



TO-08-4159  
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IN THE MATTER OF  
the *Health Care Consent Act*  
S.O. 1996, chapter 2, schedule A,  
as amended

AND IN THE MATTER OF  
**E**  
A patient at  
**University Health Network-Toronto Western Hospital**  
TORONTO, ONTARIO

## REASONS FOR DECISION

### PURPOSE OF THE HEARING

A panel of the Board convened at the University Health Network- Toronto Western Hospital (“Toronto Western”) at the request of Dr. W.A. Cassar Demajo, a health practitioner. Dr. Demajo brought a Form G Application to the Board under Section 37 (1) of the *Health Care Consent Act* for a determination as to whether or not the substitute decision maker in this case has complied with the principles for substitute decision-making as they are set out in the *Health Care Consent Act* with respect to proposed treatment for E.

Dr. Demajo’s proposed treatment for E was no cardiopulmonary resuscitation including defibrillation and withdrawal or non re-institution of ventilator support.

An Application to the Board under subsection 37 of the *Health Care Consent Act* is deemed, pursuant to subsection 37.1 of the *Health Care Consent Act* to include an application to the Board under Section 32 by E with respect to his capacity to consent to treatment proposed by a health practitioner unless the person’s capacity to consent to such treatment has been determined by the Board within the previous six months.

## **DATES OF THE HEARING, DECISIONS AND REASONS**

The hearing took place on Tuesday March 10, 2009, Wednesday March 11, 2009 and Tuesday April 14, 2009. Written submissions were then received from all parties. On April 29, 2009 the panel released its Decisions. Reasons were released on May 13, 2009.

## **LEGISLATION CONSIDERED**

The *Health Care Consent Act*, including s.2, 4, 5, 11, 15, 16, 20, 21, 32, 37 and 37.1

## **PARTIES**

E's Deemed Form G – Treatment Application

E, patient

Dr. W.A. Cassar Demajo, health practitioner

Dr. W.A. Cassar Demajo's Form G – Treatment Application concerning E

Dr. W.A. Cassar Demajo, health practitioner

E, patient

V, E' son and substitute-decision maker.

E did not attend the Hearing. Dr. Demajo attended a portion of the Hearing and was excused after his oral testimony. V attended the Hearing and gave evidence.

## **PANEL MEMBERS**

Michael Newman, Presiding Lawyer Member

Emmanuel Persad, psychiatrist member

Panos Petrides, public member

## APPEARANCES

E was represented at the hearing by counsel, Ms. M. Tucker

Dr. Demajo was represented at the hearing by counsel Ms. E. Baron

V was represented at the hearing by counsel, Ms. N. Chaves

## PRELIMINARY MATTERS

The panel was advised that there had not been within the previous six months a determination by the Board of E's capacity to consent to the proposed treatment in this case. The panel was also advised that E did not have a Guardian of the Person or a Power of Attorney for Personal Care containing a provision waiving his right to apply for the review of the health practitioner's finding in accordance with Section 32 of the *Health Care Consent Act*. E did not have a Power of Attorney for Personal Care. We determined that the Board had jurisdiction to continue with the Hearing.

In addition, at the commencement of the Hearing, E's wife M through her then counsel Ms. Chaves resigned as E's substitute-decision maker. V then became E's substitute-decision maker as E's only child, pursuant to the hierarchy set out in Section 20 of the *Health Care Consent Act*.

## THE EVIDENCE

The evidence at the hearing consisted of the oral testimony of three witnesses, Dr. Demajo, Dr. Hawryluck and V (E's son and substitute-decision maker), and eighteen Exhibits:

1. M's Resignation as Substitute Decision Maker dated March 10, 2009
2. M's Compassionate Care Form dated March 7, 2006
3. Medication Administration Record
4. Dr. Hawryluck's Opinion Note dated February 10, 2009
5. Dr. Tai's Neurological Consult dated December 23, 2008
6. Dr. Lang's Neurological Consult dated January 29, 2009
7. Arrhythmia Event Records (7 pages)
8. Clinical Notes-Family Meeting dated December 18, 2008 (18:52) (2 pages)
9. Clinical Notes-Family Meeting dated December 20, 2008 (17:00) (1 page)
10. Clinical Notes-Family Meeting dated December 20, 2008 (1 page)
11. Interdisciplinary Clinical Notes-Family Meeting dated December 20, 2008 (1 page)
12. Interdisciplinary Clinical Notes-Family Meeting dated December 22, 2008 (1 page)

