**Consent and
Capacity Board**

**Commission du consentement
et de la capacité**

Ontario

**16-1452-01
16-1452-02**

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

AND IN THE MATTER OF
PN
A PATIENT OF
PETERBOROUGH REGIONAL HEALTH CENTRE
PETERBOROUGH, ONTARIO

REASONS FOR DECISIONS

PURPOSE OF THE HEARING

A panel of the Board (sitting as a senior lawyer member sitting alone) convened a Hearing at Peterborough Regional Health Centre ("PRHC") at the request of Dr. M. Maraschiello, the health practitioner who had proposed treatment for PN. Dr. Maraschiello had brought a Form G Application to the Board 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-maker for PN had complied with section 21 of the *HCCA*, the principles for substitute decision-making, when making a decision about proposed treatment for PN.

An Application to the Board under section 37 of the *HCCA* is deemed, pursuant to section 37.1 of the *Act* to include an application to the Board under section 32 of the *HCCA* by PN with respect to his capacity to consent to the proposed treatment unless the person's capacity to consent to such treatment has been determined by the Board within the previous six months. As no such prior finding had been made, the Board also considered PN's deemed application.

DATES OF THE HEARING, DECISIONS AND REASONS

The hearing commenced July 6, 2016 but adjourned. The hearing resumed and concluded on July 8, 2016. The panel released its Decisions the same day. On July 11th the Decision with respect to capacity was forwarded to the parties as the original had not been dated. I held that PN was not capable of consenting to the proposed treatment and that IN had not complied with the principles of substitute decision making as required by section 21 of the *Health Care Consent Act*. I directed IN to consent to the treatment by July 9th at 12 p.m.

Reasons for these Decisions, contained in this document, were requested by Dr. Maraschiello and were released on July 25, 2016.

LEGISLATION CONSIDERED

The *Health Care Consent Act* (“*HCCA*”), including s. 1, 2, 4, 10, 11, 21, 32, 37 and 37.1.

PANEL MEMBERS

Lora Patton, senior lawyer member

PARTIES & APPEARANCES

Deemed Form A Application

PN, the patient, was represented by Ms J. Gillespie.

Dr. Maraschiello, the health practitioner, represented himself and, when he excused himself following the conclusion of his evidence, was represented by his agent, Ms P. Fisher, MSW RSW.

Form G Application

JN, the patient, was represented by Ms J. Gillespie.

IN, PN's substitute decision-maker, was represented by Mr. R. Tanner.

Dr. Maraschiello, the health practitioner, represented himself and, when he excused himself following the conclusion of his evidence, was represented by Ms P. Fisher, MSW RSW.

PRELIMINARY MATTERS

The Proposed Treatment:

Dr. Maraschiello had proposed: comfort based or palliative care in the event of a deterioration, including no CPR, no defibrillation, no mechanical ventilation, no non-invasive ventilator.

THE EVIDENCE

The evidence at the hearing consisted of the oral testimony of three witnesses, Dr. Maraschiello, IN (the substitute decision-maker) and EN (the brother of PN and son of IN). There were 2 Exhibits taken into evidence:

1. Consent and Capacity Board Summary, prepared by Dr. Maraschiello, dated July 5, 2016; and
2. Excerpts from the clinical record of PN.

INTRODUCTION

PN was a 52-year-old man who, prior to his hospitalization, had lived with his brother. PN had experienced schizophrenia for many years and in April 2016 had been diagnosed with a brain tumour. On May 4th PN underwent surgery in Kingston and he initially showed signs of recovery but on May 7th it was determined that he had experienced bleeding in his brain. Despite interventions, PN had remained in a persistent vegetative state.

PN was transferred to PRHC on June 6th. Over the course of his hospitalization, his level of consciousness did not change and at the time of the hearing he remained in a persistent vegetative state. He was entirely dependent on others for all forms of care: he received food through an abdominal feeding tube, he was not able to protect his airway and required deep suctioning several times a day, he was turned several times each day to prevent skin injury and he required multiple medications which were administered 15-20 times each day with 1-2 new piercings of the skin daily. There was agreement among PN's healthcare team that any meaningful neurological recovery was unlikely. Dr. Maraschiello proposed the treatment plan in light of the above history, status and prognosis.

IN, PN's mother and substitute decision-maker, had refused consent to the treatment plan.

THE LAW

In these applications, the onus is always on the health practitioner at a Board hearing to prove his or her case. The standard of proof on any application under the *HCCA* is proof on a balance of probabilities. The Board must consider all evidence properly before it. Hearsay evidence may be accepted and considered, but it must be carefully weighed. In order for the Board to find in favour of the health practitioner, it must hear clear, cogent and compelling evidence in support of the case.

