Scardoni et al. v. Hawryluck; The Attorney-General of
Ontario et al., Intervenors

[Indexed as: Scardoni v. Hawryluck]

69 O.R. (3d) 700
[2004] O.J. No. 300
Court File No. 03-94/03

Ontario Superior Court of Justice
Cullity J.
February 5, 2004

2004 CanLII 34326 (ON SC)

Mental health -- Incapable person -- Withholding life saving treatment -- Substitute decision maker -- Even insufficiently specific expressed wishes of patient that are therefore not "applicable to circumstances" within s. 21(1) of the Health Care Consent Act should still be considered when deciding what is in best interests of incapable person -- Consent and Capacity Board not erring in holding that general statement by person giving daughters power of attorney years earlier that wished to be kept alive in all circumstances not specific enough to satisfy requirements of s. 21(1) of Act -- Board erring in its application of s. 21(2) of Act by rejecting evidence of patient's religious beliefs on basis that her Church had other beliefs -- Focus under s. 21(2) should be on patient's subjective beliefs -- Board misapprehending medical evidence -- Decision of Board directing substitute decision-makers to consent to withholding of life-prolonging medical treatment set aside -- Health Care Consent Act, 1996, S.O. 1996, c. 2, Sched. A, s. 21.

The patient was 81 years old and suffered from Alzheimer's disease. She was unable to communicate verbally but was not in a vegetative state. She developed aspiration pneumonia and was admitted to hospital, where she was periodically placed on a ventilator. The patient's doctor, H, believed that the use of the ventilator took a terrible toll on the patient, and that additional discomfort was caused by the intravenous tubing required for the administration of other drugs. The patient's medical team became convinced that the benefits to the patient of the treatment she would receive in the intensive care unit were outweighed by the burdens it would impose on her and what they considered to be the lack of any enduring beneficial effects. H proposed to the patient's daughters, the appellants, [page701] that the treatments that had been administered in intensive care should be dispensed with in the future and that instead, every effort should be made to treat the patient's infections in the internal medical ward and to keep her as comfortable as possible with painkillers and sedatives. The appellants refused to consent to this proposal and H brought an application to the Consent and Capacity Board for a determination whether, in refusing to consent to the proposal, the appellants had complied with the principles for substitute decision-making set out in s. 21 of the Health Care Consent Act, 1996. The Board found that the appellants had not done so and ordered them to consent to H's proposal. The appellants appealed.

Held, the appeal should be allowed.

The legislature has entrusted to the Board, and not to the court, the task of deciding whether s. 21 of the Act was complied with, and the court should not interfere with the Board's decision unless it is unreasonable in light of the findings of fact on which it is based or dependent on an incorrect determination of a question of law. In determining whether there was compliance with s. 21(2) of the Act, the question for the Board is not whether the substitute decision-makers turned their minds to the right question and weighed the considerations referred to in paras. (a) and (b), or even whether their decision was reasonable, but whether they arrived at the correct conclusion with respect to the patient's best interests.

The Board did not err in concluding that "well-being" in s. 21(2)(c) of the Act includes considerations such as the person's dignity and levels of pain. The Board erred, however, in its interpretation of s. 21(2)(b), which directs that, in determining what an incapable person's best interests are, a substitute decision-maker "shall take into consideration . . . any wishes expressed by an incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1)". The Board wrongly found that wishes expressed by an adult person that do not fall within s. 21(1) because they are insufficiently specific should be considered for the purposes of s. 21(2)(b).

The appellants, who were appointed by the patient as her attorneys under a power of attorney for personal care executed by the patient before she knew that she had Alzheimer's disease, told the Board that the patient had always expressed a belief in prolonging life and not taking it. The Board correctly found that the provision of a power of attorney that authorizes a person to give, or refuse, consent to treatment to which the Act applies is not, without more, the expression of "a wish applicable to the circumstances" within the meaning of s. 21(1)1. However, it did not follow that the existence of a power of attorney for personal care had no relevance. The existence of the patient's power of attorney, which referred expressly to consent to treatment to which the Act applied, formed part of the context insofar as it indicated that she contemplated that, for one reason or another, she might, in the future, lack capacity to make decisions with respect to treatment. However, the Board's finding that the patient had not expressed a wish "applicable to the circumstances" was open to it on the evidence. A general statement of a person giving a power of attorney that she wished to be kept alive in all circumstances will not necessarily satisfy the requirements of s. 21(1)1.

The Board had before it evidence that the patient was a Roman Catholic and accordingly believed in and valued the sanctity of human life, but found that the patient's religious beliefs had no relevance as "the Church had no fixed guidelines regarding treatment at all cost for the purpose of prolonging life when there was no prospect but death sooner or later" and that the Church "recognized the sanctity of life but also the right to die with dignity". However, the question was not [page702] whether the patient's beliefs coincided with the official views of the Roman Catholic Church or were otherwise soundly based in its tenets, it was whether, and how strongly, she held those beliefs. The fact that a patient's views do or do not represent institutionalized views or that they are or are not shared by anyone else is irrelevant under s. 21(2). The Board also discounted the patient's maxim, "Where there's life, there's hope" on the basis that there was little hope in the circumstances of this case. In so doing, the Board ignored the consideration that it is the fact, and not the correctness, of the patient's belief to which weight and significance are to be attributed for the purposes of s. 21(2).

In considering and weighing the factors under s. 21(2)(c), the Board may have been influenced by its misapprehension of the medical evidence. The Board mistakenly believed that the patient had suffered cardiac arrests for which she had been admitted to the intensive care unit for cardiopulmonary resuscitation. It also believed, erroneously, that the patient had stopped breathing while in hospital. It could not be assumed that the Board's decision would have been the same if it had properly understood the medical evidence.

No rehearing before the Board is ordered. The patient's doctor has now had the benefit of hearing the evidence of the patient's daughters which provided additional insight into the patient's views and the patient's medical condition has changed. If the treatment team wishes to reapply to the Board at a later date, it may do so. There will be no order as to costs.

Fleming v. Reid (1991), 4 O.R. (3d) 74, 48 O.A.C. 46, 82 D.L.R. (4th) 298 (C.A.), revg (1990), 73 O.R. (2d) 169 (Dist. Ct.); Fleming v. Starson, [2003] 1 S.C.R. 722, 225 D.L.R. (4th) 385, 304 N.R. 326, 2003 SCC 32, [2003] S.C.J. No. 33 (QL) (sub nom Starson v. Swayze); T. (I.) v. L. (L.) (1999), 46 O.R. (3d) 284, 181 D.L.R. (4th) 125 (C.A.), affg (1998), 57 C.R.R. (2d) D-1 (Ont. Gen. Div.), consd

Other cases referred to

Canada (Director of Investigation and Research) v. Southam Inc., [1997] 1 S.C.R. 748, 144 D.L.R. (4th) 1, 209 N.R. 20, 71 C.P.R. (3d) 417; Conway v. Jacques (2002), 59 O.R. (3d) 737, 214 D.L.R. (4th) 67 (C.A.); Dr. Q. v. College of Physicians and Surgeons of British Columbia, [2003] 1 S.C.R. 226, 223 D.L.R. (4th) 599, 302 N.R. 34, [2003] 5 W.W.R. 1, 2003 SCC 19, 11 B.C.L.R. (4th) 1, [2003] S.C.J. No. 18 (QL); Griffen v. Teplitsky, [1999] O.J. No. 1152 (QL) (S.C.J.); Inland Revenue Commissioners v. Baddeley, [1955] A.C. 572, [1955] 1 All E.R. 525, [1955] 2 W.L.R. 552, 99 Sol. Jo. 166, 48 Rt. & I.T. 157 (sub nom. Baddley Trustees of Newton Trust) v. I.R. Comrs.), 35 Tax Cas. 34 A.T.C. 22 (H.L.); Janzen v. Janzen (2002), 44 E.T.R. 217 (Ont. S.C.J.); London Health Sciences Centre v. K. (R.) (Litigation guardian of) (1997), 152 D.L.R. (4th) 724 (Ont. Gen. Div.); M. (A.) v. Benes (1999), 46 O.R. (3d) 271, 180 D.L.R. (4th) 72, 70 C.R.R. (2d) 29 (C.A.), revg (1999), 166 D.L.R. (4th) 658, 57 C.R.R. (2d) 120 (Ont. Gen. Div.), supp. reasons (1998), 173 D.L.R. (4th) 758 (Ont. S.C.J.); Mercer v. Sijan (1977), 14 O.R. (2d) 12, 72 D.L.R. (3d) 364, 1 C.P.C. 281 (C.A.); Phillips v. Nova Scotia (Commission of Inquiry into the Westray Mine Tragedy), [1995] 2 S.C.R. 97, 141 N.S.R. (2d) 1, 124 D.L.R. (4th) 129, 180 N.R. 1, 403 A.P.R. 1, 28 C.R.R. (2d) 1, 98 C.C.C. (3d) 20, 39 C.R. (4th) 141 (sub nom. Phillips v. Richard); Sengmueller v. Sengmueller (1994), 17 O.R. (3d) 208, 111 D.L.R. (4th) 19, 1 L.W.R. 46, 25 C.P.C. (3d) 61, 2 R.F.L. (4th) 232 (C.A.)

Statutes referred to

Canadian Charter of Rights and Freedoms, ss. 2, 7, 15

Courts of Justice Act, R.S.O. 1990, c. C.43, s. 134(4)(b)

Health Care Consent Act, 1996, S.O. 1996, c. 2, Sched. A, ss. 1, 2(1) "treatment", "plan of treatment", 10(1), 13, 20(1)2, 21, 29, 37, 75, 80

APPEAL from a decision of the Consent and Capacity Board.

Joyce Chan, for appellants, Patricia Scardoni and Margaret Holland.

