Consent and Capacity Board
Commission du consentement et de la capacité

Ontario

18-4288-01
18-4288-02

2019 CanLII 47034 (ON CCB)

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

AND IN THE MATTER OF
VB
A patient at
TRILLIUM HEALTH PARTNERS – MISSISSAUGA HOSPITAL
MISSISSAUGA, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

A panel of the Board convened a hearing at the request of Dr. N. Antman, the health practitioner who was treating VB. Dr. Antman had brought an application to the Board (a "Form G" application under section 37(1) of the *Health Care Consent Act* ("*HCCA*" or the "*Act*")) for a determination as to whether or not the substitute decision-makers ("SDMs") for VB had complied with section 21 of the *HCCA*. An application to the Board under section 37 is deemed, pursuant to section 37.1 of the *Act*, to include an application to the Board under section 32 of the *HCCA* by VB with respect to her capacity to consent to the proposed treatment. The panel considered and determined both issues.

DATES OF THE HEARING, DECISIONS AND REASONS

The hearing occurred on January 3rd and concluded January 10th, 2019. The Decisions were released January 11th. The panel unanimously held that VB was not capable of consenting to the proposed treatment. Further, the panel unanimously determined that the SDMs had not complied with the principles of substitute decision-making as required by section 21 of the *Act*. We directed CH, PH, RH and HH to consent to the treatment by January 12th at 5pm. Reasons for Decisions, contained in this document, were requested by Ms. Szigeti (counsel appointed to represent VB) at the hearing and were released on January 17th, 2019.

LEGISLATION CONSIDERED

The *Health Care Consent Act* ("*HCCA*"), including sections 4, 21 and 37.

PANEL MEMBERS

Lora Patton, senior lawyer member
Henry Pateman, public member
Gary Strang, public member

PARTIES & APPEARANCES

VB, the patient, was represented by counsel, Ms A. Szigeti.
Dr. Antman, the health practitioner, was represented by counsel, Ms. Marotta and Ms. Hunter.
CH, PH, RH and HH, substitute decision-makers ("SDMs"), were self-represented.

PRELIMINARY MATTERS

The Proposed Treatment relevant to the Form G application

Dr. Antman's finding of incapacity and Form G application related to a palliative treatment plan including removal from ventilator/ extubation with no further resuscitation or life extending treatments. It was expected that VB would die shortly after being removed from the ventilator.

Adjournment January 3, 2019

Following Dr. Antman's direct evidence on January 3rd, the SDMs began cross-examination. As PH was asking questions, a number of issues were put to Dr. Antman that required his access to VB's clinical record so that he could answer accurately. For example, PH asked Dr. Antman to see MRI imaging of his mother's brain compared with an uninjured brain and a recent picture of his mother's pressure sore on her lower back. These questions, and several others related to VB's initial condition and the possible causes of her current state, were not relevant to the issues before the panel; however, in recognition of the fact that VB's family was trying to understand her condition and the fact that all SDMs were not represented, questions that were strictly beyond the scope of the hearing were permitted at the outset.

Unfortunately, the hearing was not located at the Hospital but at a different site to allow for the participation by videoconference of a lawyer. Dr. Antman did not have access to VB's chart and could not answer these questions or provide specific information about other issues that may have been within the bounds of testing credibility. Further, Ms. Szigeti raised the concern that the SDMs may in fact be seeking an adjournment to obtain the clinical record (which was not apparent at that point). On questioning, the SDMs did request access to VB's chart and sought an adjournment to do so.

In considering the request to adjourn, the panel considered a number of factors. Counsel for Dr. Antman identified the significant delay that had already occurred with respect to VB's care. She noted that a previous application had been initiated in November 2018 when VB's spouse was acting as her substitute decision-maker. That application was delayed due to, in part, the actions of VB's sons such that the panel took the extraordinary step of appointing counsel for the SDM due to interference and undue pressure by his children. That application was dismissed after VB's spouse ultimately declined to act as SDM and this application was filed.

Although the SDMs were involved in this matter dating from early November, it was unclear that they had taken meaningful steps to prepare for the hearing, including seeking access to the record. This was in evidence during the prehearing conference when none of the SDMs called in and only after significant effort was one located to participate. However, it was unclear whether or not there had been confusion about how to access the record, something that may have impaired the SDMs ability to participate in the process.