13. Interdisciplinary Clinical Notes-Family Meeting dated February 19, 2009 (18:40)(3 pages)
14. Interdisciplinary Clinical Notes-Family Meeting dated December 30, 2008 (1 page)
15. Interdisciplinary Clinical Notes-Family Meeting dated January 1, 2009 (14:20) (1 page)
16. Interdisciplinary Clinical Notes-Family Meeting dated January 2, 2009 (15:50) (2 pages)
17. Interdisciplinary Clinical Notes-Family Meeting dated January 20, 2009 (15:00)(2 pages)
18. Interdisciplinary Clinical Notes-Family Meeting dated January 29, 2009 (10:00)(2 pages)

## INTRODUCTION

E was a 72 year old gentleman who was married to M. They had one surviving adult child, V. E came to Canada from Portugal at the age of 49 years. He had been employed in Portugal as a dockyard supervisor. In Canada he worked as a welder. E's first language was Portuguese. V said his father's understanding of English was of "technical English", obtained from working in international shipping. V said his father continued to speak Portuguese at work and at home.

Several years ago E suffered cognitive decline and was diagnosed with dementia. In January 2006, E went to reside in Fairview Nursing Home as a consequence of his dementia and other medical conditions. These other medical conditions included diabetes, coronary artery disease, high blood pressure and glaucoma. According to Dr Hawryluck's report filed, in the 3-4 months prior to December 2008 E's cognition had worsened. Dr. Hawryluck noted in her report that E was "minimally verbal with dysphasia."

On December 17, 2008 E was admitted to Toronto Western from his nursing home residence suffering from increased shortness of breath. In hospital E's symptoms were treated as aspiration pneumonia. He subsequently experienced a fluttering heart rate.

In the early hours of December 18, 2008 while in hospital, E suffered a cardiac arrest. At the time E was found without a pulse. Cardio pulmonary resuscitation was administered and E was eventually resuscitated. According to medical evidence including that of Dr. Hawryluck, E's "downtime" was between 15 and 27 minutes. Following resuscitation, E showed signs of significant anoxic brain injury, including myoclonic jerking and was absent pupillary and motor responses. There was also medical evidence of shock to his liver and acute renal dysfunction. E was then transferred on December 18, 2008 to the Intensive Care Unit ("ICU") where he remained as of the Hearing. Dr. Demajo, the Clinical Director of the ICU then became E's treating physician.

Dr. Demajo assessed E's capacity with respect to his treatment and found him incapable. Dr. Demajo believed that because he was unable to set up a form of communication with E evidenced that he did not have the cognitive ability to understand the information that was relevant to his treatment. Dr. Demajo noted that he could not get E's attention for him to learn or understand.

Dr. Demajo said that in addition to failing the first branch of the test for capacity E also failed on the basis of his inability to appreciate the reasonably foreseeable consequences of a decision or lack of decision. He said E failed this second part of the two part capacity test for the same reasons he failed the first branch of the test. Dr. Demajo said E's incapacity was a consequence of the effect on him of his dementia, recent cardiac arrest and anoxic brain injury. E was declared incapable with respect to the proposed treatment of no cardiopulmonary resuscitation including defibrillation and withdrawal or non re-institution of ventilator support. Dr. Demajo then turned to E's substitute decision-maker, his wife M to provide treatment decisions for E. M subsequently stepped aside as substitute decision maker in favour of V, who according to Dr. Demajo has refused to provide consent to the proposed treatment plan.

## **THE LAW**

### **General**

The onus is always on the health practitioner at a Board Hearing to prove his or her case. The case must be proved on a civil balance of probabilities. In order for the Board to find in favour of the health practitioner, it must hear cogent and compelling evidence in support of the health practitioner's case. The patient appearing before the Board does not have to prove anything; the onus being entirely on the health practitioner. The Board may consider both direct and hearsay evidence, although hearsay must be assigned only that weight which is appropriate to it in the circumstances.

### **Incapacity with Respect to Treatment**

The *Health Care Consent Act, 1996* states that a health practitioner who proposes a treatment for a person shall ensure that it is not administered unless, he or she is of the opinion that the person has given consent; or he or she is of the opinion that the person is incapable with respect to the treatment, and another person has given consent in accordance with the *Health Care Consent Act, 1996*.