Harry Underwood and Erica Baron, for respondent, Dr. Hawryluck.

Sarah Wright and Diana Schell, for the intervenor, the Attorney-General of Ontario.

Hugh Scher, for the intervenor, Euthanasia Prevention Coalition of Ontario.

[1] CULLITY J.: -- Substitute decisions that are increasingly required by advances in medical science and technology can be agonizing when they concern a withdrawal, or withholding, of treatment that may prolong the life of a close relative. In this case, the appellants, Mrs. Patricia Scardoni and Ms. Margaret Holland, refused to consent to a proposal by their mother's physician that such treatment should be withheld. The Consent and Capacity Board disagreed with their belief that the treatment was in their mother's best interests and directed them to consent. This is an appeal from the decision of the Board.

[2] The appellants' mother, Mrs. Joyce Holland, is a patient at Toronto Western Hospital. Under a power of attorney for personal care executed by Mrs. Holland on February 10, 1998, she appointed her daughters as her attorneys.

[3] On October 6, 2003, the Board directed Mrs. Scardoni and Ms. Holland to authorize "the non-provision or withdrawal of ventilatory support and inotropic support to treat respiratory failure and/or septic shock" that Mrs. Holland might experience in the future. Such treatment is administered in the intensive care unit of the hospital.

[4] The direction of the Board was made pursuant to s. 37 of

the Health Care Consent Act, 1996, S.O. 1996, c. 2, Sched. A (the "Act") following an application to the Board by the respondent, Dr. Hawryluck -- a specialist in intensive care -- for a determination whether, in refusing to consent to her proposal that such treatments should be withheld, Mrs. Scardoni and her sister had complied with the principles for substitute decision-making set out in s. 21 of the Act. The Board found they had not done so and made the direction accordingly.

[5] Appeals to this court from decisions of the Board on questions of law or fact are permitted by s. 80 of the Act. On an appeal, the court is authorized to exercise all the powers of the [page704] Board, to substitute its opinion for that of a physician, a substitute decision-maker or the Board or to refer the matter back for a rehearing. The decision is to be made on the basis of the record, including the transcript of the proceedings before the Board, but the court "may receive new or additional evidence as it considers just" (s. 80(9)).

## Mrs. Holland's Medical Condition

[6] At the time of the hearing, Mrs. Holland was 81 years of age. She suffers from advanced Alzheimer's disease and it was not disputed that she is incapable of making decisions with respect to her personal care. The disease appears to have been first diagnosed in October 2001, shortly after she became a resident of Toronto Rehabilitation Long-Term Care Facility. She is unable to communicate verbally. The appellants believe that she recognizes them and is aware of their presence. The physicians and the nursing staff have not observed this and have had no similar experiences. They agree that Mrs. Holland is capable of hearing and that she will open her eyes when her name is called and look at the speaker. While the appellants believe she watches television, Dr. Hawryluck thinks it is not clear whether this is really the case. However, it is agreed that she is conscious and is not in a coma, or vegetative state.

[7] As a result of her Alzheimer's disease, Mrs. Holland began to aspirate -- to swallow into her lungs rather than her stomach -- and on June 26, 2003, she was admitted to Toronto

Western Hospital with aspiration pneumonia. She suffers from recurrent infections in her lungs and other parts of her body and, also, from severe and painful bedsores which are a source of infection. The infections have affected her blood pressure at different times and give rise to phlegm in her lungs. This requires suctioning. She has a tracheotomy and is fed through a tube into her stomach. She is bedridden and suffers from permanent reflection contractures of her joints.

[8] After Mrs. Holland's initial admission to the hospital, her condition worsened and she was transferred to the intensive care unit on July 5, 2003 suffering from an infection caused by her pneumonia. There she was placed on a ventilator to assist with her breathing and, as well as antibiotics to deal with the infections, inotropic drugs were administered to raise her blood pressure. She was released from intensive care on August 3 but readmitted on August 10 suffering from pneumonia and an infection from an intravenous tube. Again her breathing and blood-pressure were affected and she required the ventilator and inotropic drugs. She [page705] remained in the intensive care unit until September 2 when she was returned to the internal medical ward.

[9] At the time of the hearing before the Board on October 5, 2003, Mrs. Holland was undergoing suctioning at approximately 45-minute intervals and had continued to develop infections and fevers that required treatment with antibiotics. In her evidence before the Board, Dr. Hawryluck spoke of the discomfort, pain and loss of dignity inflicted by the treatment Mrs. Holland received in intensive care. Although it assisted her breathing while her pneumonia and lung infections were treated with medication, the use of the ventilator takes, in Dr. Hawryluck's words, a "terrible toll" on the patient. Additional discomfort is caused by the intravenous tubing required for the administration of the inotropic drugs. Dr. Hawryluck believes there is a risk that Mrs. Holland will die while in intensive care and, at the hearing before the Board, she estimated that any readmission to the unit was likely to reduce by one half her chance of discharge from hospital. She had estimated this to be about 20 per cent to 30 per cent if the problems that required treatment in the intensive care unit

did not recur. She believed, however, that a recurrence was likely. The treatment Mrs. Holland received there had no effect on the Alzheimer's disease which would ultimately cause her death even if she survived further treatment in intensive care. Dr. Hawryluck stated that she did not know whether Mrs. Holland would survive for longer than six months to a year but, when pressed in cross-examination, she agreed that Mrs. Holland's condition was stable and she expressed surprise that it was deteriorating more slowly than she would expect.

[10] After Mrs. Holland was released from intensive care the first time, there were some discussions among members of her medical team about the desirability of returning her there if she had a recurrence of respiratory and blood pressure difficulties. After the second occasion, Dr. Hobson and the members of the medical team became convinced that the benefits to Mrs. Holland of the treatment she would receive in the unit were outweighed by the burdens it would impose on her and what they considered to be its lack of any enduring beneficial effects.

[11] At a meeting with the appellants on September 26, 2003, Dr. Hawryluck proposed that resort to the treatments that had been administered in intensive care should be dispensed with in the future. Instead, every effort would be made to treat Mrs. Holland's infections in the internal medical ward and to keep her as comfortable as possible with painkillers and sedatives. Mrs. Scardoni and Ms. Holland refused to consent to this proposal and Dr. Hawryluck made the application to the Board on the same day. [page706]

[12] The hearing was held on October 5, 2003. Pursuant to s. 37(2) of the Act, the parties were Mrs. Holland, the appellants and Dr. Hawryluck. Mrs. Holland and the appellants were represented by counsel and the appellants gave evidence. Dr. Hawryluck appeared in person and testified, as well as calling three other members of Mrs. Holland's medical team as witnesses. The Board's decision was released the following day and I understand the parties were provided with its written reasons within two business days of the hearing.

[13] Three-and-a-half months elapsed between the hearing before the Board and that of this appeal. There was no motion to adduce new evidence of Mrs. Holland's condition and, at the commencement of the hearing, counsel informed me that they intended to argue the appeal on the basis of the record. On a subsequent day, I was provided with a brief agreed statement of facts with respect to Mrs. Holland's progress in the period since the Board's decision. I accepted the statement as part of the record as well as Mr. Underwood's submission that I should not draw inferences from it that would lead me to substitute my opinion for that of the Board without a rehearing there that would permit the significance of the agreed facts to be examined.

[14] In the judgment of the majority of the Supreme Court of Canada in Starson v. Swayze, [2003] 1 S.C.R. 722, [2003] S.C.J. No. 33 (QL), it was said that new evidence relating to a patient's deterioration after the hearing of the Board is irrelevant on an appeal from a determination of his or her capacity. I do not believe that the statement, or the reasoning on which it was based, is necessarily applicable to a case of a decision to withhold specific treatment in the future. Such a decision will not only determine whether the treatment will be provided, it will affect future decisions with respect to the treatment required to deal with the consequences of withholding it. More fundamentally, where the consequences of the decision's implementation are likely to significantly advance the time of the patient's death, I do not think a court on appeal could be expected to ignore evidence of facts that occurred after the hearing and that indicate that the Board's decision was vitiated by a material error of law or fact -- including a finding of the likelihood of future changes, or deterioration, in a patient's condition that is inconsistent with the facts that have subsequently emerged. Despite the inclusion of a plan of treatment in the definition of "treatment" in the Act, the words of provisions such as s. 21(2)(c) are more easily applied to the positive administration of treatment than to its discontinuance or withdrawal. The latter may, I believe, sometimes give rise to different considerations. [page707]

[15] The new evidence would, in my opinion, have been properly admitted in the interests of justice in accordance with s. 80(9) of the Act, s. 134(4)(b) of the Courts of Justice Act, R.S.O. 1990, c. C.43 and the principles applied by the Court of Appeal in Sengmueller v. Sengmueller (1994), 17 O.R. (3d) 208, 111 D.L.R. (4th) 19 (C.A.) and Mercer v. Sijan (1977), 14 O.R. (2d) 12, 72 D.L.R. (3d) 364 (C.A.). Much of the medical evidence before the Board had been directed at the likely course of Mrs. Holland's illness in the future including the likelihood that the conditions that would call for readmission to the intensive care unit would recur, the consequences of further treatment there, and the likelihood that the particular health problems caused by Alzheimer's disease would be cured, or alleviated to an extent that would permit her discharge from hospital and return to the Toronto Rehabilitation Long-Term Care Facility. To the extent that the evidence consisted of predictions with respect to Mrs. Holland's future condition, the agreed facts cast some light on their correctness. They also satisfied me that Mr. Underwood's submission was correct. In view of the issues raised on the appeal, and the potential consequences of my decision, it was also a cause of some relief that I was not left entirely in the dark with respect to Mrs. Holland's present condition.

