Consent and Capacity Board

Commission du consentement et de la capacité

16 – 3084 - 1
16 – 3084 - 2

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

AND IN THE MATTER OF

A PATIENT AT
HAMILTON GENERAL HOSPITAL
HAMILTON, ONTARIO

REASONS FOR RULING

PURPOSE OF THE HEARING

UH was a patient at the Hamilton General Hospital where he was taken after he was struck by a motor vehicle on October 1, 2016. His substitute decision-maker applied to the Board for directions pursuant to s. 35 of the *Health Care Consent Act.* A deemed application about UH's capacity to consent to treatment was initiated as a result.

DATES OF THE HEARING, DECISIONS AND REASONS

The hearing began on October 19, 2016 when the panel considered a motion brought by Dr. Corey Sawchuk in which he asked the Board to dismiss the application. The Ruling on this motion was issued the following day. All parties asked the Board to consider and rule on this motion before hearing evidence relating to the merits of the Application. In addition, Counsel for UH asked the panel to provide written Reasons for the Ruling. Those Reasons contained in this document were released on October 28, 2016.

LEGISLATION CONSIDERED

The *Health Care Consent Act, (HCCA)* sections 2, 32 and 35
The *Vital Statistic Act,* section 21
The *Public Hospitals Act,* R.R.O. 1990 Regulation 965 s. 17
Trillium Gift of Life Network Act, R.S.O. 1990, c H.20 s. 7
Consent and Capacity Board Rules of Practice.

PARTIES

UH, the incapable person
AD, the Substitute Decision Maker
Dr. Corey Sawchuk, the health care practitioner

PANEL

Mr. Eugene Williams, senior lawyer and presiding member

APPEARANCES

Mr. James Orme represented UH.
Mr. Paul Marshall represented AD
Ms. Erica Baron represented Dr. Corey Sawchuk.

WITNESS:

Dr. Corey Sawchuk

THE EVIDENCE

The evidence consisted of the testimony of Dr. Sawchuk and two exhibits as follows:

1 Notice of Motion and Affidavit of Dr. Corey Sawchuk including Exhibits A – E inclusive; and,
2 Medical Certificate of Death (blank) Form 16.

INTRODUCTION

UH was a 20-year -old man who was critically injured on October 1, 2016. He received medical attention, including mechanical ventilation, in the Intensive Care Unit of the Hamilton General Hospital. However, his condition deteriorated. On October 14, 2016, UH's doctors issued a Death Certificate for him pursuant to the *Public Hospital Act*. That Certificate stated that death had occurred on October 6, 2016 at 12:45. It was issued after the attending physician had performed certain neurological tests and confirmed that UH had met the neurological criteria for brain death (NDD).

UH's treatment team advised AD, UH's substitute decision-maker, that they intended to remove the mechanical ventilation. AD was opposed to this action and applied to the Board pursuant to section 35 of the *Health Care Consent Act, (HCCA)* to ask the Board for directions concerning consent for this action.

Prior to the hearing, Counsel for the hospital and the attending physician notified the parties and the Board of their intention to raise a preliminary issue concerning the Board's jurisdiction to consider AD's application for Directions.

PRELIMINARY ISSUE

In a Notice of Motion delivered to the Board on October 17, 2016, Erica Baron, Counsel for the attending physician, Dr. Sawchuk, brought a motion seeking a ruling as to whether the *HCCA*

applied in this case. The issue was whether the *HCCA* applied where, as here, there was a neurological determination of death.

The affidavit of Dr. Sawchuk, Chief of Critical Care Medicine at Hamilton Health Sciences, and its accompanying exhibits were tendered as Exhibit 1 on the motion. In his affidavit, Dr. Sawchuk stated that UH suffered "catastrophic injuries including acute head trauma" on October 1, 2016. Following his admission to the Intensive Care Unit of the Hamilton General Hospital, the treatment team instituted invasive medical treatments including mechanical ventilation.

Over the next few days, UH's medical condition deteriorated. Dr. Sawchuk stated that it was apparent to the physicians treating him that he would be unable to recover from his injuries. Clinical examinations performed by the treating physicians on October 6, 2016 disclosed that UH had experience neurological death or brain death.

Dr. Sawchuk described the medical criteria for neurological death, and provided documentation setting out the requirements necessary to meet the criteria for determining neurological death. He stated that UH "was found to meet the neurological criteria for brain death on October 6, 2016." Dr. Sawchuk noted that at the request of UH's family testing to determine neurological death, was postponed by a few days. An exhibit to his affidavit outlined the testing that was conducted and the test results upon which the determination of neurological death was based.

Dr. Sawchuk deposed that UH was found to meet the neurological criteria for brain death. He noted that several physicians including a cardiologist, neurologist, respirologist and a critical care physician, have concurred with that finding since that date. He said that "[t]he etiology that could have caused brain death for [UH] was increased intercranial pressure (ICP) and catastrophic closed head injury, which were caused by the head trauma he suffered in the accident." Dr. Sawchuk noted that UH had no confounding factors for brain death testing and two physicians completed the testing to support the finding of neurological death.