The test for capacity is set out in Section 4(1) of the *Health Care Consent Act, 1996* which states that a person is capable with respect to treatment if the person is able to understand the information that is relevant to making a decision about the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

The section goes on to say that a person is presumed to be capable with respect to treatment and that a person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment.

Section 2 of the *Health Care Consent Act* in part reads as follows:

“plan of treatment” means 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; (“plan de traitement”)

“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.

Section 5 of *Health Care Consent Act* read as follows:

**Wishes**

5. (1) A person may, while capable, express wishes with respect to treatment, admission to a care facility or a personal assistance service. 1996, c. 2, Sched. A, s. 5 (1).

**Manner of expression**

(2) Wishes may be expressed in a power of attorney, in a form prescribed by the regulations, in any other written form, orally or in any other manner. 1996, c. 2, Sched. A, s. 5 (2).

**Later wishes prevail**

(3) Later wishes expressed while capable prevail over earlier wishes. 1996, c. 2, Sched. A, s. 5 (3).

Sections 21 and 37 of the *Health Care Consent Act* read as follows:

21. (1) A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles:

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.
2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.

21.(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

- (a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;
- (b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1) ; and
- (c) the following factors:

1. Whether the treatment is likely to,
  - i. improve the incapable person's condition or well-being,
  - ii. prevent the incapable person's condition or well-being from deteriorating, or
  - iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

37. (1) If consent to a treatment is given or refused on an incapable person's behalf by his or her substitute decision-maker, and if the health practitioner who proposed the treatment is of the opinion that the substitute decision-maker did not comply with section 21, the health practitioner may apply to the Board for a

determination as to whether the substitute decision-maker complied with section 21. 1996, c. 2, Sched. A, s. 37 (1).

### **Parties**

- (2) The parties to the application are:
1. The health practitioner who proposed the treatment.
  2. The incapable person.
  3. The substitute decision-maker.
  4. Any other person whom the Board specifies. 1996, c. 2, Sched. A, s. 37 (2).

### **Power of Board**

(3) In determining whether the substitute decision-maker complied with section 21, the Board may substitute its opinion for that of the substitute decision-maker. 1996, c. 2, Sched. A, s. 37 (3).

### **Directions**

(4) If the Board determines that the substitute decision-maker did not comply with section 21, it may give him or her directions and, in doing so, shall apply section 21. 1996, c. 2, Sched. A, s. 37 (4).

### **Time for compliance**

(5) The Board shall specify the time within which its directions must be complied with. 1996, c. 2, Sched. A, s. 37 (5).

### **Deemed not authorized**

(6) If the substitute decision-maker does not comply with the Board's directions within the time specified by the Board, he or she shall be deemed not to meet the requirements of subsection 20 (2). 1996, c. 2, Sched. A, s. 37 (6).

### **Subsequent substitute decision-maker**

(6.1) If, under subsection (6), the substitute decision-maker is deemed not to meet the requirements of subsection 20 (2), any subsequent substitute decision-maker shall, subject to subsections (6.2) and (6.3), comply with the directions given by the Board on the application within the time specified by the Board. 2000, c. 9, s. 35.

### **Application for directions**

(6.2) If a subsequent substitute decision-maker knows of a wish expressed by the incapable person with respect to the treatment, the substitute decision-maker may, with leave of the Board, apply to the Board for directions under section 35. 2000, c. 9, s. 35.

### **Inconsistent directions**

(6.3) Directions given by the Board under section 35 on a subsequent substitute decision-maker's application brought with leave under subsection (6.2) prevail over inconsistent directions given under subsection (4) to the extent of the inconsistency. 2000, c. 9, s. 35.

### **P.G.T.**

(7) If the substitute decision-maker who is given directions is the Public Guardian and Trustee, he or she is required to comply with the directions, and subsection (6) does not apply to him or her. 1996, c. 2, Sched. A, s. 37 (7).

### Deemed application concerning capacity

**37.1** An application to the Board under section 33, 34, 35, 36 or 37 shall be deemed to include an application to the Board under section 32 with respect to the person's capacity to consent to treatment proposed by a health practitioner unless the person's capacity to consent to such treatment has been determined by the Board within the previous six months. 2000, c. 9, s. 36.