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 Dr. Maraschiello.

The test for capacity to consent to treatment and admission to a care facility 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 a substitute decision-maker 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.

PN'S CAPACITY TO CONSENT TO THE PROPOSED TREATMENT

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

Dr. Maraschiello's evidence was that on June 28, 2016, he had determined that PN was not able to understand the information relevant to the treatment decision, or any other treatment decisions. It was his opinion that PN was, at the time of the hearing, in a persistent vegetative state caused by a brain injury (bleeding on the brain) sustained following brain surgery to remove a tumor. Some reference had been made in his written evidence to PN possibly being in a minimally conscious state, based on statements by IN; however, Dr. Maraschiello indicated that he had not witnessed any evidence of a minimally conscious state and that, regardless, it would not change his impression of PN's ability to understand information.

Dr. Maraschiello's evidence was that the brain injury sustained by PN was in the area that allowed for awareness. He stated that PN was unable to interact in any way and did not foresee a change in that state. His evidence included the reports of multiple other physicians who had also diagnosed a persistent vegetative state (Dr. Yu at Kingston General Hospital speaks to a Glasgow Coma Scale of 3-4, Exhibit 2, page 1; Dr. McMillan speaks of a “deep coma,” Exhibit 2, page 7; Dr. Brown states that “his baseline level of consciousness, according to the neurology assessments …indicate a [Glasgow Coma Scale] of, occasionally 4, which one point for his eyes opening to pain, but otherwise no verbal response, no pain response and eyes usually closed,” Exhibit 2, page 11).

He stated that PN was not taking any medications that would impact his level of consciousness or ability to communicate.

Dr. Maraschiello’s evidence was clear and well documented. I determined that PN was likely in a persistent vegetative state and was unable to understand information about his treatment. He was equally unable to appreciate the reasonably foreseeable consequences of the proposed treatment.

APPLICATION TO DETERMINE COMPLIANCE WITH THE *HCCA*

Did IN apply PN’s known capable wishes about his treatment when making decisions about the proposed plan of treatment?

The parties advised that there was no known prior capable wishes.

Did IN consider PN’s values and beliefs that she knew PN held when capable and believed he would still act upon if capable (s.21(2)(a)) and PN’s wishes that he had expressed about treatment that were not prior capable wishes (s.21(2)(b))?

Both IN and EN (PN’s brother) testified at the hearing. EN’s evidence was that he had lived with PN for most of his adult life. For a period of time, approximately 8-9 years, they lived together with their father. EN stated that when their father was alive, PN would make statements after watching news stories that indicated that he was opposed to palliative or hospice care. In EN’s words, PN was “vehemently against” both. EN stated that PN believed that palliative care was “pro-suicide,” “anti-Christian,” and “against God.” EN also recalled that PN had commented about the Pope suffering from illness and noted his willingness to live notwithstanding that suffering. EN stated that suffering was a way to become closer to God. He stated that he and PN had a close relationship as related to their Christian faith and had many conversations about how God punishes those who sin, cuts them off from their families and had directed punishment at Sodom and Gomorrah because of homosexual behaviour. He felt that PN shared these beliefs.

Later, when their father was in hospital, PN reported to EN that he had overheard people in the hospital talking about his father’s care and specifically that they wanted to “terminate” him. PN was reportedly quite alarmed by this statement. EN also stated that PN had wanted his father to keep living but the doctor did not listen to him even though he was the Power of Attorney and had, instead, taken direction from their mother (who was divorced from their father at the time).

More recently, EN stated that PN had watched a news story about Prince William and Princess Catherine visiting a hospice for children. Something negative had happened to Catherine the next day and PN had indicated that God was punishing her for promoting hospices.

IN stated that if this were PN’s decision, he would not consent to the treatment plan. She stated that he had strongly held beliefs about what should happen such that he had even developed a plan, some years previously, to move to France with his brother because it was his belief that France did not “terminate” people. IN did not know the origin of these beliefs or the specifics of them.

Multiple discussions had occurred between the family and health practitioners during PN’s hospitalization. Dr. Lakshimi noted that “family faith prevents them from making decision for DNR” (Exhibit 2, page 15). On June 21st, EN stated that he and PN were “strong Christians and we don’t know what God’s will would be in this situation” (Exhibit 2, page 25). On June 22nd, nursing notes indicate that PN was not considering his brother’s condition and wishes, when he stated that he was adamantly opposed to the treatment plan:

> Brother insisted that patient would [want aggressive measures] and that he does as well, despite information given to writer upon previous conversations. Mother was quite upset by what brother was saying… brother stated "Everyone suffers! I was very depressed and was suffering, so I tried to kill myself. I cut my chest with a knife. Everyone suffers!"…Dr. Rice reminded brother that the situation being discussed is what [PN] would want and that [PN's] situation is different and he is not able to make his own decisions. Brother insisted that he would not be changing his mind regarding this. Brother stated again "We're good Christians. I don't want to pull the plug and then I will be punished and so will you and you" (indicating writer and Dr. Rice) (Exhibit 2, page 29-30).