Although the panel determined that most of the questions being asked in cross-examination were not relevant to the issues to be resolved at the end of the hearing and although it was unclear that the SDMs were seeking access to the record for the purposes of the hearing (rather than other litigation or further delay), we determined that access to the record was potentially important to the ability of the SDMs to cross-examine Dr. Antman and test the medical evidence. The panel determined that access to the record may assist in ensuring that further questioning of the doctor would focus on the issues that the panel would ultimately decide. The SDMs sought a three week adjournment but the panel held that a much shorter timeframe was important in light of the delay and the evidence received up until that time about VB's condition.

Assistance on January 10th

When the hearing resumed on January 10th, cross-examination of Dr. Antman proceeded. Notwithstanding access to the record, the SDMs were preoccupied in their questioning with the initial cause of VB's condition and the quality of her care throughout hospitalization. The panel attempted to assist in providing direction as to the decisions that the panel would make, by providing copies of the relevant section of the legislation and by re-ordering the proceedings. Ultimately, some of the cross-examination had to be curtailed as irrelevant or argumentative or without any evidentiary basis. Although care was shown to the unrepresented SDMs, fairness also required the impact to Dr. Antman and the integrity of the hearing process itself.

THE EVIDENCE

The evidence at the hearing consisted of the oral testimony of Dr. Antman, CH, PH, RH and HH and one Exhibit:

1. Document Brief of Dr. Antman, December 17, 2018 (9 Tabs)

INTRODUCTION

VB was a 71-year-old woman who had lived with her husband in the Etobicoke area before her hospitalization. She had four sons and many grand and great-grandchildren. On September 5th, 2018, VB had apparently become lightheaded while shopping. She began to fall backwards and was cushioned in her fall by a bystander. Chest compressions were initiated by a bystander and VB was ventilated by ambulance attendants. On her arrival at Mississauga Hospital (the "Hospital") VB was unconscious and had remained in that state until the conclusion of the hearing.

In November 2018, Dr. Antman brought an application to the Board. He had proposed a palliative treatment plan for VB and VB's husband had not consented to the plan. That application was dismissed in December 2018 after VB's husband declined to act as her SDM. Dr. Antman then sought consent to the treatment plan from VB's four sons, equally ranking SDMs, who unanimously refused consent. This application was then filed to resolve the treatment issue.

THE LAW

Capacity to Consent to Proposed Treatment

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

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

> *A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information*

> *that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.*

Obligations of Substitute Decision-Making

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

> *21. (1) A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles:*
> *1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.*
> *2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.*
>
> *21.(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,*
> *(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;*
> *(b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and*
> *(c) the following factors:*
>
> *1. Whether the treatment is likely to,*
> *i. improve the incapable person's condition or well-being,*
> *ii. prevent the incapable person's condition or well-being from deteriorating, or*
> *iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.*
> *2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.*
> *3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.*
> *4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.*

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

> *37. (1) If consent to a treatment is given or refused on an incapable person's behalf by his or her substitute decision-maker, and if the health practitioner who proposed the treatment is of the opinion that the substitute decision-maker did not comply with section 21, the health practitioner may apply to the Board for a determination as to whether the substitute decision-maker complied with section 21.*
>
> ***Parties***
> *(2) The parties to the application are:*
>
> > *1. The health practitioner who proposed the treatment.*
> >
> > *2. The incapable person.*
> >
> > *3. The substitute decision-maker.*
> >
> > *4. Any other person whom the Board specifies.*
>
> ***Power of Board***
> *(3) In determining whether the substitute decision-maker complied with section 21, the Board may substitute its opinion for that of the substitute decision-maker.*
>
> ***Directions***
> *(4) If the Board determines that the substitute decision-maker did not comply with section 21, it may give him or her direction and, in doing so, shall apply section 21.*
>
> ***Time for compliance***
> *(5) The Board shall specify the time within which its directions must be complied with.*
>
> ***Deemed not authorized***
> *(6) If the substitute decision-maker does not comply with the Board's directions within the time specified by the Board, he or she shall be deemed not to meet the requirements of subsection 20 (2).*
>
> ***Subsequent substitute decision-maker***
> *(6.1) If, under subsection (6), the substitute decision-maker is deemed not to meet the requirements of subsection 20 (2), any subsequent substitute decision-maker shall, subject to subsections (6.2) and (6.3), comply with the directions given by the Board on the application within the time specified by the Board.*