[16] The agreed statement of facts is as follows:

1. From the time of the hearing before the Consent and Capacity Board on October 6, 2003 to October 23, 2003, Mrs. Joyce Holland was off the ventilator and remained on the medical unit.

2. On October 23, 2003, Mrs. Joyce Holland was admitted to the Intensive Care Unit (I.C.U.) for hypoxemia (insufficient oxygen in the blood) because of respiratory distress caused by mucus plug(s) in her airway and/or lungs and pneumonia (when occurring); and Mrs. Joyce Holland was put on a ventilator to assist her with her breathing.

3. Suctioning and subsequent chest physiotherapy treatments were given to Mrs. Joyce Holland to clear her mucus

plug(s). She also received antibiotics for pneumonia.

4. Mrs. Joyce Holland has been on the ventilator since her admission to the Intensive Care Unit on October 23, 2003.

5. On October 23, 2003, although Mrs. Joyce Holland was in respiratory distress, at no time, did Mrs. Joyce Holland suffer a cardiac arrest which means the stopping of her heart or a respiratory arrest which means the stopping of her breathing altogether.

6. Mrs. Joyce Holland has been medically stable; her blood pressure has been normal; her heart rate has been normal, except for a couple of days around November 14, 2003 where she showed extra heart beats (P.V.C. on the electrocardiogram). [page708]

7. Mrs. Joyce Holland also has been able to digest (metabolize) her feedings via her J-tube; Mrs. Joyce Holland's renal (kidney) and liver functions are normal.

8. During her current stay at the I.C.U., Mrs. Joyce Holland has been on seven course of antibiotics for infections diagnosed by taking cultures.

9. Mrs. Joyce Holland's chest has been clear; she requires minimal suctioning; her mucus (phlegm) is clear colour which indicates that she does not have a chest infection (pneumonia) at this time.

10. The level of ventilatory support was decreased between November 2003 and December 2003, but has increased since January 1, 2004. However, Mrs. Joyce Holland currently is not on full/maximum ventilatory support, she is on moderate ventilatory support. This means that Mrs. Joyce Holland is able to breath spontaneously but not sufficiently, and therefore she still requires moderate assistance from the ventilator.

11. Currently, Mrs. Joyce Holland's colour is satisfactory and she does not have pneumonia.

12. Continuing daily attempts have been made to wean Mrs. Joyce Holland off the ventilator. So far, this has not been possible.

13. Mrs. Joyce Holland has been observed by nursing staff in the I.C.U. who noted on the clinical record that Mrs. Joyce Holland is "comfortable and calm".

14. Neurologically, Ms. Joyce Holland remains unchanged, which means no improvement or deterioration, from the time of her hearing before the Consent and Capacity Board on October 6, 2003 to the present. Ms. Joyce Holland is conscious; and intermittently, she opens her eyes spontaneously when she is being woken up.

## The Legislation

[17] The Act deals with the circumstances in which consent to a patient's treatment must be obtained and provided, the persons who may give that consent when a patient lacks capacity and the principles that such persons must observe when determining whether to give or refuse consent. To the extent that they relate to such matters, the purposes of the legislation are described in s. 1 as follows:

> 1. The purposes of this Act are,
>
> (a) to provide rules with respect to consent to treatment that apply consistently in all settings;
>
> (b) to facilitate treatment . . . for persons lacking the capacity to make decisions about such matters;
>
> (c) to enhance the autonomy of persons for whom treatment is proposed . . . by . . . [page709]
>
> (iii) requiring that wishes with respect to treatment . . . expressed by persons while capable and

> after attaining 16 years of age be adhered to;
> . . .
>
> (e) to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment . . . .

. . . . .

[18] The obligation of a medical practitioner to obtain consent to the treatment of a patient who lacks capacity is imposed by s. 10(1)(b):

> 10(1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

. . . . .

> (b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act.

[19] The obligation will exist only when a treatment is proposed and will extend only to the administration of a treatment. Section 2(1) defines "treatment" as

> . . . anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, . . .

[20] The term "plan of treatment" is defined to mean "a plan that, . . .

> (a) is developed by one or more health practitioners,
>
> (b) deals with one or more of the health problems that

a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and

(c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition[.]

[21] Arguably, it is only by virtue of that definition that a decision to withdraw, or withhold, treatment would be a "treatment" for the purpose of s. 10 and would require a consent.

[22] Section 13 provides:

> 13. If a plan of treatment is to be proposed for a person, one health practitioner may, on behalf of all health practitioners involved in the plan of treatment,
>
> (a) propose the plan of treatment; [page710]
>
> (b) determine the person's capacity with respect to the treatments referred to in the plan of treatment; and
>
> (c) obtain a consent or refusal of consent in accordance with this Act,
>
> . . . . .
>
> (ii) from the person's substitute decision-maker, concerning the treatments with respect to which the person is found to be incapable.

[23] Section 20(1)2 authorizes an attorney for personal care to give or refuse consent to treatment on behalf of an incapable person "if the power of attorney confers authority to give or refuse consent to the treatment".

[24] Section 21 sets out the principles that govern the decision of a substitute decision-maker to give, or refuse, consent:

> 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.
>
> (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. [page711]

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.

[25] As already indicated, the application to determine whether Mrs. Holland's daughters had complied with the principles in s. 21 was made by Dr. Hawryluck pursuant to s. 37 of the Act which, in part, reads as follows:

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 s. 21, the health practitioner may apply to the Board for a determination as to whether the substitute decision-maker complied with s. 21.

(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.

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

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

. . . . .

(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).

[26] The consequence of a deemed failure to comply with the requirements of subsection 20(2) is that the subsequent decision-maker who has not complied with the Board's direction will cease to have authority to give, or refuse, consent with respect to the particular treatment. If there is no other person authorized to give consent pursuant to the Act, or, presumably, if all such persons fail to comply with the Board's direction, the decision is to be made by the Public Guardian and Trustee.

[27] Finally -- in view of certain comments in the Court of Appeal in T. (I.) v. L. (L.) (1999), 46 O.R. (3d) 284, 181 D.L.R. (4th) 125 (C.A.) to which I shall refer -- I note that s. 75 imposes an obligation on the Board to provide the parties, or their representatives, [page712] with a copy of the decision within one day after the hearing ends and, if any party requests reasons, written reasons are to be provided within two business days of the request. In this case a request for reasons was made at the conclusion of the hearing and I was informed that the Board complied with its obligations under s. 75.

[28] The above provisions were designed to fill gaps in the common law and previous statutes relating to the obligation to

obtain, and the ability to give and require, consent to the treatment of an incapable person. Section 29 of the Act addresses the related question of the protection to be afforded to health practitioners who rely on the consent of a substitute decision-maker. It reads, in part, as follows:

> 29(1) If a treatment is administered to a person with a consent that a health practitioner believes, on reasonable grounds and in good faith, to be sufficient for the purpose of this Act, the health practitioner is not liable for administering the treatment without consent.
>
> . . . . .
>
> (3) If a treatment is withheld or withdrawn in accordance with a plan of treatment and with a consent to the plan of treatment that a health practitioner believes, on reasonable grounds and in good faith, to be sufficient for the purpose of this Act, the health practitioner is not liable for withholding or withdrawing the treatment.

## The Appeal

[29] The appellants asked me to set aside the decision of the Board on the ground that it erred in fact and in law. They seek a declaration that the statutory requirements set out in the Act were not met at the time of the hearing. I understand this to mean that the Board was in error in finding that the appellants had not complied with s. 21 and, in consequence, was not entitled to override their decision to refuse consent.

[30] In the alternative, the appellants seek declarations that the provisions of the Act with respect to consent to treatment by subsequent decision-makers contravene s. 7 of the Canadian Charter of Rights and Freedoms and that the Act, as applied by the Board to Mrs. Holland and the appellants, contravenes ss. 2, 7 and 15 of the Charter.

[31] The Attorneys General of Canada and Ontario were served with notice of the appeal and of the constitutional questions and the Attorney-General of Ontario intervened and was

represented by counsel. On December 24, 2003, the Euthanasia Prevention Coalition of Ontario was given leave to intervene by Greer J. and its counsel made submissions at the hearing on the constitutional issues raised by the appellants. [page713]

Analysis

[32] It is hardly necessary to say that this is a difficult case. It is understandable that the proceedings, as well as the events that preceded them, have been a source of considerable pain and distress to the appellants. Neither their credibility as witnesses at the hearing nor their good faith has been impugned. On the contrary, the Board found:

> . . . in our view they thought they were doing the right thing. They were fighting for their mother's life and could not be faulted for advancing what they believe were her wishes, values, beliefs and best interests.

Similar conclusions should, I believe, be drawn with respect to Dr. Hawryluck's role in the proceedings. There has been no challenge to her credibility as a witness, or to her professional competence. Her sensitivity and concern to exercise her ethical and legal responsibilities as a health practitioner in the best interests of Mrs. Holland are evident from the transcript of her evidence. Nor was it suggested before the Board, or on this appeal, that her recommendation to the appellants, or her decision to make the application, was in any way affected, or motivated, by the availability of health-care resources. Her evidence that such considerations were not involved was accepted by the Board.

It was submitted on behalf of the appellants that certain questions asked of them by members of the Board demonstrated bias. There is no merit in this submission. The questions of the members were probing and, although, in one or two instances, they were, perhaps, a little "over the top" -- to use Mr. Underwood's expression -- they were invariably directed at the matters in issue and designed to elucidate relevant facts. The transcript indicates that the hearing was conducted in an entirely professional manner and the Reasons for Decision are lucid and remarkably comprehensive given the obligation to provide them within two business days of the hearing.