Dr. Maraschiello documented other family interactions with staff members. He noted that a social work note from June 24th reported that IN said EN "was controlling her and would not speak to her if she did not do everything to let the patient live" and that "she was concerned that [PN] was in pain and stated that she did not think that his current situation should go on forever, but she stated that she could not do this [consent to the palliative plan] because [EN] would be quite upset and it would ruin her relationship with [him]" (Exhibit 2, page 5). On May 28th Dr. Maraschiello spoke directly to IN:

> She made it quite clear on numerous instances that he would never want to suffer and be in hospital forever and she hoped with the expectation that he would die peacefully and without aggressive intervention" but that "we hold the decision until she could get [EN] to come around (Exhibit 2, page 5).

In the same discussion, IN stated that PN would not want to "pull the plug" and Dr. Maraschiello confirmed that such was not the nature of the proposed treatment plan.

IN repeatedly expressed concern about pressure from EN in being able to make the decision, saying, for example that she "doesn't want him to suffer and go on living like this but feels pressure from son [EN] who says he won't talk to her again if they make DNR or withdraw" (Exhibit 2, page 32; also see page 35).

Throughout Dr. Maraschiello's evidence there was reference to the incapacity of the SDM, either due to lack of understanding about the proposed plan of treatment or due to influence from EN. These concerns culminated in a telephone call to the Office of the Public Guardian and Trustee on June 10th, during which a Social Worker inquired as to next steps should the SDM be found to be incapable. Ultimately, this was not pursued but issues surrounding capacity were raised more than once following that call.

In her own evidence, IN said that when PN first went to hospital he had said to her “I’m going to die.” In her view, this meant that he had accepted his death. She reiterated that she did not want to see PN in this state and that she wanted him to die but she wanted to have her shared birthday with her other son first and felt that he would die immediately once the decision was made to proceed with the treatment plan.

In his submissions, counsel for IN stated that the SDM would consent to the treatment, that she felt that this was consistent with his best interests, but only to the extent that the decision would be implemented the following Friday.

Did IN consider whether the proposed treatment plan was likely to improve PN’s condition or well-being, prevent it from deteriorating or reduce the rate at which it was likely to deteriorate (s.21(2)(c)(1))? And did IN consider whether PN’s condition was likely to improve, remain the same or deteriorate without the treatment; whether the benefit outweighed the risk of harm; and whether a less restrictive or less intrusive treatment would be as beneficial (s.21(c)(2-4))?

Dr. Maraschiello’s evidence was that PN had experienced a significant bleed in the brain following surgery to remove a cancerous tumour. The bleeding had caused damage such that multiple physicians had determined that there was little chance of any meaningful neurological recovery. This prognosis was repeated throughout the clinical record, beginning with the discharge summary from Kingston General Hospital in which Dr. Yu stated that “changes in code status has been discussed with [PN’s] mother (SDM), and he remains full code at the time of transfer despite his poor prognosis” (Exhibit 2, page 2). PN still had cancer which continued to progress and was not being treated with chemotherapy, radiation or any other cancer treatment.

In Peterborough, both Dr. Maraschiello (Exhibit 2, page 4: “dismal prognosis”) and Dr. McMillan (Exhibit 2, page 8): “extremely poor prognosis and the fact at this point is that it is incredibly unlikely he will ever wake up and interact”) documented a likely poor outcome. Dr.

Maraschiello stated that the treatment team in Peterborough, comprised of multiple intensive care physicians, were in agreement that PN would not likely regain any level of consciousness that would allow him to interact with others.

At the time of the hearing, PN was bed bound and completely dependent on others for all forms of care. He was at risk of infections (from being hospitalized and being bed bound), blood clots and skin ulcers. PN required a number of interventions to stay alive. He had a weak cough and an inability to protect his own airway and was at risk of pneumonia and respiratory distress. He had required deep suctioning (in which a tube is inserted deep into the throat to clear the airway) multiple times a day and had required mechanical ventilation at times. He required frequent turning to prevent skin ulcers (bed sores). He received blood thinners to avoid blood clots and other medications (up to 20 times a day) which could be noxious. Medications required 1-2 new piercings of the skin daily. He had an intravenous catheter which was used to provide some medications; however this increased the potential for blood infection. He had tubes to provide food (into his abdomen) and to remove waste. None of these interventions were likely to be reduced; rather, to keep PN alive, escalations in interventions would be required.