Conway v Jacques 2002 CanLII 41558 (ON C.A.), (2002), 59 O.R. (3d) 737, was an appeal from the Consent and Capacity Board in which the Court of Appeal discussed the principles for substitute consent to treatment. The case addressed psychiatric medication rather than end of life decision-making. Justice Sharpe's analysis is on point and binding:

“[30] Ontario's *Health Care Consent Act*, 1996 is the legislature's response to the successful *Charter* challenge in *Fleming*. The Act requires close attention to the patient's wishes by those who make treatment decisions on the patient's behalf. The wishes of the patient are to be considered by the substitute decision-maker at two stages under the Act: 1) in acting in accordance with a prior capable wish applicable to the circumstances pursuant to s. 21 (1) 1; and 2) in determining the incapable person's best interests pursuant to s. 21 (2) where there is no prior capable wish applicable to the circumstances.

[31] 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. As Robins J.A. held in *Fleming* at p. 94:

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 the 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.

[32] 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) 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.

[33] The appeal judge held that the Board failed to consider whether Paul Conway would have consented to the anti-psychotic medication suggested by Dr. Jacques if he had been capable of giving or refusing consent. In my respectful opinion, that is not the test mandated by the Act for determining whether a prior capable wish is applicable to the circumstances. To require the substitute decision-maker or the Board to consider what the incapable person would have decided in light of changed circumstances would replace the two-stage test mandated by the Act with a different test that is not supportable under the language of the Act. Paul Conway's prior capable wish was either applicable to the circumstances or not applicable to the circumstances. If a prior capable wish is not applicable to the circumstances, the question for the substitute decision-maker is not what the patient would have decided in light of the change, but rather what is in the best interests of the patient. I would therefore reject the analysis of the appeal judge and his conclusion that the Board erred in law and failed to make a crucial factual finding”.

*M., A. v. Benes*, 1999 CanLII 3807 (ON C.A.), (1999), 46 O.R. (3d) 271 was another Court of Appeal decision on appeal from the Consent and Capacity Board. The case involved psychiatric treatment but also contains general principles applicable to any review by the Board of treatment decisions made by substitute decision-makers.

“[42] An S.D.M. does not stand in the shoes of an incapable person at least on questions of consent to treatment. The S.D.M. is important but only as part of a statutory regime which, by its terms, tries to respect an incapable person’s well-being and dignity where that person’s consent or refusal to treatment cannot be established.

[45] Values, beliefs and non-binding wishes are not the only elements of the best interests test. The likely effect of the proposed treatment is a key element as well. The S.D.M. is not likely to have special knowledge about the possible effects of medical treatment and thus, as a general rule, must rely on the expertise of the treating health practitioner.

[46] 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.”

*Scardoni v. Hawryluck*, 2004 CanLII 34326 (ON S.C.), (2004), 69 O.R. (3d) 700 was another appeal from the Consent and Capacity Board. Justice Cullity made these observations about the Board's interpretation of the phrase, "well-being”.

[45] A question of statutory interpretation that was more directly in issue in the appeal concerned the meaning of the word "well-being" in section 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 page 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 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 section 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 well-being 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 *IR.C. v. Baddeley*, [1955] A.C. 572 (H.L.), at page 616, 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 (S.C.J.) in which the interpretation of section 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 (*sic*) quality of life. I consider the concept of "well-being" a very broad concept which encompasses many considerations, including quality of life. Many of the interventions contemplated as being necessary to prolong Mr. Janzen's life involve procedures that could be painful or uncomfortable for Mr. Janzen. 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.”

## ANALYSIS

We carefully carried out our statutory responsibility, considered and reviewed the evidence, submissions, and the law, including the criteria set out in the applicable legislation.

The main application before the Board was the Form G brought pursuant to the *Health Care Consent Act*. Dr. Demajo a health practitioner applied for a determination as to whether or not V as his father's substitute-decision maker complied with the principles for substitute decision making as set out in the *Health Care Consent Act* with respect to the proposed treatment. Throughout our deliberations, we imposed the onus of proof upon Dr. Demajo. That onus was on a balance of probabilities.

By statute, this type of application triggered an application by E with respect to his own capacity to consent to the proposed treatment unless that capacity had been determined by the Board within the previous six months. There was no evidence of any such prior determination. We found the Board had jurisdiction in this matter.