[33] In the submissions of counsel for the appellants and counsel for EPCO, the importance of the case transcends its immediate facts as it should be considered to represent a significant step down the slippery slope towards professionally-assisted euthanasia or mercy killing. Mrs. Holland is not in a vegetative state and is not brain-dead. At the time of the hearing she was not receiving treatment in intensive care and was said by Dr. Hawryluck to be "holding her own". It is possible that, if the conditions that have given rise to her need for the ventilator and the inotropic drugs recur, she will continue to respond to such treatment -- as, indeed, appears now to have happened -- and would be released from the intensive care unit. Dr. Hawryluck does not exclude the [page714] possibility that she may even be discharged from hospital. This, therefore, is not a case where -- as in London Health Sciences Centre v. K. (R.) (Litigation guardian of) (1997), 152 D.L.R. (4th) 724 (Ont. Gen. Div.) -- it can be said that the patient is "totally dependent on the ventilator to maintain life" or that there is no hope of any improvement at all in her existing condition. Mrs. Holland is not on "life support" in that sense. Further, in the submission of Ms. Chan, the Board effectively ignored Mrs. Holland's personal beliefs, values and wishes and determined the case entirely on the basis of its estimate of the benefits and burdens to her health and quality of life and the weight that it would give to them. She submitted, that by so doing, the Board gave no weight to the value to be placed on Mrs. Holland's personal autonomy -- a value that the legislation is intended to reflect, and protect.

## 1. The standard of review

[34] Although the court is authorized on an appeal to substitute its decision for that of the Board, this does not mean that the question for the court is whether it agrees or disagrees with the Board's decision. It is now established that deference is to be given to the Board's findings of fact -- and of mixed law and fact -- and that they should only be disturbed if they do not satisfy the standard of reasonableness: Starson,

paras. 83-88; T. (I.) at pp. 290-92 O.R.; Conway v. Jacques (2002), 59 O.R. (3d) 737, 214 D.L.R. (4th) 67 (C.A.), at p. 748 O.R., p. 80 D.L.R.; Griffen v. Teplitsky, [1999] O.J. No. 1552 (QL) (S.C.J.). In T. (I.) and Conway, the standard of reasonableness was held to be applicable to appeals from the Board's decisions on a substitute decision-makers compliance -- or failure to comply -- with s. 21 of the Act. Deference is required to be given to the Board's findings on the question whether the patient had expressed a prior capable wish within the meaning of s. 21(1) and, also, to the Board's determination of her best interests for the purposes of s. 21(2). With respect to the latter, the Board -- consisting in this case of a lawyer, a psychiatrist and a member of the public -- is considered to have a special expertise that is not possessed by a judge hearing an appeal: T. (I.), at p. 292 O.R.; Conway, at p. 80 D.L.R. Where, however, the finding relates to questions of statutory interpretation -- to the meaning to be attributed to the words of the Act -- the standard of correctness would appear to be applicable: Starson, at paras. 5 and 110.

[35] In consequence, the legislature has entrusted to the Board -- and not to the court -- the task of deciding whether the appellants complied with s. 21 of the Act and the court should not [page715] interfere with the decision unless it is unreasonable in the light of the findings of fact on which it is based or dependent on an incorrect determination of a question of law. In T. (I.), the Court of Appeal quoted [at p. 291 O.R.], and applied, an extract from the judgment of Iacobucci J. in Canada (Director of Investigation and Research, Competition Act) v. Southam Inc., [1997] 1 S.C.R. 748, 144 D.L.R. (4th) 1 that included the following passage:

> An unreasonable decision is one that, in the main, is not supported by any reasons that can stand up to a somewhat probing examination. Accordingly, a court reviewing a conclusion on the reasonableness standard must look to see whether any reasons support it. The defect, if there is one, could presumably be in the evidentiary foundation itself or in the logical process by which conclusions are sought to be drawn from it. An example of the former kind of defect would be an assumption that had no basis in the evidence, or that

> was contrary to the overwhelming weight of the evidence. An example of the latter kind of defect would be a contradiction in the premises or an invalid inference.

[36] It is important to note that, in determining whether there has been compliance with s. 21(2), the question for the Board is not whether the substitute decision-makers turned their minds to the right question and weighed the considerations referred to in paras. (a) and (b) -- or even whether their decision was reasonable -- but whether they arrived at the correct conclusion with respect to the patient's best interests. In M. (A.) v. Benes (1999), 46 O.R. (3d) 271, 180 D.L.R. (4th) 72 (C.A.) at p. 283 O.R., the court stated:

> A case will come before the Board only when the health practitioner disagrees with the S.D.M.'s application of the best interests test 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.

[37] In T. (I.), the Court of Appeal included among its reasons for the need for deference to the Board's determination of an incapable person's best interests, the importance of expeditious decision-making, the consequential desirability that delay resulting from appeal should be avoided, together with an inference that the Board was intended to have "some leeway" that can be drawn from its statutory obligations to release the decision within one day after the completion of the hearing and to provide written reasons within two days of

receiving a request. [page716]

[38] The Court of Appeal was considering a case of a refusal by a substitute decision-maker to consent to the application of certain drugs and not, as here, a refusal to consent to the future withholding of particular treatments. I will assume that the degree of deference is to be the same in each case although the need for expeditious decisions may not be as obvious in cases such as this. As far as the leeway dictated by the strict time limits is concerned, I do not believe the court was intended to shut its eyes to the possibility that hasty decisions are not always as likely to be as reasonable as those provided after mature reflection with the assistance of a transcript of the evidence. The point is, I believe, of some relevance in this case where I am satisfied that, despite, or possibly because of, its successful efforts to comply with the very tight time constraints imposed by the Act -- the Board misapprehended the evidence of both Mrs. Scardoni and Dr. Hawryluck in a number of respects. Before considering these matters and the Board's findings with respect to the application of s. 21, there are some questions of statutory interpretation that arise out of the Board's decision.

## 2. Interpretation of the Act

### (a) Consent to the withholding of treatment: section 10(1)(b)

[39] The first question is whether s. 10(1)(b) imposes an obligation on a health practitioner to obtain the consent of the substitute decision-maker to a decision to withdraw, or withhold, particular treatment. Notwithstanding the inclusion of such proposals in the definition of a "plan of treatment" and the inclusion of such plans in the definition of "treatment", Mr. Underwood suggested that the correct interpretation of s. 10 might well be that implementation of a proposal to withdraw, or withhold, treatment is not to be considered an administration of treatment within the meaning of s. 10. While a proposal of a plan of treatment that includes a withdrawal, or withholding, of one or more particular treatments would be a proposal of treatment within the opening

words of s. 10, the obligation "not to administer treatment" would, on this interpretation, apply only to positive steps to be taken to treat the patient's condition. On this line of reasoning it would follow that a substitute decision-maker's consent -- or, presumably, that of a capable person -- to a withholding of treatment is not required by s. 10(1) and, to that extent, in Mr. Underwood's submission, the Act does not alter the common law.

[40] This interpretation was supported by counsel for the Attorney-General who submitted that the Act should not be [page717] interpreted as permitting a patient -- or her substitute decision-maker -- to choose the health treatment to be administered. I believe that, as a general proposition, this is correct. It does not, however, follow that there is no room for a distinction between treatments that should be considered to be withdrawn, or withheld, for the purposes of the statutory definition of a plan of treatment, and other treatments that health practitioners would consider to be inappropriate for a patient's medical condition. If consent is required for the former, the statute does confer an important element of choice on a capable patient, and requires a consideration of the factors in s. 21 when the patient is incapable.

[41] Mr. Underwood submitted that it was unnecessary on the present facts to consider whether the above interpretation of the Act is correct as the consent of the appellants had been requested by Dr. Hawryluck and withheld. In effect, he asked me to find that, even if there was no obligation on her to obtain their consent before deciding that Mrs. Holland would not receive the treatments in the intensive care unit in the future, she was able to impose an obligation on them to determine whether this would be in the best interests of their mother and, when they refused to consent, to apply to the Board to have the question determined.

[42] An alternative interpretation that Ms. Chan supported is that all references to "treatment" in s. 10(1) include a plan of treatment and that the obligation imposed by the subsection relates to the plan as a whole, including the withholding or withdrawing of particular treatment. This interpretation is, I

believe, more consistent with the definitions in s. 2 that are reproduced above. Section 13 is, I think, ambiguous in that the permissive "may" in the opening words could relate simply to the authority of one of a number of practitioners, or it could reflect a legislative intention that the decision whether or not to obtain consent to a plan of treatment is entirely within the discretion of the health practitioner. A difficulty with the second alternative construction of s. 13 is that the provision is not confined to consent to the withholding or withdrawal of treatment. If it reflects the absence of an obligation to obtain consent to a plan of treatment, this would appear to apply equally to particular treatments to be administered in accordance with the plan. The distinction between treatment that is rejected by health practitioners as appropriate on health grounds, and treatment that is part of a plan of treatment is withheld, may be difficult -- and even very difficult -- to apply in some cases, but not, I think, here where the application of the treatment in intensive care for specific health problems of Mrs. Holland has been found by her physicians in the past to be medically appropriate and would be administered in the future but for [page718] their views of her best interests within the meaning of s. 21 of the Act and, specifically, s. 21(2)(c). As a practical matter, where physicians are in doubt whether consent is required, the substitute decision-maker would presumably be asked to consent and recourse to the Board would be available if consent is refused.

[43] I recognize the practical difficulties that may be created for health care practitioners if they are forced to distinguish between decisions to withhold treatment and decisions to administer certain treatments and not others. Legislative attention to this question might be helpful. There would also be a question whether it is possible for decisions to withhold, or withdraw, treatment to be made independently of a plan or a proposal.