It was Dr. Maraschiello's evidence that PN was displaying indications of pain or discomfort with deep suctioning and turning: high blood pressure, grimacing, gagging and elevated heart rate. He noted that the brain's pain response was located in the brain stem, unrelated to the area of PN's brain that had been injured. On cross-examination, Dr. Maraschiello acknowledged that he could not be sure that PN was experiencing pain but he stated that multiple interventions to prolong life, such that were required in this case, when there was a poor chance of recovery were at the expense of PN's comfort and dignity.

Analysis of the Factors in section 21 of the **HCCA**

After a careful review of all of the evidence and submissions, determining PN's values and beliefs was quite difficult. EN gave evidence in a clear manner and had strong recollections of his brother's religious beliefs regarding what he described as "palliative and hospice care." EN was undoubtedly the person who knew PN the best. However, woven throughout the evidence were indications that the beliefs attributed to PN were focussed more on the idea of ending life-saving treatment or "pulling the plug." PN's beliefs seem to have been particularly intense in relation to his father's care which appeared to be a situation in which life saving measures were removed. This was echoed in PN's wish to move to France where people were not "terminated" by health practitioners. Based on EN's testimony combined with that of IN's statements, I determined that it was most likely that PN's values and beliefs would not support consent to ending of life saving treatments. However, this was not the issue that was before me.

Dr. Maraschiello had proposed a plan of treatment that would not further escalate interventions in the event that PN's condition declined. It was not a plan that would immediately bring about his death by the removal of life saving treatments. He was not presently dependent on a ventilator and all other forms of treatment (suctioning, feeding) would continue.

In contrast, to the evidence regarding PN's values and beliefs, the evidence relating to section 21(2)(c) was clear and cogent. I found that PN had experienced a significant brain injury as the consequence of bleeding which occurred following surgery. I also found that he was in a persistent vegetative state and had been since the bleeding had occurred. I held that he was unlikely to experience neurological recovery that would allow him to be aware of his environment, his condition or others; he was likely to remain in the same bed-bound, in a completely dependent state until a complication arising from his condition could not be overcome. All of this evidence was documented by multiple physicians both at Kingston and at PRHC and was not in dispute.

Further, I found that on-going, aggressive interventions negatively impacted PN's well-being and dignity. I adopt the broad definition of "well-being" outlined in *Scardoni v Hawryluck* (Ont. Crt of Justice, February 5, 2004), where the court discussed the interpretation of "well-being" in the context of section 21(2)(c) of the *HCCA*. That Court approved the definition used by the Board in its Decision:

> 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 the person's illnesses and physical situation. "Well-being" includes considerations such as the person's dignity and levels of pain.

While Dr. Maraschiello could not definitively state that PN was experiencing pain, it was his evidence that there were objective indicators which were consistent with a pain response. I found it likely that there was pain or discomfort but regardless, the invasive, constant intervention which offered no means of improving PN's underlying condition were an insult to his dignity.

It was unclear to me whether PN had ever conceived of himself in the present circumstances and whether he had put his mind to what he would want to happen. I was unable to conclude that his values and beliefs extended to all forms of aggressive therapy in all circumstances.

I found that in applying section 21 of the *Health Care Consent Act*, the SDM must consent to the proposed plan of treatment.

I considered IN's submissions to delay consent until the Friday following the hearing. It was clear to me that the reasons for the delay did not relate to PN but, instead, related to the needs of his family, IN and EN. Undoubtedly this was a painful and fraught time for both IN and EN, both of whom clearly cared deeply for PN and were already experiencing the loss of his companionship. I considered very carefully Dr. Maraschiello's submission that if the consent were delayed, PN may decline and require mechanical ventilation (or some other form of aggressive intervention) – something that would not be in PN's best interest. Further, the removal of life supporting therapy would be a new treatment proposal, subject to new considerations and intense stress for the family. I concluded that there was no evidence before me that any delay in consent would be in PN's best interest. Although not a consideration before me, it would also not meet the needs of IN as she had articulated.

2016 CanLII 68738 (ON CCB)

RESULT

I held that PN was not capable of consenting to the proposed treatment. I also held that IN, the substitute decision-maker, had not complied with the principles for substitute decision making set out in the *HCCA* and ordered that IN consent to the plan by July 9, 2016 at 12 p.m.

Dated: July 25, 2016

Lora Patton
Presiding Member