The general law relating to capacity to consent to treatment is set out in the *Health Care Consent Act* (HCCA). That legislation also sets out a scheme for identifying substitute decision makers (SDM's) for incapable persons. It also described how SDM's should make decisions and the available options should SDM's not be making proper decisions.

The Purposes of the HCCA are set out at its very beginning. These include providing rules with respect to consenting to treatment, facilitating treatment for incapable persons, enhancing the autonomy of persons for whom treatment is proposed and promoting communication and understanding between health practitioners and their patients.

Furthermore, the HCCA in Section 2 requires that a health practitioner must (emphasis mine) determine whether a person is capable to consent to treatment. The HCCA also provided that all health practitioners must be members of their respective professional colleges in Ontario. Physicians are included as health practitioners.

As noted earlier the test for capacity is set out in Section 4(1) of the HCCA as follows:

4. (1) Capacity – a person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.
- (2) Presumption of capacity – a person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services.
- (3) Exception – a person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission or the personal assistance service, as the case may be.

There is a presumption of treatment capacity on which a person is entitled to rely unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment.

By Section 15(1) and (2) capacity can fluctuate and capacity also can vary over time and in relation to the type of treatment. The determination of capacity is therefore issue and time specific. The health practitioner must look at the specific treatment or plan and determine whether the person is capable for the particular treatment.

In the event that a person has been found incapable, a substitute-decision maker may give consent to treatment on behalf of the incapable person. Section 16 of the HCCA provides that if the incapable person becomes capable, the person's own decision to give or refuse consent to treatment prevails.

*Starson v Swayze* (2003) SCC 32 is the leading case in relation to the law on consent to treatment in Ontario. As set out earlier, Section 4(1) of the HCCA provides a two part test to determine whether a person is capable with respect to a treatment.

Justice Major wrote the majority opinion for the Supreme Court in the *Starson* decision. He commented upon the onus of proof required to displace the statutory presumption of capacity at paragraph 77: "I agree with the Court of Appeal that proof is the civil standard of a balance of probabilities."

Chief Justice McLachlin, who wrote the dissent, agreed on this point. At paragraph 13, she wrote,

“the person is presumed to be competent and the standard of proof for a finding of incapacity is a balance of probabilities.”

Justice Major analyzed capacity at paragraph 78 of the Starson decision as follows:

“Capacity involves two criteria. First, a person must be able to understand the information that is relevant to making a treatment decision. This requires the cognitive ability to process, retain and understand the relevant information. Second, a person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one. This requires the patient to be able to apply the relevant information to his or her circumstances, and to be able to weigh the foreseeable risks and benefits of a decision or lack thereof.

Before turning to an analysis of the reviewing judge’s decision, two important points regarding this statutory test require comment. First, a patient need not agree with the diagnosis of the attending physician in order to be able to apply the relevant information to her own circumstances. Psychiatry is not an exact science, and “capable but dissident interpretations of information” are to be expected. While a patient need not agree with a particular diagnosis, if it is demonstrated that he has a mental “condition”, the patient must be able to recognize the possibility that he is affected by that condition. Professor Weisstub comments on this requirement as follows (at p. 250, note 443):

Condition refers to the broader manifestations of the illness rather than the existence of a discrete diagnosable pathology. The word condition allows the requirement for understanding to focus on the objectively discernible manifestations of the illness rather than the interpretation that is made of these manifestations.

As a result, a patient is not required to describe his mental condition as an “illness”, or to otherwise characterize the condition in negative terms. Nor is a patient required to agree with the attending physician’s opinion regarding the cause of that condition. Nonetheless, if the patient’s condition results in him being unable to recognize that he is affected by its manifestations, he will be unable to apply the relevant information to his circumstances, and unable to appreciate the consequences of his decision.

Secondly, the Act requires a patient to have the ability to appreciate the consequences of a decision. It does not require actual appreciation of those consequences. The distinction is subtle but important... In practice, the determination of capacity should begin with an inquiry into the patient’s actual appreciation of the parameters of the decision being made: the nature and purpose of the proposed treatment; the foreseeable benefits and risks of treatment; the alternative courses of action available; and the expected consequences of not having the treatment. If the patient shows an appreciation of these parameters-regardless of whether he weighs or values the information differently than the attending physician and disagrees with the treatment recommendation – he has the ability to appreciate the decision he makes.