> ***Application for directions***
> *(6.2) If a subsequent substitute decision-maker knows of a wish expressed by the incapable person with respect to the treatment, the substitute decision-maker may, with leave of the Board, apply to the Board for directions under section 35.*
>
> ***Inconsistent directions***
> *(6.3) Directions given by the Board under section 35 on a subsequent substitute decision-maker's application brought with leave under subsection (6.2) prevail over inconsistent directions given under subsection (4) to the extent of the inconsistency.*
>
> ***P.G.T.***
> *(7) If the substitute decision-maker who is given directions is the Public Guardian and Trustee, he or she is required to comply with the directions, and subsection (6) does not apply to him or her.*
>
> ***Deemed application concerning capacity***
> *37.1 An application to the Board under section 33, 34, 35, 36 or 37 shall be deemed to include an application to the Board under section 32 with respect to the person's capacity to capacity to treatment proposed by a health practitioner unless the person's capacity to consent to such treatment has been determined by the Board within the previous six months.*

VB's CAPACITY TO CONSENT TO THE PROPOSED TREATMENT

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

It was Dr. Antman's evidence that VB lacked the ability to understand the information and appreciate the reasonably foreseeable consequences because she was neither awake nor aware. It was his evidence that VB had been unconscious and incapable upon her admission to the Hospital and had remained incapable throughout. VB's Glasgow Coma Scale level was "3" – the lowest level possible; the scale measures eye, verbal and movement responses and, in each case, VB had none. Dr. Antman testified on January 10th that he had conducted his most recent examination the day prior and VB's condition had not changed.

Although VB was initially receiving various medications that caused sedation, she had not received these for several weeks and, in Dr. Antman's view, there was nothing artificial impeding her level of consciousness. It was Dr. Antman's evidence that VB's lack of consciousness and awareness was a result of a serious brain injury that had occurred which impaired all cognitive functioning as well as brain stem functioning. This was caused because her brain had not received oxygen for some time during or shortly after the initial fall or faint and because the uncontrolled (and uncontrollable) seizures that had lasted several weeks compounded the original injury.

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It was Dr. Antman's evidence, based on his own examination of VB, chart review and review of the findings of specialists, that VB had a diffuse brain injury that was irreversible and that precluded consciousness or awareness of her environment. As such, VB was not capable of making decisions about the treatment.

The panel accepted Dr. Antman's evidence on the capacity issue, noting that it was uncontested and was clear and compelling. His evidence was corroborated by other intensivists in the written materials and by two neurologists. We determined that VB was not capable of making a decision about the proposed treatment at the time of the hearing.

APPLICATION TO DETERMINE COMPLIANCE WITH THE *HCCA*

Prior Capable Wish:

The *HCCA* sets out the principles for substitute decision-making (the relevant sections are set out above). Unless there is a known prior capable wish that applies to the circumstances, an SDM must make decisions in the best interest of the person.

In this case, no one argued that there was any prior capable wish. All of the evidence was that VB had never discussed what she may want to have happen in such a case and had never been exposed to a similar situation with family or friends. Although she had spoken of her death (specifically the location of her burial), her children denied that she had addressed any health care directions in the event that she required machines to stay alive. No one was relying on a prior capable wish as the basis for the decision about the proposed treatment plan. The panel, therefore, focused on VB's best interests as defined in the legislation.

Best Interests, Values and Beliefs and Wish that was not a Prior Capable Wish:

The first element of a best interest analysis is a consideration of the person's values and beliefs she held while capable and that she would act on if able to do so. The panel was unable to determine very much about VB's values and beliefs: the little evidence was provided was vague and did not directly relate to how VB may make the treatment decision. VB was described by her family as being "Christian" and believing in a "higher power" (Exhibit 1, Tab 5, page 2); that she "was a Christian and would not support suicide" (Exhibit 1, Tab 5, page 5). At the hearing, PH stated that VB was "Christian" and that she attended Church regularly although she had stopped going weekly due to arthritis pain. He also stated that VB believed in an "afterlife" and that he did not believe that she was afraid of dying because of this. However, no evidence was provided that fleshed out VB's religious beliefs nor was any evidence provided that spoke about how her beliefs may have influenced the treatment decision. To the extent that some statements were made attributed to VB, there were no details; for example, although it was said that she would not support suicide, there was no further information that spoke about how this was determined to be the case (quite apart from whether VB would see a palliative treatment plan as 'suicide'). The panel was unable to draw any inferences from VB's religious values and beliefs as offered.

