bound to touch the sensibilities of even the most detached observer. Eventually,

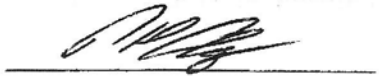
> pervasive bodily intrusions, even for the best motives, will arouse feelings akin to humiliation and mortification for the helpless patient. When cherished values of human dignity and personal privacy, which belong to every person living or dying, are sufficiently transgressed by what is being done to the individual, we should be ready to say: enough.

The fact that S.R. was not in a vegetative state and clearly felt pain every moment of his prolonged life lead us to the conclusion that his well-being required that we state that he has suffered enough and should be allowed remission from his pain.

RESULT

We found that S.R. was incapable with respect to all medical treatment including palliative care.

We found that T.R. had not complied with the principles for substitute decision making set out in the *Act* and we directed that she consent to palliative care including the withdrawal of all blood pressure medications, feeding tube, pressors and ventilator support and the provision of all appropriate comfort care including medications to alleviate pain. The SDM shall comply with the Board's direction by noon on November 21, 2011. If the SDM does not comply with the Board's direction within the time specified by the Board, she shall be deemed not to meet the requirements for substitute decision making as they are set out in section 20(2) of the *Act*.



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