However, a patient’s failure to demonstrate actual appreciation does not inexorably lead to a conclusion of incapacity. The patient’s lack of appreciation may derive from causes that do not undermine his ability to appreciate consequences. For instance, a lack of appreciation may reflect the attending physician’s failure to adequately inform the patient of the decision’s consequences.

Accordingly, it is imperative that the Board inquire into the reasons for the patient's failure to appreciate consequences. A finding of incapacity is justified only if those reasons demonstrate that the patient's mental disorder prevents him from having the ability to appreciate the foreseeable consequences of the decision."

As Justice Day stated in *Neto v Klukach* [2004] O.J. No. 394 at paragraphs 10-13:

"Chief Justice McLaughlin, in her dissenting judgment (but not dissenting on this point) quoted with approval three common indicators of a person's ability to meet the second branch of the test, set out by commentators such as B.F. Hoffman in *The Law of Consent to Treatment in Ontario* (2<sup>nd</sup> ed. 1997), at p. 18. One indicator is whether the person is able to acknowledge the fact that the condition for which treatment is recommended may affect him or her. A second indicator is whether the person is able to assess how the proposed treatment and alternatives, including no treatment could affect his or her quality of life. A third indicator is whether the person's choice is substantially based on a delusional belief.

In determining capacity, the court in *Starson* cautioned that capable individuals have the right to take risks and are presumed free to make decisions that are considered unreasonable. The test is not whether the choice by the patient appears reasonable or wise, but whether the patient is capable, within the meaning of the statute, of making the decision. The Board is not to inject its own personal values, judgments, and priorities into the process. As Justice Harris stated in *Bartoszek v Ontario (Consent and Capacity Board)*, [2002] O.J. No. 3800 (S.C.J.) at para 20, "It is mental capacity, not wisdom, that is at issue here. The appellant, Mrs. Bartoszek carries with her, like all citizens, the right to be wrong".

In addition, the court in *Starson* held that the Board must avoid the error of equating the presence of a mental disorder with incapacity. People who have mental disorders are perhaps most at risk of having their personal autonomy overridden by the likely unconscious imposition of value judgments. It is easy to conclude that if a person chooses a course of treatment, which appears to be reasonable and wise, then the person is capable; whereas, if a person chooses treatment that doctors consider to be contrary to the best interests of the patient, or even patently unwise, then the person is incapable. Those with mental illness are perhaps most vulnerable to having their experiences with reactions to medications and personal views regarding treatment options not taken seriously, but instead attributed to the mental illness itself, if contrary to what is considered conventional wisdom.

Adjudicators however must take pains to avoid such conclusions. The reasonableness of the patient's wishes, or the patient's best interest, should not be the basis of a judicial finding, as this would treat persons with mental illnesses as person with lesser states. The Court of Appeal in *Fleming v Reid* (1991), 82 D.L.R. (4<sup>th</sup>) 298 at 311 stated that:

"Mentally ill persons are not to be stigmatized because of the nature of their illness or disability; nor should they be treated as persons of lesser status or dignity. Their right to personal autonomy and self-determination is no less significant, and is entitled to no less protection, than that of competent persons suffering from physical ailments."

Indeed, the court in *Fleming* held at 312 that:

“The common law right to bodily integrity and person autonomy is so entrenched in the traditions of our law as to be ranked as fundamental and deserving of the highest order of protection. This right forms an essential part of an individual’s security of the person and must be included in the liberty interests protected by s. 7 [of the Charter]”.

***Did the evidence establish that E was unable to understand the information relevant to making a decision about the treatment in question?***

E was a seventy two year old man with dementia admitted to Toronto Western on December 17, 2008 with increased shortage of breath. Early in the morning of December 18, 2008 E suffered a cardiac arrest. He was found in his room without a pulse. CPR was administered and he was eventually resuscitated. The medical evidence was that his “down time” was between 15-27 minutes. There was no contradictory evidence on these points. The Board accepted that evidence and found them to be factual. We also found as factual the uncontradicted medical evidence that immediately following E’s resuscitation; he showed signs of a significant anoxic brain injury including myoclonic jerking and was absent pupillary and motor responses, had liver shock and renal dysfunction. We accepted the medical evidence that these clinical signs represented a very poor prognosis for eventual recovery from the brain injury.