HH stated that his mother would not want to consent to the palliative treatment plan and that he knew this because he knew her. When probed, he could offer no further details about that. HH also indicated that VB was "a fighter" and would not give up. This was also referenced in notes from a family meting when the family stated that "'whenever she was sick she would 'fight to get better'" (Exhibit 1, Tab 6, page 1). HH described VB as strong-willed. This sentiment was echoed by his brothers. However, although VB had previously fought through sickness, it was unclear to the panel that this offered any insight into how she would respond to her current circumstances. The panel could draw very little from these statements.

Dr. Maham had noted during a family meeting on October 14th that VB's spouse had said that "felt that his wife may not want to continue the current treatment plan given the prognosis" (Exhibit 1, Tab 2, page 4). A further note, completed by the social worker about the same meeting stated that VB's spouse thought VB was "'suffering' but he wanted his sons to have a chance to speak their minds" (Exhibit 1, Tab 5, page 8). VB's spouse's comments were not repeated to Dr. Antman when he took over VB's care and the statements were questioned by the SDMs as being inaccurate or based on their father's lack of understanding or having been pressured. Without additional detail about the statements, the panel placed little weight on these although they were reflected in medical records and recorded by two different health professionals. Further, Dr. Maham was not involved in these proceedings and the statements were made very early in the process, before an application was contemplated. However, the statements as noted were equivocal and vague and consequently did not ultimately assist to any great extent except to further the panel's view that VB's values and beliefs were completely unclear.

Other reasons were given by the SDMs for refusing the treatment plan but these did not speak to VB's values and beliefs but, rather, the brothers' own thought process or beliefs. For example, PH stated that because his mother had never told him that she would want the ventilator removed in this type of case, he could not consent. PH said that making a decision to move to a palliative plan would not be possible for him, saying "I don't think I could live with that." CH said that his mother had the right to be alive like anyone else and that he did not "have the right to kill anybody." During the December 10th family meeting, Dr. Maham recorded that the family had said that "she/ or the hospital would have to make the decision to stop [treatment] because they would not" (Exhibit 1, Tab 5, page 8) and that the family "will never agree to stop trying" (Exhibit 1, Tab 6, page 7). Reference was also made to the fact that the SDMs wanted "a natural death" for VB (Exhibit 1, Tab 5, page 2). It was not clear that this was a value held by VB but rather a desire of the SDMs to allow VB to continue in her current state until resuscitation attempts were unsuccessful. Without evidence, statements were made about the physicians being motivated by VB being an organ donor or to "cover up" either medical experimentation or medical errors. None of these statements furthered VB's values and beliefs.

The panel determined that there was no cogent or compelling evidence respecting VB's values and beliefs that would assist in understanding how VB may make this decision if able to do so. Nor was there any evidence of a wish that was not a prior capable wish. The panel, therefore, placed all weight in reaching its Decision on the balance of the best interest factors (section 21(2)(c), *HCCA*).

Best Interests, Medical Factors:

Dr. Antman's evidence was that on September 5, 2018, VB was brought by ambulance to the emergency department of the Hospital after she had experienced dizziness and lost consciousness. It was unclear what had caused this initial incident although various causes had been ruled out (infectious disease, meningitis). VB had remained unconscious and dependent on a ventilator since her admission. VB had experienced seizures on admission and, after weeks of continuous seizures despite different medication management strategies, VB was transferred to Toronto Western Hospital whose capacity for continuous ECG readings could offer better diagnostic and treatment information. Upon discharge from the Toronto Western, VB's diagnosis was anoxic brain injury (diffuse injury as a result of lack of oxygen), myoclonic status epilepticus (uncontrolled seizures) and spinal cord and medullary infarct (damage caused to the spinal cord and brain stem due to lack of oxygen) (Exhibit 1, Tab 9, pages 1-2). Dr. Tai, a neurologist at Toronto Western, had identified at that time VB's poor prognosis and the need to consider how to move forward with treatment.

Dr. Antman explained VB's diagnosis. Although the initial cause was uncertain, it was suspected that VB's spinal cord had deteriorated due to arthritis and the fall or some other cause had resulted an inability of the upper spinal cord and brain stem to receive oxygen. What happened next was that both the brain and spinal cord were deprived of oxygen. The damage caused by the lack of oxygen was permanent, having caused the effected cells to die. Further, several weeks of uncontrolled seizures had caused further damage to the brain.