[44] In view of the desirability that health practitioners should be able to obtain a determination from the Board on the question whether a decision to withhold, or withdraw, treatment is in a patient's best interests -- and the likelihood that

this was reflected in the legislative intention -- I believe each of the alternative interpretations supported by Mr. Underwood and Ms. Chan is more likely to be correct than a finding that the Board has no jurisdiction where the issue of consent relates to that question. In these circumstances, I intend to accept Mr. Underwood's invitation to leave the choice between the competing alternatives to be dealt with if and when a case ever arises in which the correct interpretation of the section is directly in issue.

### (b) The concept of "well-being": section 21(2)(c)

[45] A question of statutory interpretation that was more directly in issue in the appeal concerned the meaning of the word "well-being" in s. 21(2)(c) of the Act. The interpretation accepted by the Board was central to its finding that further treatment in the intensive care unit was not in Mrs. Holland's best interests. At p. 20 of its Reasons for Decision, the Board stated:

> 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.

[46] This interpretation was challenged by Ms. Chan who submitted that matters that are to be considered relevant to the well-being of a patient were intended to be confined to those relating to her health. In her submission, the Board erred in law in taking into consideration evidence with respect to Mrs. Holland's quality of life and, particularly, that of the discomfort and [page719] indignity she had experienced in undergoing treatment in the intensive care unit and would experience again if she was returned there.

[47] The phrase "quality of life" is used in other sections of the Act in connection with decisions with respect to an incapable person's best interests. It does not appear in the

sections relating to consent to treatment. Whether or not the considerations on which the Board relied are aptly encapsulated by the phrase, I am satisfied that the Board's interpretation of the reference to the "well-being" of a patient is to be preferred to the more narrow definition that Ms. Chan urged me to accept.

[48] The interpretation accepted by the Board is supported by dictionary definitions of wellbeing that refer to a person's state of happiness, contentment and prosperity as well as good health: see for example, the New Oxford Shorter Dictionary; Random House Unabridged Dictionary; and Nelson's Canadian Dictionary of the English Language. Generally, the dictionaries treat the term as synonymous with "welfare". Similarly, in Inland Revenue Commissioners v. Baddeley, [1955] A.C. 572, [1955] 1 All E.R. 525 (H.L.), at p. 616 A.C., Lord Somervell of Harrow referred to a person's "wellbeing" as meaning "a happy or contented state".

[49] Finally, in Janzen v. Janzen (2002), 44 E T.R. 217 (Ont. S.C.J.) in which the interpretation of s. 21(2) of the Act was considered in the context of competing applications for appointment as an incapable person's guardian of the person, Aitken J. 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 as pneumonia or kidney or heart failure; but according to the medical evidence it would not improve Mr. Jansen'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.

[50] I accept that interpretation and find no error of law in the Board's conclusion on the meaning of "well-being" in the

Act.

(c) Expressed wishes outside section 21(1): section 21(2)(b)

[51] I do not, however, believe that the Board was correct in its interpretation of s. 21(2)(b) which directs that, in determining what an incapable person's best interests are, a substitute decision-maker "shall take into consideration . . . any wishes [page720] expressed by an incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1)".

[52] The Board addressed the meaning, and significance, of this paragraph as follows:

> Did the legislature mean a wish expressed that was incapable or that was expressed before the person attained the age of 16, or did the legislature mean a wish that was not applicable to the circumstances, or both? In our view, a wish had to be applicable to the circumstances in order to be covered by this provision.

[53] Paragraph 21(2)(b) must be read in the light of para. 21(1)1, which stipulates that:

> If the person [i.e., a substitute decision-maker] 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. [See Note 1 at end of the document]

[54] The relevance of an incapable person's wishes was explained by Sharpe J.A. in Conway as follows [at p. 738 O.R.]:

> The wishes of the patient are to be considered by the substitute decision-maker at two stages under the Act: in acting in accordance with a prior capable wish applicable to the circumstances pursuant to s. 21(1)1; and in determining the incapable person's best interests pursuant to s. 21(2) where there is no capable wish applicable to the

> circumstances.
>
> . . . . .
>
> At the first stage, the substitute decision-maker must act in accordance with a wish expressed while capable that is applicable to the circumstances. However, I agree with the appeal judge that prior capable wishes are not to be applied mechanically or literally without regard to relevant changes in circumstances. Even wishes expressed in categorical or absolute terms must be interpreted in light of the circumstances prevailing at the time the wish was expressed . . .
>
> At the second stage, the substitute decision-maker must decide whether or not to consent to treatment on the basis of the best interests test under s. 21(2). Under s. 21(2)(b), the substitute decision-maker must take into account "any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under [s. 21(1) para. 1]", namely any wishes that are not prior capable wishes applicable to the circumstances. It is only at the second stage that the Act allows for consideration of the decision the patient would have made in light of changed circumstances. [page721]

[55] In the light of that reasoning, I cannot agree that wishes expressed by an adult person that do not fall within s. 21(1) because they are insufficiently specific to permit an inference that they are "applicable to the circumstances" cannot be "wishes . . . that are not required to be followed" under s. 21(1) for the purposes of s. 21[(2)](b). Unless the changed circumstances to which Sharpe J.A. referred are shown to have been in the contemplation of the donor at the time her wishes were expressed they will not be "applicable to the circumstances" referred to in s. 21(1). Such wishes may, however, still permit an inference with respect to the decision that the incapable person would have made in the new circumstances -- an inference that is to be taken into consideration when applying s. 21(2). As such an inference will necessarily be speculative to some extent, it is not to be

treated by the substitute decision-maker as conclusive. It is just one of the factors to be considered under s. 21(2) and the weight to be given to it will depend upon the facts. Expressed wishes that, for example, are held to be outside s. 21(1), because they are insufficiently specific to satisfy the substitute decision-maker -- or the Board -- that they were in the contemplation of the patient when capable, may still permit an inference with respect to what the patient's wishes would have been in the changed circumstances. In my opinion, s. 21(2)(b) directs that they be considered in determining the patient's best wishes and the Board erred in law in finding to the contrary.

[56] The importance to be attributed to the requirement of a patient's informed consent to treatment was strongly emphasized by the Court of Appeal in Fleming v. Reid (1991), 4 O.R. (3d) 74, 82 D.L.R. (4th) 298 (C.A.), in which provisions of the Mental Health Act, R.S.O. 1980, c. 262, as amended, dealing with consent to treatment, were held to deprive patients of the right to security of the person conferred by s. 7 of the Charter. In delivering the judgment of the court, Robins J.A. stated [at pp. 85, 88 and 94 O.R.]:

> The right to determine what shall, or shall not, be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in our common law. This right underlies the doctrine of informed consent. With very limited exceptions, every person's body is considered inviolate, and, accordingly, every competent adult has the right to be free from unwanted medical treatment. The fact that serious risks or consequences may result from a refusal of medical treatment does not vitiate the right of medical self-determination. The doctrine of informed consent ensures the freedom of individuals to make choices about their medical care. It is the patient, not the doctor, who ultimately must decide if treatment -- any treatment -- is to be administered.

. . . . . [page722]

> Indeed, in my view, the common law right to determine what

> shall be done with one's body and a constitutional right to security of the person, both of which are founded on the belief in the dignity and autonomy of each individual, can be treated as co-extensive.
>
> In my view, no objection can be taken to procedural requirements designed to determine more accurately the intended effect or scope of an incompetent patient's prior competent wishes or instructions. As the Act now stands, the substitute consent-giver's decision must be governed by wishes which may range from an isolated or casual statement of refusal to reliable and informed instructions based on a patient's knowledge of the effect of the drug on him or her. Furthermore, there may be questions as to the clarity or currency of the wishes, their applicability to the patient's present circumstances, and whether they have been revoked or revised by subsequent wishes or a subsequently . . . accepted treatment program. The resolution of questions of this nature is patently a matter for legislative action. But, in my respectful view, it is incumbent on the legislature to bear in mind that, as a general proposition, psychiatric patients are entitled to make competent decisions and exercise their right to self-determination in accordance with their own standards and values and not necessarily in a manner others may believe to be in the patients' best interests.

[57] Sections 21(2)(a) and (b) were enacted after the decision in Fleming and, in my opinion, represent a legislative acceptance of the value to be attributed to a patient's individual autonomy and right to medical self-determination and, also, a response to the court's comments on the level of clarity in the earlier provisions that referred to a patient's wishes. Although the Court of Appeal was considering the administration of treatment -- and not its withdrawal, withholding or discontinuance -- I do not believe the Act distinguishes decisions on these matters as far as the principles governing a substitute decision-maker's consent, or refusal, to treatment are concerned.

[58] I believe it is fair to say that Mr. Underwood did not seek to support the Board's narrow interpretation of s. 21(2)

(b) with much enthusiasm. Whether or not it was correct was, in his submission, of no significance as it was sufficiently clear that the Board had taken the evidence of Mrs. Holland's expressed wishes into consideration when inquiring into her "values and beliefs" under para. (a) of s. 21(2). I understand the thrust of Mr. Underwood's submissions to be that, even if the Board erroneously interpreted para. (b), it had taken the matters referred to there into consideration along with the other factors in s. 21(2) and that its decision that further treatment in intensive care was not in Mrs. Holland's best interests was reasonable in the light of those considerations and of the evidence at the hearing. In Ms. Chan's submission, the decision should not be considered to be reasonable as the Board had misapprehended, or failed to give adequate consideration to, Mrs. Holland's wishes, values, beliefs and actual medical condition.

### 3. The Board's decision

[59] In Starson, McLachlin C.J.C. described the Act as representing "a careful and balanced response to the problem of accommodating the individual autonomy of the medically ill person and the aim of securing effective treatment for mentally ill people" (at para. 11). For the purpose of consent to treatment, the interests of a patient's individual autonomy are reflected in s. 21(1)1. Where the wishes of the patient are not known with sufficient exactness to satisfy the requirements of that provision, they may still be given weight under paras. (a) and (b) of s. 21(2) in determining the patient's best interests.