Since E’s admission to the ICU a number of meetings have been held attended by E’s family members, including his substitute-decision maker and only child V and hospital staff. On December 18, 2008 a family meeting was held at which, Dr. Barthos, a resident physician in the ICU, discussed with M, E’s wife, V, E’s son and V’s two daughters the prognosis for E and what level of care was appropriate in view of that prognosis. Dr. Barthos discussed E’s care at length with his family and explained that E’s neurological prognosis and survival prognosis were poor. While the family expressed the desire to make a decision about ongoing care at home with M, V expressed his opinion at that time that the “patient’s wishes ... were to be allowed to pass away”. However, V acknowledged that his mother would have difficulty in following these wishes. A further family meeting was arranged for the following day. In his testimony V disputed the charted medical evidence about what transpired at the meeting.

On December 20, 2008 a further meeting was held with Dr. McCullaugh, M and V. At that time, a Portuguese speaking respiratory therapist named Denise Silva was present to assist with any necessary interpretation. Dr. McCullaugh explained again to the family that E had suffered irreversible brain damage because of his cardiac arrest and that as a result, there was no prospect of neurological recovery. As

approximately three days had passed since E's cardiac arrest, according to the medical evidence it was apparent there was unlikely to be a recovery of E to his pre-admission condition since most neurological assessments are usually conducted at least 72 hours after a global brain injury such as that suffered by E. At that time, M expressed the view that she would rather that E die on full life support.

On December 22, 2008, a further meeting was held with E's family. This time Dr. Golan, a staff attending physician, Dr. Young a resident physician and E's nurses met with V. Dr. Golan explained again that E's neurological prognosis was very poor. Given the family's hope that E might recover, Dr. Golan arranged for a neurological consultation. At that time, Dr. Golan also confirmed that given E's condition, CPR, defibrillation and dialysis was not being offered to E.

On December 23, 2008, some 5 days after the cardiac arrest, the initial neurological consultation occurred. Dr. Tai, the neurologist concluded:

“Although some evidence of returning brainstem function, there are multiple factors pointing towards a very poor prognosis including history of probably myoclonic status epileptics and absent motor, pupillary responses at day 3 (not documented same). With his baseline poor function with dementia in a nursing home, suspect that chances of return to any reasonable/worthwhile quality of life essentially nil”.

On December 30, 2008 a further meeting was held with V and his daughter. At that time, Dr. Fan a staff attending physician provided a clinical update and confirmed that E had suffered a brain injury. V advised Dr. Fan that they did not wish for E to receive CPR in the event of a further cardiac arrest and agreed to revisit the issue of whether there should be other limits on the care provided.

On January 1, 2009 Dr. Fan met with V again. At that time, V advised that after discussing the matter with his mother that the family desired that all resuscitative measures be taken in the event of a cardiac arrest. Dr. Fan arranged for a meeting the following day with the benefit of a translator to confirm the change in instructions.

On January 2, 2009 Dr. Fan met with M, E's wife and E's granddaughter. A nurse from the cardiology department provided translation. Dr. Fan explained to the family again that a further cardiac arrest would result in an even poorer quality of life with no meaningful chance of neurological recovery. At that time the family agreed that the doctors should do what they thought would benefit E without prolonging his suffering. Dr. Fan therefore communicated that CPR would not be offered in the event of a further cardiac arrest and that, once weaned, mechanical ventilation would be re-instituted.

No further meetings occurred until January 20, 2009. At that time, Dr. Abdul Alraqobi, a neurologist met with V and M. V provided translation for his mother at this meeting. Dr. Alraqobi confirmed that E's neurological condition was unchanged. At that time M's expressed her view that E might be communicating by blinking. V expressed a desire to continue testing his father and that God might help his father. Dr. Alraqobi advised V that E was unlikely to recover and that E was at risk of infection and bed sores. Notwithstanding these risks, V advised that he was opposed to withdrawing care. V also requested dialysis for his father, but was advised that it was not medically indicated.

On January 29, 2009, Dr. Demajo, met with M, V and E's brother. Also present were a bio-ethicist, a Chaplin, a social worker and an interpreter. At that time, Dr. Demajo explained to the family members that there had been no meaningful neurological recovery and that given the passage of time, there was unlikely to be any meaningful neurological recovery in the future. At that time, Dr. Demajo explained that mechanical ventilation would not improve E's condition and therefore the medical team did not wish to continue this treatment as it was not in E's best interests.

On the same day, a further neurology consultation was obtained. Dr. Lang, the neurologist concluded that there was "essentially no chance that this poor gentleman will have any useful neurological recovery."