In his affidavit Dr. Sawchuk also said that neurological death is accepted as death in Ontario. He noted that once such a declaration has been made, "a death certificate is signed indicating the date

of death as the date on which brain death occurred ... ." Attached as an Exhibit to his affidavit was the death certificate for UH that was issued pursuant to the *Public Hospitals Act*.

In reply to the panel's questions, Dr. Sawchuk stated that testing revealed that UH had no brain stem function. Brain stem function directs bodily responses such as gag reflex, spontaneous breathing, and eye movements. He said that without brain stem functions the body would not respond to stimuli. He also stated that in his clinical experience there is no possibility of a return to brain stem function once it has been lost. He said that the loss of brain stem function is standard declaration of death. He also confirmed that with one exception, the October 6, 2016 tests to determine the neurological definition of death were repeated the following day and the results confirmed that UH had experienced brain death.

In response to questions from the panel, Dr. Sawchuk stated that UH's condition differed from that of a person in a vegetative state. He noted that those in a vegetative state have some degree of brain stem function that can permit them to respond to stimuli. He said that the circumstances relating to UH differed from those in the Rasouli case[1].

Counsel for AD and UH were given an opportunity to cross-examine Dr. Sawchuk. In reply to questions from Mr. Marshall. Mr. Marshall asked about the impact that the insertion of a tube in UH's chest would have on the neurological test results. Dr. Sawchuk stated that the insertion of a chest tube would not impair UH's drive or ability to breathe and would not account for the significant rise in Carbon Dioxide levels that were noted during one of the tests. Dr. Sawchuk acknowledged that the tube could splinter breathing but added that since UH had no drive to breathe the tube did not affect the results. He noted that UH could still breathe with the tube in place if he had the drive to breathe.

Counsel for Dr. Sawchuk, Ms. Baron, submitted that the Board lacks jurisdiction to deal with the application because the *HCCA* has no application when the patient has been declared dead. Counsel submitted that the neurological definition of death is the legal definition of death.

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[1] *Cuthbertson v. Rasouli,* [2013] S.C.C. 53

Counsel argued that s. 35 of the *HCCA* authorizes either a substitute decision-maker or a health practitioner who proposed a treatment to apply to the Board for directions. Counsel submitted that in this case UH has died. And, where a person has died, removing mechanical ventilation is not a withdrawal of treatment because the person has died.

Counsel also submitted that the removal of the mechanical ventilation does not fall within the definition of treatment in s. 2 of the *Act*. Counsel argued that removing the mechanical ventilation is not something done for a therapeutic or preventive or other health related purpose because of the person's death. Counsel submitted that the definition of treatment is purposive and requires one to look at why the treatment is proposed. Counsel sought to distinguish the facts of this case from the circumstances in Rasouli on this basis.

Counsel also submitted that if the removal of the mechanical ventilation could be viewed as treatment, it was specifically excluded by paragraph 'g' in the definition of treatment. That was because in the circumstances of this case, removing the mechanical ventilation poses little or no risk of harm to the person.

Counsel for UH, Mr. Orme, submitted that the evidence he had received caused him to conclude, on the date of the hearing that UH was dead. In his view, the death of his client brought this application to an end. In his submissions Counsel also urged the Board to consider using a reporter for pre-hearings for these types of cases and to consider an in-person hearing before determining the outcome of applications such as these. Counsel stressed the importance of providing a record because of the magnitude of these decisions.

In arguing that the Board has jurisdiction, Counsel for AD, Mr. Marshall, noted that the *HCCA* does not speak to "benefit" and added that the definition of treatment does not depend on establishing a benefit to the patient. He stated that the *Act* relates to actions that require consent. In Counsel's submission, the use of mechanical ventilation falls within the definition of treatment because it is something that is done for a therapeutic or preventive purpose. It is therapeutic because it keeps the body alive and it is preventive in that it avoids death.

ANALYSIS

Are the pre-conditions for a HCCA section 35 application met where directions are sought in relation to a person for whom a Death Certificate has been issued?

Section 35 (1) of the *HCCA* reads as follows:

> *35. (1) A substitute decision-maker or a health practitioner who proposed a treatment may apply to the Board for directions if the incapable person expressed a wish with respect to the treatment, but,*
>
> *(a) the wish is not clear;*
>
> *(b) it is not clear whether the wish is applicable to the circumstances;*
>
> *(c) it is not clear whether the wish was expressed while the incapable person was capable; or*
>
> *(d) it is not clear whether the wish was expressed after the incapable person attained 16 years of age. 1996, c. 2, Sched. A, s. 35 (1); 2000, c. 9, s. 33 (1).*

Treatment is defined in section 2 of the *Act* as follows:

> *"treatment" means 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, but does not include,*
>
> *(a) the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the Substitute Decisions Act, 1992 of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,*
>
> *(b) the assessment or examination of a person to determine the general nature of the person's condition,*
>
> *(c) the taking of a person's health history,*
>
> *(d) the communication of an assessment or diagnosis,*
>
> *(e) the admission of a person to a hospital or other facility,*

(f) a personal assistance service,

(g) a treatment that in the circumstances poses little or no risk of harm to the person,

(h) anything prescribed by the regulations as not constituting treatment. ("traitement") 1996, c. 2, Sched. A, s. 2 (1); 2000, c. 9, s. 31; 2007, c. 8, s. 207 (1); 2009, c. 26, ss. 10 (1, 2); 2009, c. 33, Sched. 18, s. 10 (1).