[60] Paragraph 21(2)(c) is concerned with the consequences of giving, or withholding, treatment on the patient's health and well-being. Although the evidence of health practitioners that reflects their expertise will inevitably be essential, the weighing of benefits and burdens under the section cannot be achieved scientifically. The imponderables involved -- and the difficulty of the exercise -- are increased significantly when the qualitatively different considerations referred to in s. 21(2)(a) and (b) are added to the scales.

[61] In considering the reasonableness of the Board's decision and findings of fact, I must be guided by the decisions of the Court of Appeal that based the standard on the deference to be given to the Board's expertise in weighing all of the factors in s. 21(2) -- an expertise that is not possessed by the substitute decision-maker, health practitioners or the court. I note, also, the warning given by the Supreme Court of Canada in Dr. Q. v. College of Physicians and Surgeons of British Columbia, [2003] 1 S.C.R. 226, [2003] S.C.J. No. 18 (QL) that, in considering the reasonableness of the Board's findings of fact the reviewing judge must be careful not to mistake correctness for reasonableness. As McLachlin C.J.C. stated in that case [at para. 41]:

> . . . when applying a standard of reasonableness simpliciter, the reviewing judge's view of the evidence is beside the point; rather, the reviewing judge should have asked whether the [tribunal's] conclusion . . . had some basis in the evidence.

[62] Where, however, the Board has made findings of fact -- or of mixed law or fact -- that have no basis in the evidence, such findings must be considered be unreasonable and may affect the reasonableness of the decision. Similarly, if the Board clearly ignored -- or misapprehended -- evidence that was relevant to its determination of the issues before it, this might justify a finding that its decision was unreasonable. Whether it would do so may depend on the extent to which it would have provided support for [page724] a different decision and the existence of other evidence on which the Board relied and which, by itself, could provide a basis for the decision.

(a) Mrs. Holland's expressed wishes

[63] In Ms. Chan's submission, the Board either ignored, or misapprehended, evidence of the appellants with respect to their mother's expressed wishes. Mrs. Scardoni's evidence was that her mother had told her that she believed in "prolonging life and not to take it" and that she wanted to "continue and if necessary take all the precautions that were out there for her to continue". When asked by her counsel what she and her

sister were trying to achieve by keeping their mother alive in intensive care, she replied:

> My mother's wishes. They were her wishes. I want to keep her wishes because I'm her daughter.

[64] Mrs. Scardoni was questioned by the chairman of the panel and other members on the generality of her discussions with her mother and on whether the mother's desire that her life should be prolonged would have existed in all circumstances. Part of the transcript reads as follows:

> Q. Mrs. Scardoni, is it fair of me to think that the conversations that you and your mother had about her end of life decisions were very general only and not very specific? Is that fair?
>
> A. No, they were specific . . .
>
> Q. Okay, so what specifically did she say?
>
> A. That she would want everything to prolong her life and being as a Catholic, she always said "here [sic] there is life there's hope" and I'm going by her last wishes.
>
> Q. And did you contemplate or did you and she talk about specific circumstances that might have arisen?
>
> A. No.
>
> Q. So the information she gave you was basically quite general, is that fair?
>
> A. Yeah, and she would want everything used to prolong her life, yes. If that's what you mean generally.
>
> Q. Yeah, that's what I meant, thank you for that.
>
> . . . . .
>
> Q. Can you imagine any situation at all in any circumstance

whatsoever where your mother's sense to you of the need to prolong life at any cost, she would modify that view, in any circumstance?

A. I can't think of any . . . [page725]

Q. Suppose prolonging her life cost the life of one of her children, is that something she would want?

A. I can't answer that. . . .

Q. Okay. I just want to suggest to you that it is not an unequivocal absolute when someone, like your mother, says prolong my life at any, in any circumstance. Can you accept that?

A. Yes.

Q. Okay, So there are some circumstances in which she would qualify her instruction to you? Or are there not?

A. I'm not sure. I can't answer that.

Q. And I would guess that not surprisingly one of the reasons you can't answer that is because in 1998 you didn't have the detailed conversation that we always learn the hard way we perhaps should have had, is that fair? You didn't go into huge detail.

A. Exactly.

Q. Okay. So although you have this particular instruction from your mother, there is some vague edges to it, is that fair?

A. I guess you -- well -- in what way do you mean vague edges?

Q. Well, for example, you didn't say to her what if da da, da da, da, da this particular thing happens or that precise thing happens.

A. No, okay, okay.

Q. So you didn't talk about specific situations.

A. No.

Q. Okay. Because sometimes when people execute a power of attorney it is in anticipation of a particular operation or a particular medical procedure and they do it with regard to those particular risks and the particular benefits and possible results of that so you can have a concrete conversation.

A. M'hm.

Q. But you weren't in that circumstance with your mother.

A. No.

[65] I believe it is quite clear from the transcript that Mrs. Scardoni's evidence was that her mother told her that she wanted every available treatment used to prolong her life in any circumstances and that the members of the Board understood that her evidence was to that effect. However, while the Board made no finding that Mrs. Scardoni's evidence lacked credibility and, indeed, accepted that she and her sister were "advancing what they believed were their mother's wishes . . .", it concluded [at p. 17, Reasons for Decision]:
[page726]

> Whatever approach we took to determining whether Mrs. Holland had expressed a prior capable wish applicable to her circumstances as at the Hearing, it was our view she had not. There was nothing in Mrs. Holland's power of attorney to guide her daughters. She never knew she had Alzheimer's disease and therefore could not have specifically directed her mind to that diagnosis. There were no conversations between Mrs. Holland and the substitute decision-makers she appointed regarding end of life decisions beyond, "where there's life there's hope["].

> That phrase, noble by which to live, was in our view too general, not concrete enough, to be considered a directive applicable no matter what. Using the words of Justice Sharpe in Conway v. Jacques, "prior capable wishes are not to be applied mechanically or literally without regard to relevant changes in circumstances. Even wishes expressed in categorical or absolute terms must be interpreted in light of the circumstances prevailing at the time the wish was expressed". Also interpreted at the time the wish had to be applied.
>
> With the guidance of Conway v. Jacques, we were not prepared to hold that Mrs. Holland had expressed a prior capable wish applicable to her circumstances as at the Hearing.

[66] On that basis, the Board found that s. 21(1)1 was not applicable to the facts before it. The fact that, unlike the position in Conway, Mrs. Holland had executed a power of attorney for personal care was not considered to have any relevance to the question.

[67] The power of attorney for personal care executed by Mrs. Holland while she was capable consisted of a law stationer's form that is in common use and which authorizes the donor's attorneys "to make decisions concerning my personal care in accordance with the Substitute Decisions Act and any conditions, restrictions, specific instructions or special powers contained herein" and, "specifically, on my behalf to give or refuse to consent to treatment to which the Health Care Consent Act, 1996 applies". The words "or as follows" that appear on the form after the second of these provisions were crossed out and the word "NONE" was inserted in spaces provided for conditions, restrictions, specific instructions or special provisions.

[68] The Board recognized that the existence, and the terms, of the power, indicated that Mrs. Holland trusted her daughters "to interpret her values and beliefs and decide her best interests". However, it held [at p. 17, Reasons for Decision] that:

> The legislation did not accord attorneys for personal care any higher status or regard in an application of this kind than any other substitute decision-maker. Their decisions regarding consent to treatment were as reviewable as any other substitute decision-maker.

[69] In the view of the Board, the power of attorney was "of no help to us in deciding this case". It follows that, in the opinion of the Board, the provision of a power of attorney that authorizes a person to give, or refuse, consent to treatment to which the Act [page727] applies is not, without more, the expression of "a wish applicable to the circumstances" within the meaning of s. 21(1)1. I believe this is a correct interpretation of the Act. By virtue of s. 20(1)2 such an attorney is a person who must observe the principles set out in s. 21(1) and I do not believe it was intended that the existence of the power would, by itself, satisfy the requirement in s. 21(1)1. The deference to be shown to the capable wishes of a patient does not extend to a wish to delegate.

[70] However, it does not follow that the existence of a power of attorney for personal care has no relevance to an inquiry into the application of s. 21(1)1 -- that it cannot be helpful in determining whether a patient's expressed capable wishes are to be considered to have been applicable to the circumstances.

[71] The Board found that there was nothing in Mrs. Holland's power of attorney to guide her daughters and stated [at p. 17, Reasons for Decision]:

> She never knew she had Alzheimer's disease and could not have specifically turned her mind to that diagnosis.

[72] Dr. Hawryluck gave the same reason for concluding that Mrs. Holland had expressed no wish within the meaning of s. 21(1)1. She, however, did not know -- and had not inquired whether -- Mrs. Holland had given her daughters a power of attorney for personal care.

[73] In determining whether a patient's expressed wishes are applicable to the circumstances, they must be considered in their context. The existence of Mrs. Holland's power of attorney, which referred expressly to consent to treatment to which the Act applies, formed part of the context insofar as it indicated that she contemplated that, for one reason or another, she might, in the future, lack capacity to make decisions with respect to treatment. That possibility provides the main purpose for granting such powers.

[74] If, by its references to Alzheimer's disease, the Board intended to imply that there must be evidence that a patient contemplated the specific circumstances in which a lack of capacity might occur, that would, I believe, be to impose too high a standard. If, however -- as I believe was probably the case -- the Board intended to indicate that it was not satisfied that Mrs. Holland had turned her mind to the nature and extent of the effects of Alzheimer's disease that have given rise to her present condition and the request for her daughters' consent, I believe its finding that she had not expressed a wish "applicable to the circumstances" was open to it on the evidence.