Dr. Antman testified that on examination VB was found to be primarily in a persistent vegetative state with some fluctuation to unconscious state. He stated that VB was dependent on mechanical ventilation for breathing and did not breath "above" the ventilator (initiate her own breaths). It was his view that the damage to her brain stem had made it impossible for her to regain the ability to breathe on her own in light of the damage to the brain stem. VB also received nutrition and hydration through a tube. VB did not respond to verbal command or, for the most part, to pain stimuli. The latter was tested both in the extremities and sternum and, due to her spinal cord injury, her face. No improvement had been noted in VB's condition since her September 5th admission.

Dr. Antman's evidence was that since admission, VB had experienced a number of significant complications. She had experienced four cardiac arrests when turned and required resuscitation to restart her heart (Exhibit 1, Tab 2, page 5). Dr. Antman explained that VB did not have a cough reflex and could not cough to clear mucous from her airway. Although a tube was fed into her throat at various times throughout the day to clear the mucous through suction, VB was susceptible to choking, leading to cardiac arrest, particularly when being turned. Each of the four cardiac arrests had occurred as a result of VB's inability to breath due to mucous.

VB had a large pressure sore (10 cm) on her lower back where the skin had broken down. The wound was 4 cm deep, penetrating to the bone. Dr. Antman stated that the wound could not be effectively treated, despite best efforts, because VB was bedbound and the ongoing pressure prevented the skin from healing. This was further complicated by VB's dependence on the ventilator and the risk of cardiac arrest with turning. A smaller wound in VB's foot had improved. Dr. Antman's evidence was that these types of pressure sores were likely to continue.

VB had experienced infections and had been treated. She was at risk of pneumonia and urinary tract infection. She was at risk of blood clots.

It was Dr. Antman's evidence that it was difficult to determine whether or not VB experienced pain or distress from the complications or medical interventions. While it was his evidence that the types of things experienced by VB on a daily basis would cause discomfort typically (the force of mechanical chest compressions, being unable to breath due to mucous, pain associated with the skin ulcer), it was impossible to know whether VB was in pain or suffering because of both her lack of consciousness and spinal cord injury.

Two different neurologists had offered opinions on VB's prognosis. At Toronto Western Hospital, on October 5, 2018, Dr. Tai wrote that the "chances of recovery to any meaningful quality of life are infinitesimally small and goals of care should be discussed" (Exhibit 1, Tab 8, page 1). On October 11th, at Mississauga Hospital, Dr. Lockey stated that "the overall prognosis is very poor, she has little to no hope for any mean[ful] neurological recovery, and I strongly recommend a family meeting to discuss withdrawal of life sustaining therapies" (Exhibit 1, Tab 3, page 3). Dr. Lockey had a further chance to evaluate VB on November 9th and wrote that "her prognosis was very, very poor a month ago when I last saw her, it is even worse today because she has had no improvement in the interim month" (Exhibit 1, Tab 4, page 2). It was Dr. Antman's evidence that some improvement would have been expected within 4-6 weeks of the incident if any were likely. Dr. Antman stated that VB's underlying brain and spinal injuries were "irreversible and permanent" and that VB would not regain consciousness, breathe on her own, or be aware of or interact with her environment.

It was Dr. Antman's position that a palliative course of treatment was in VB's medical best interest. It was his evidence that the palliative plan had been recommended by several physicians before him, including Drs. Maham, Milosevic and McCreedy. He testified that the underlying brain and spinal injuries could not improve and that VB would, absent a palliative plan, continue to experience complications and invasive, possibly painful interventions that served no purpose as there was no chance of recovery. In submissions, Dr. Antman's counsel noted that, absent a palliative plan, VB would experience a longer dying process with continued suffering and noted that the outcome whether palliative or not, would be death: the difference being the complications and suffering in that process.

The panel accepted Dr. Antman's evidence that VB's condition was irreversible and permanent and that she would not experience any quality of life that saw her aware of her surroundings or able to interact, able to move or speak or able to breathe on her own. We also accepted his evidence that VB was experiencing ongoing, invasive procedures that may cause pain or suffering (physical chest compressions, airway suctioning, turning) and was experiencing complications that potentially could cause pain or suffering (pressure sores, infections, choking). Dr. Antman's was the only medical evidence introduced and his evidence was not weakened by cross-examination. Further, his evidence was supported by clinical records before the panel which included the observations and opinions of other health practitioners.