In granting the motion, I did not accept the submissions of Mr. Marshall. I accepted the evidence of Dr. Sawchuk that on October 6, 2016 UH experienced neurological death, and therefore, death according to the law of Ontario. The evidence that there was a neurological determination of death at that time was not contradicted. The evidence also establishes that technology exists that permits the ventilation of those who have been declared to conform to the neurological definition of death, (and thus the legal definition of death,) to remain on a ventilator after death. This occurs, for example, where organs are to be harvested.

In Re *EI, (CCB decision released on September 30, 2016)* Vice Chair Lora Patton dealt with a similar application and noted, based on the evidence the panel heard, that there may be an interval between neurological death and cardiac death. In *EI,* the issuance of the Medical Certificate of Death was also an indication that death had occurred. Vice Chair Patton found that it was not the role of the Board to question a determination of death made by a physician, p12. Earlier she had remarked:

> *While cardiac death typically results in fairly short order following death by neurological criteria due to the role of the brain stem in supporting all body functions, it may take days or weeks, leaving the health care team and family in a legal and medical limbo.*
>
> *Such a circumstance creates a number of concerns for the health practitioners and broader healthcare team. Continuation of "treatment" for someone declared dead offers, obviously, no medical benefit and there would be no ethical or moral reason to continue.* (Re *EI at page 9)*

Included as Exhibit B to Dr. Sawchuk's affidavit was a 2006 article published in the *Canadian Medical Association Journal* titled: "Brain arrest: the neurological determination of death and organ donor management in Canada." That article was also an Exhibit in *EI*. As noted by Vice Chair Patton in *EI, supra,* the article "sets out the definition, qualification for physicians who declare death by neurological testing and the criteria to be employed when doing so." Vice Chair Patton added:

> *In that article neurologically determined death is defined as "the irreversible loss of the capacity for consciousness combined with the irreversible loss of all brain stem functions... including the capacity to breathe" (at page S3)." Dr. Murthy explained that the focus on the brain stem relates to the fact that this portion of the brain is the integrative centre that controls all aspects of the body including breathing, organ management and temperature control.*
>
> *The first step in assessing a patient in these circumstances ... is to determine whether or not there has been an injury in the brain capable of causing brain death. Further consideration is given to the factors that may confound the diagnosis (such as sedation, hypothermia or pre-existing conditions) At that stage, a bedside examination takes place to test the brain function (pupil responses, reflexive reaction to protect the eye, gag and cough reflexes, pain response apnea (breathing capacity) testing). Only if all criteria are established may a physician declare death by neurological criteria.*

As in *EI*, the steps outline above were performed on UH in order to reach the determination that he had experienced neurological death.

Whether or not EI was a "person" under the *HCCA* was considered but not determined by Vice Chair Patton. However, the Vice Chair queried whether there is a person subject to a treatment as contemplated by the *HCCA*. Vice Chair Patton observed: "I *note that the language in this case is difficult and "person" may not be the correct legal terminology following death and query whether there is a "person" subject to a "treatment" such that the HCCA would be triggered... ."*

I considered the question and concluded that death terminates the person. Thus, when death occurs, there is no longer a "person" who is subject to "treatment" under the *HCCA*. Since section 35 of the *HCCA* contemplates that an application for directions under that section relates to treatment of a person, where there is no person to treat, neither the substitute decision maker nor the attending physician may apply under that section for directions. That is because the preconditions for an application are absent. Therefore, the *HCCA* can have no application and there is no role for the Board in circumstances such as these.

In the circumstances of this case, the application of mechanical ventilation to the dead body of UH does not fall within the definition of "treatment" as set out in section 2 of the *Act*. I disagree with the submissions of counsel for AD, when he asserted that the application of mechanical ventilation was for either a therapeutic or preventive purpose; and therefore, was treatment as defined in the section. I have concluded that the application of mechanical ventilation was neither therapeutic nor preventive because UH had experienced neurological death, and thus was legally dead. Contrary to counsel's submission, mechanical ventilation could not prevent death, in these circumstances, because UH had died. Similarly, mechanical ventilation could not be considered therapeutic, i.e. beneficial, remedial, restorative or corrective in these circumstances because there is no condition to correct.

In the event that the application of mechanical ventilation is "treatment" in the circumstances of this case, I found that its utilization with UH, was captured by paragraph "g" in the definition of treatment. That paragraph states that treatment does not include ***a treatment that in the circumstances poses little or no risk of harm to the person.*** The utilization of mechanical ventilation in this case poses little or no risk of harm to UH because he is neurologically dead. Accordingly, its use does not constitute treatment. The result is that there is no "treatment" to which AD can apply to the Board for directions.

RESULT

For the reasons stated above, the panel granted the motion and dismissed the Form D application.

Dated: October 28, 2016

Eugene Williams
Presiding Member