[75] I believe the Board was correct in finding that it is implicit in the reasons in Conway that a general statement of [page728] a person giving a power of attorney that she wished to be kept alive in all circumstances will not necessarily satisfy the requirements of s. 21(1)1 although whether this is so may depend on the circumstances existing when the wish was expressed, as well as those that subsequently occurred. I do not believe I would be justified in rejecting the finding of the Board with respect to the requirements of s. 21(1)1 on the ground that it was unreasonable.

[76] The Board's statement that there were no end of life discussions between Mrs. Holland and her two daughters beyond "where there's life there's hope" is more puzzling. Mrs. Scardoni and her sister used the phrase to indicate one of their mother's philosophies of life and, as such, one basis for her mother's expressed wish. However, the statement that the

discussions did not extend beyond this is simply not supported by the evidence. Even if I were to assume that the Board's statement must have reflected an unexpressed rejection of Mrs. Scardoni's credibility rather than an encapsulation of her evidence, it is difficult to find an evidential basis for the conclusion that the discussions between Mrs. Holland and the appellants were so limited.

[77] Having found that there were no wishes expressed by Mrs. Holland that were applicable to the circumstances, the Board then considered whether a continuation of the treatments in intensive care would be in her best interests in the light of the factors set out in s. 21(2).

### (b) Mrs. Holland's values and beliefs: section 21(2)(a)

[78] Mrs. Scardoni's evidence was that, as a Roman Catholic, Mrs. Holland believed in, and valued, the sanctity of human life and that this provided motivation for the wishes she had expressed and for the decision Mrs. Scardoni believed her mother would have made in the light of the changed circumstances. The Board found that Mrs. Holland's religious beliefs had no relevance. It stated [at p. 18, Reasons for Decision]:

> Mrs. Holland was Catholic but the Church had no fixed guidelines regarding treatment at all costs for the purpose of prolonging life when there was no prospect but death sooner or later. According to Ms. Wright, the Church recognized the sanctity of life but also the right to die with dignity. We could not ascribe any relevance to Mrs. Holland's religious beliefs.

[79] Ms. Wright is a social worker who was engaged by the Toronto Western Hospital to give advice to staff, patients and families on bioethical questions. She was present at the meeting with the appellants at which they were asked to consent to the proposals to withhold future treatment in intensive care for Mrs. Holland. In [page729] giving evidence at the hearing she stated that her understanding was that there was a spectrum of beliefs among Roman Catholics about end of life decisions

but that there was a strong respect for the sanctity of life. She stated also that there was "a lot of regard for dignity of the person but there is a wide interpretation of that".

[80] She stated further that the family had told the meeting that they had never had discussions with their mother about end of life decisions and that they provided no religious or other reason for their decision to refuse consent other than "where there's life there's hope". There was also evidence that, although there had been no discussion of religious beliefs at the meeting, the family had declined to meet with the non-denominational chaplain at the hospital and that they had indicated that they did not want to bring a priest to the meeting.

[81] Ms. Margaret Holland testified that she had told the medical staff that her mother's habitual use of the expression "where there's life there's hope" stemmed from her religion.

[82] Having rejected the relevance of Mrs. Holland's religious beliefs, the Board then examined her belief that there was always hope while life remained. The Board found [at p. 19, Reasons for Decision] that it should be given little weight as, in the circumstances, there was little hope.

> Certainly, there could always be hope but for Mrs. Holland it was sadly scant. Mrs. Holland was inexorably approaching death's cold door and already within reach of knocking on it.
>
> Given Mrs. Holland's circumstances and even in the face of the fact that she trusted her daughters to interpret her values and beliefs, to the extent expressed in the phrase, "Where there's life there's hope", we felt obliged to give those values and beliefs less weight than the factors set out in subsection 21(2)(c).

[83] With, I believe, some justification, Ms. Chan was heavily critical of the Board's rejection of the relevance of Mrs. Holland's religious beliefs. The question, in her submission, was not whether Mrs. Holland's beliefs coincided with the official views of the Roman Catholic Church or were

otherwise soundly based in its tenets, the question was whether -- and, if so, how strongly -- she held them. Sections 21(2)(a) and (b) reflect legislative acceptance that a person's personal beliefs, values and wishes are relevant to the statutory concept of their best interests. The provisions recognize, and reflect, the value to be attributed to personal autonomy by allowing the Board to look at the question of a patient's best interests from the viewpoint of the patient. As Sharpe J.A. stated in Conway, inferences as to the decision the patient would have made in the changed circumstances if then [page730] capable are relevant under s. 21(2). The fact that a person's beliefs, values or wishes represent, or do not represent, institutionalized views, or that they are, or are not, shared by anyone else is irrelevant. Ms. Wright's evidence was not inconsistent with that of the appellants that their mother's views on life and death decisions stemmed from her religious beliefs.

[84] This is not a case where the Board rejected the evidence of the appellants with respect to their mother's beliefs. Rather, it considered whether justification for them was to be found in the teachings of the Roman Catholic Church. This approach ignored the legislative purpose of s. 21(2)(a) and misinterpreted its provisions. As such, it involved a mistake of law to which the standard of correctness applies.

[85] Similarly, to discount the belief expressed in the maxim "where there's life there's hope" on the basis of a finding that any hope was negligible, ignored the consideration that it is the fact, and not the correctness, of the belief to which weight and significance are to be attributed for the purposes of s. 21(2). In its application of s. 21(2)(a), the Board made no reference to Mrs. Scardoni's evidence of the wishes expressed by her mother or to the possibility that they might support an inference as to the wishes she would have expressed if her present condition had been contemplated while she was capable, or the wishes she would express now if she had capacity. I have found nothing in the Board's Reasons to support Mr. Underwood's submission that the Board considered what, if any, weight was to be given to Mrs. Holland's expressed wishes that she would want "everything done to

prolong her life" and "if necessary to take all precautions that were out there for her to continue" in its application of s. 21(2)(a), other than their refusal to accept the maxim that refers to life and hope as relevant to her existing medical condition.

[86] In short, by virtue of what I consider to be its erroneous interpretation of s. 21(2)(b) and, to the extent that its conclusion with respect to the weight to be given to Mrs. Holland's values and beliefs under s. 21(2)(a) was based on evidence that there was a spectrum of beliefs among Roman Catholics -- and no official position of the Church -- on life and death decisions and on Mrs. Holland's short life expectancy, the Board either ignored, misapprehended or confused the fundamental differences between the personal, subjective factors to be considered under those provisions and the values they reflect, on the one hand, and the considerations that are relevant to the application of s. 21(2)(c), on the other. [page731]

### (c) Balancing benefits and burdens: section 21(2)(c)

[87] In considering and weighing the factors referred to in s. 21(2)(c), the Board was concerned essentially with the consequences of the proposal to withhold further administration of the treatments in intensive care. In so doing, it very largely -- and quite properly -- confined its attention to the evidence of Dr. Hawryluck. It made the following findings:

(a) the use of the ventilator and inotropic drugs in the intensive care unit would keep Mrs. Holland alive but would not improve her underlying medical conditions, prevent further deterioration from Alzheimer's disease, or its complications, or reduce the risk of infection in the future.

(b) such treatments would erode Mrs. Holland's dignity;

(c) some pain was associated with the use of the ventilator but the pain that Mrs. Holland would suffer if her condition deteriorated as a result of withholding treatment would-be "as difficult to determine and minister to";

(d) the pain, discomfort and loss of dignity "all to [sic] briefly maintain her life when she was at her best barely aware of those circumstances and deteriorating physically and mentally with virtually no possibility of leaving hospital was not a fair trade-off";

(e) Mrs. Holland's quality of life was lower when under intensive care than in the internal medical ward; and

(f) the treatments could not be said to "benefit" Mrs. Holland in the sense that the prolongation of life did not outweigh the pain, discomfort and loss of dignity she would experience in intensive care.

[88] To the extent that these findings were supported by the evidence, I do not believe a decision based only on s. 21(2)(c) that it was in Mrs. Holland's best interests to withhold further administration of the treatments in intensive care would fail the standard of reasonableness. Moreover, as McLachlin C.J.C. indicated in Starson (at para. 5), it is not the role of the court to determine, on the basis of the record, whether it agreed with the Board's findings of fact or its understanding and assessment of the evidence.

[89] However, essential to the Board's weighing, or balancing, of the factors in s. 21(2)(c) was an understanding of Mrs. Holland's existing condition and prognosis for the future. On this [page732] point, as I mentioned earlier in these reasons, I am satisfied that certain of the Board's factual conclusions had no basis in the evidence and some were quite clearly contradicted by it.

[90] The Board mistakenly believed that Mrs. Holland had suffered cardiac arrests for which she had been admitted to the intensive care unit for cardiopulmonary resuscitation ("CPR"). It also believed that she had stopped breathing while in hospital. There was no evidence that either of these events had occurred. Dr. Hawryluck's evidence was that Mrs. Holland "has no cardiac issues, has never had problems with her heart" and

that the ventilator would be used to assist her with her breathing when this was required in the event of respiratory failure or to overcome strain and tiredness caused by frequent suctioning of the lungs.

[91] Dr. Hawryluck referred to CPR in connection with a recommendation made to the family during Mrs. Holland's first period in intensive care. The recommendation was that, in the event of a cardiac arrest, CPR would not be administered as there would be less than a one per cent chance that it would be successful. In these circumstances, the physicians believed that CPR would be -- in Dr. Hawryluck's words -- "medically futile". A second opinion was obtained from a physician at another hospital and the family were informed that a "no CPR note" would be placed on Mrs. Holland's chart. I was informed by Mr. Underwood that this was subsequently done. As Mrs. Holland has not suffered a cardiac arrest, this evidence has no direct bearing on the issues that were before the Board.