As such, we accepted that the proposed treatment plan was likely to prevent VB's further deterioration through complications and reduce the likelihood of her experiencing pain and suffering as a result of those complications. The panel acknowledged that it was impossible to know whether VB felt pain or experienced distress but also applied a broader definition to well-being, as set out by the courts that addressed quality of life, suffering and dignity. The panel found that with no chance of improvement in VB's underlying condition, the constant invasive and potentially uncomfortable or painful procedures impacted any quality of life. We also found, for the same reasons, that VB's condition or well-being was likely to deteriorate without a palliative plan.

While the panel noted that the SDMs may find it difficult to consider that death was a "benefit" for VB, in the circumstances of this case, the panel found that it was. Whether VB continued to receive life-extending treatment or whether she received palliation, she was going to die. Her underlying condition could not be improved. By continuing with life-extending treatments, VB's quality of life would not improve and she would be enduring sometimes violent (cardiac chest compressions) and typically uncomfortable (airway suctioning) treatments, together with the complications of her condition (bed sores, choking on mucous, etc.). VB was going to die in any event and a palliative plan would be of greater benefit in the dying process that on-going life-extending treatments.

Finally, the panel determined that a palliative course was the least intrusive treatment available for VB. As stated above and clearly established on the evidence, VB required constant interventions to keep her body functioning. If life-extending treatments continued, she would also be required to undergo surgeries to relocate her breathing tube and feeding tube.

VB's family undoubtedly believed that they were acting in her best interest – all of them testified to that position at the hearing. However, the panel found that the SDMs were not applying the principles for substitute decision-making when they refused to consent to the treatment plan proposed. Throughout the evidence, the panel heard the SDMs state that they would continue to keep VB alive, that enduring ongoing chest compressions was her right, that staying alive regardless of her condition was her right, that nothing would change their minds from that decision. The SDMs clearly were preoccupied with the mechanism of VB's initial injury and her quality of care. This was evident in the questions put to Dr. Antman which focused on these issues regardless of redirection and support. By the conclusion of the hearing, these preoccupations had escalated to accusations put to the doctor without any evidence: that he was trying to "kill" their mother from the time he took on her care, that he had allowed medical experimentation that he was covering up medical error, that he was interested in obtaining her organs.

While the panel could understand the distress and frustration that must occur when a woman who was apparently healthy suddenly collapsed and was so perilously injured without a clear cause, the preoccupation contributed to the inability of the SDMs to consider VB's current condition and the decision that must be made. The SDMs distrusted the doctor (even though multiple doctors at two different facilities reached the same conclusion) and could not accept the reality of VB's current condition. They were closed to the idea that there may be any value to VB in a palliative course of treatment and they were unwilling to consider the option. They were unable or unwilling to consider that forcing her body to continue may negatively impact her well-being. As one SDM said, if they kept her alive, they could still hope for a miracle.

The panel considered whether or not the SDMs were sufficiently informed about how to make this decision prior to the application being filed, an issue raised by counsel for VB. We found that they were. Dr. Antman testified that he had specifically arranged the December 10th family meeting to inform the SDMs of their obligations and to provide information and answer questions. He spoke about his usual practice and also stated that he had an independent recollection of providing this information to the SDMs. He also stated that the hospital ethicist had met with the SDMs immediately before his meeting with them and had further explained the principles for substitute decision-making and provided a pamphlet on the same. Although some of the SDMs denied receiving a document or did not recall having discussions about the decision-making process, at least one corroborated some of Dr. Antman's testimony (notably, the first SDM to testify). Dr. Antman's testimony was clear and unequivocal while the SDMs could not recall or denied the specifics. The panel found that it was likely that the information had been provided and that the SDMs were no more able to receive that information than they were at the hearing or at any other point during VB's hospitalization, as had been carefully charted.

The panel found that regardless of how information was provided to the SDMs and by whom, the SDMs were unable or unwilling to apply the principles of decision making. We held that a palliative treatment course was in VB's best interest.

RESULT

The panel determined that VB was incapable of consenting to the proposed treatment. Further, we held that that the substitute decision-makers had not complied with the principles for substitute decision-making set out in the *HCCA*. We ordered that the SDMs consent to the proposed treatment be provided by January 12th, 2019 at 5pm.

Dated: January 17, 2019

Lora Patton
Presiding Member