[92] However, the Board confused this evidence with that relating to the decision to withhold the treatments with which this appeal is concerned and, in various places throughout its reasons, it used the initials "CPR" to refer to the use of the ventilator to assist Mrs. Holland with her breathing if she had a recurrence of the conditions that had previously led to her admission to the intensive care unit.

> It was for the treatments that required return to ICU that Dr. Hawryluck asked consent not to administer. These were the ventilator, used for cardiopulmonary resuscitation, or CPR, and the adrenaline-type drugs to reverse the drop in blood pressure that resulted from "septic shock", a doctor's phrase for serious infection. Authorization to withhold CPR meant Mrs. Holland's most responsible physician in the internal medicine unit would sign a "Do Not Resuscitate" Order, or DNR. It Mrs. Holland stopped breathing again, she would be made as comfortable as possible until she died -- the chances of survival without CPR were less than one per cent.

(Reasons for Decision, p. 7)

> ICU imposed greater burdens. The CPR and drug treatments there would temporarily halt or slow Mrs. Holland's infection but subject her to a lot at [page733] high cost. Dr. Hawryluck said CPR was medically futile because it was impossible to reverse the advanced stage of Mrs. Holland's Alzheimer's. Dr. Hawryluck confirmed this with another specialist called in from Sunnybrook Hospital to consult, who agreed.

(Reasons for Decision, p. 8)

> Further heroic measures, and in our view that was the nature of the proposed treatments in issue although the phrase was not used during the Hearing, were medically futile, a phrase that was used in the Hearing. Medically futile means the treatments would not, in the opinion of Mrs. Holland's doctors, help her.

(Reasons for Decision, p. 23)

[93] I am satisfied that the Board misunderstood the context of Dr. Hawryluck's evidence with respect to CPR. She did not describe the treatments in intensive care as "medically futile" and she did not state that Mrs. Holland's chance of survival "if she stopped breathing again" was less than one per cent without the use of the ventilator. There is no evidence that Mrs. Holland had ever stopped breathing and Dr. Hawryluck did not speak of DNR orders other than in relation to cardiac arrest. The reference to a one per cent chance of survival and the other references to CPR were made in relation to the possibility of cardiac arrest.

[94] It was implicit in Dr. Hawryluck's evidence that a decision not to return Mrs. Holland to intensive care would shorten her life. What is missing from the evidence, and from the Board's reasons, is any consideration of how long she would survive -- and in what degree of pain and discomfort and whether she would have any chance of recovery -- if pneumonia, or a drop in blood pressure recurs, and she is not returned to the intensive care unit. Certainly, Dr. Hawryluck's estimate of a one per cent chance of survival was not directed at these

questions and the Board was mistaken in believing otherwise. In the event of respiratory failure, Dr. Hawryluck indicated that it would be possible to keep Mrs. Holland comfortable and pain-free by administering drugs such as morphine or valium which would take away any sense of shortness of breath. Again, however, she did not refer to pain and discomfort that Mrs. Holland will experience if her death ultimately occurs as a result of the other complications that, in the past, have been treated in the intensive care unit. The Board assumed, without evidence, that death would be prompt if there was no further recourse to intensive care. In this respect, the Board's apparent belief that Mrs. Holland had stopped breathing in the past, that this had led to her admission to the intensive care unit and that it was likely to recur in the future is troubling. The Board, I believe, misunderstood Dr. Hawryluck's references to respiratory failure to mean a cessation of breathing. [page734]

[95] In delivering the judgment of the majority of the court in Starson, Major J. stated [at para. 88]:

> The standard of reasonableness "involves respectful attention, though not submission" to the Board's reasons . . . An unreasonable decision is one that "is not supported by any reasons that can stand up to a somewhat probing examination" . . .

[96] I believe it was essential for the Board to have a clear and comprehensive understanding of the medical evidence if it was to be able to perform properly the difficult task of balancing disparate factors required by s. 21(2). I cannot assume, or infer on a balance of probabilities, that the Board's decision would have been the same if it had properly understood the evidence of Dr. Hawryluck and I do not believe I should find that the Board's findings based on the factors in s. 21(2)(c) pass the test of reasonableness simply because a basis in the evidence -- properly understood -- might be found for findings either way. The findings under s. 21(2)(c) were crucial to the Board's decision and, in consequence, the appeal must be allowed and the decision of the Board set aside.

[97] In addition, I reach the same conclusion on the basis of my findings of errors of law in the Board's interpretation of s. 21(2)(a) and (b). The factors referred to in s. 21(2)(c) are not necessarily determinative when there is evidence that bears on the application of para. (a) or (b). The task of determining where a patient's best interests lie when they tend to support different overall conclusions may be of considerable difficulty and complexity. This makes it essential that the Board properly understands the nature of the inquiry to be made under each of the three paragraphs. The difficult balancing exercise is for the Board, and not for the court, to perform and the Board cannot do this if it misapprehends the principles it must apply.

[98] In view of the time that has elapsed since the hearing and the absence of detailed evidence of Mrs. Holland's present condition, I do not think it would be appropriate for me, at this stage, to substitute my opinion for that of the Board.

[99] It appears from the evidence of Dr. Hawryluck, and that of the witnesses she called, that the appellants were emotionally upset and distressed at the meeting at which they declined to consent to the proposed plan of treatment and that their evidence at the hearing was far more specific with respect to their mother's beliefs, values and wishes. Mrs. Scardoni testified that they were intimidated. At the conclusion of the hearing, Dr. Hawryluck indicated that her decision to apply to the Board was influenced by the appellants' failure at the meeting to be explicit [page735] about their mother's views. In view of the possibility that, having heard the appellants' evidence at the hearing, as well as having knowledge of Mrs. Holland's medical history since then, the physicians' opinions of Mrs. Holland's best interests may have changed, I do not intend to order a rehearing before the Board.

[100] The decision to set aside the decision of the Board will, of course, be without prejudice to any further application [to] the Board that Mrs. Holland's health practitioners may feel is warranted in the light of her condition -- including any changes that have occurred since the

hearing or may occur in the future -- in the event that the appellants refuse to consent to treatments that are proposed or are proposed to be withheld.

[101] In view of the conclusion I have reached, it is not necessary to consider the grounds for appeal based on the Charter. In Phillips v. Nova Scotia (Commission of Inquiry into the Westray Mine Tragedy), [1995] 2 S.C.R. 97, 124 D.L.R. (4th) 129, at p. 111 S.C.R., Sopinka J. stated:

> This Court has said on numerous occasions that it should not decide issues of law that are not necessary to a resolution of an appeal. This is particularly true with respect to constitutional issues and the principle applies with even greater emphasis in circumstances in which the foundation upon which the proceedings were launched has ceased to exist.

[102] This is not a case in which the foundation of the proceedings has disappeared -- so that, in that sense, the constitutional question has become moot. As Sopinka J. indicated, the principle is not restricted to such cases. He continued:

> In Attorney-General of Quebec v. Cumming, [1978] 2 S.C.R. 605, an issue arose concerning the interpretation of the word "divorce" in the Quebec Civil Code and whether an award of alimony should have been made. Another issue which arose concerned the constitutionality of the provincial legislation in terms of division of powers. Pigeon J., for the court, held at pp. 610-11:
>
> > Having come to the conclusion that the word "divorce" in the new art. 212 of the Civil Code means a divorce granted by a court and does not refer to a dissolution of marriage granted by a private Act, it is unnecessary to consider the other reason, which found favour with some of the judges of the Court of Appeal . . .
> >
> > Save in exceptional circumstances it is not desirable to express an opinion on a question of law which it is not necessary to decide in order to dispose of the case at

> hand, especially when it is a constitutional question.

[Emphasis added]

[103] I do not believe that principle is confined to cases before the Supreme Court of Canada and is inapplicable to decisions of courts from which appeals may be taken. Charter issues must be decided in the factual context before the court and not in the [page736] abstract or on hypothetical facts. This court in my opinion, should only consider the effect of the Charter on statutory provisions governing the jurisdiction of -- or the principles to be applied by -- a tribunal in situations where, under the terms of the applicable legislation, jurisdiction would otherwise exist, or the principles had otherwise been applied correctly. To do otherwise would be to consider the effect of the Charter in the context of facts that have not occurred -- in this case on an assumption that the Board had correctly interpreted the provisions of s. 21(2), considered and weighed the evidence of Mrs. Holland's beliefs, values and wishes and had arrived at the same conclusion with respect to her best interests.

[104] The Charter issues should, in my opinion, be left to be determined in subsequent cases in which the Board has properly interpreted the statute and applied its provisions to the facts before it in accordance with s. 21.

[105] There will be no order for costs. The Act permits a health practitioner to apply to the Board for a determination whether a substitute decision-maker has complied with s. 21. Although the health practitioner would necessarily provide his or her reasons for disagreeing with the substitute decision-maker's refusal, the application will not in terms be for a decision that the section has not been complied with. It is not adversarial in the usual sense. It is primarily a procedure by which there can be a determination by a neutral body that, as stated by the Court of Appeal in Benes, is likely to be in a better position than either a substitute decision-maker, or the health practitioner, to decide the question of the patient's best interests. While the possibility of costs being awarded to a substitute decision-maker who was successful on an appeal

from the Board cannot be ruled out, I do not think it would be justified in this case in view of the nature of the proceedings, the reticence of the appellants with respect to their mother's wishes and beliefs when withholding their consent and the fact that Dr. Hawryluck had relied, in good faith, on the combined expertise of the medical team with respect to the factors that are relevant under s. 21(2)(c).

Appeal allowed. [page737]

## Notes

1. The provision was omitted in the transcription of s. 21 that appears at p. 12 of the Board's reasons but this was obviously a clerical error. It is quite clear that the Board gave careful consideration to its terms.

WDPH