To ensure that the medical team that was providing care to E was fairly assessing his condition and prospects for recovery, Dr. Demajo arranged for a second opinion from another ICU physician not practicing at Toronto Western. Dr. Hawryluck, a critical care physician at Toronto General Hospital conducted that assessment on February 10, 2009. Dr. Hawryluck noted that she carefully reviewed the chart and performed an assessment of E.

Dr. Hawryluck arrived at the following assessment and plan which she confirmed in her oral testimony:

"E has suffered a severe anoxic brain injury post cardiac arrest on a background history of advance dementia. He is not capable of making decisions. His wife is his SDM.

While I have not met with his SDM/family, in early meetings her son seemed to indicate that life support would not be what his father would wish to undergo and that M would have difficulty though in withholding/withdrawing life sustaining treatment (ICU team meeting on 18/12/08)

I am not clear that if E's wishes were not to undergo life support why these were not respected by his SDM according to the framework of substitute decision-making under HCCA.

Even if E did not have prev. expressed applicable wishes, continuing life support would not be in his best interests as life support is only prolonging his dying and potentially contributing to suffering (VAP, sacral ulcer, UTI) and will not alter his terrible neurological prognosis.

In view of this would agree with ICU team's recommendation to withdraw life support and initiate a palliative care treatment plan."

Dr. Hawryluck testified that person usually suffers brain damage after 4 minutes without oxygen, and E's downtime had been 15-27 minutes. She said with the type of brain injury suffered by E the cortex of the brain was most damaged. That was the area of the brain that controlled thinking. She said that E was not capable of making treatment decisions because he could not process information. In Dr. Hawryluck's opinion the focus should be on quality of E's life, not duration. His well-being should focus on comfort, that life-support was uncomfortable and would serve to prolong E's dying and add to his suffering.

In his evidence Dr. Demajo's said that E's current condition was as follows:

- (a) From a neurological perspective, his Glasgow Coma Scale ranged from 3 to 6, a minimal change. The Glasgow Coma Scale measures neurological function and quantifies level of consciousness following traumatic brain injury. A perfect score is 15. A score of 3 is the minimum, meaning "None" for each of three scoring subtitles, eye opening, verbal response and motor response. The lower the score the worse is a person's neurological functioning. E responded to intense pain with a facial grimace. He did not follow commands. He did not react to sudden movements or threatening moves. He did not follow tracks with his eyes. His eyes open spontaneously. He has no movement of his arms or legs. He has a cough but no gag reflex. He was unable to communicate. There has been little to no improvement in his neurological function in the over four months since his admission to the ICU.
- (b) From a respiratory perspective, E has been on and off a ventilator throughout his four month admission to assist him with his breathing. When not ventilated, he required suctioning to control his secretions to help to prevent pneumonia. His heart rate is monitored constantly. Notwithstanding this treatment, he has suffered from pneumonia on and off throughout his admission. It was expected that these infections would worsen to cause problems for E. This opinion was supported by that of Dr. Hawryluck.
- (c) From a cardiac perspective, E's condition remained tenuous. He has suffered from a number of cardiac events of varying severity throughout his admission. A full resuscitation has not

been required other than on December 18, 2008. However, there was a risk such an event will occur in the future. Such an event will further impact on E's poor neurological condition as any event requiring CPR results in a loss of blood flow, and therefore oxygen, to the brain.

- (d) From a clinical perspective, E had a number of significant bed sores, including a large, 7 cm ulcer on his back which is 1 – 1.5 inches deep. He also had significant bed sores on his feet and legs. These were known complications of lengthy ICU admissions, difficult to treat and could cause recurrent infections. Dr. Hawryluck confirmed this evidence as well.
- (e) E's heart rate was monitored constantly as was his blood pressure. Nutrition was received through PEG feeds via the stomach, catheterization with regard to urinary functions. E received "full code" status meaning that his family wished for the administration of CPR including chest compressions and mechanical defibrillation of the heart, should E suffer another cardiac arrest.

According to Dr. Demajo there was essentially no hope that E will ever be well enough to leave the hospital, walk, talk or interact with the world again in view of the severity of his "anoxic" or lack of oxygen brain injury and the length of time with no recovery. Dr. Demajo said these clinical signs represented very poor prognosis for eventual recovery from brain injury. The doctor said E continued to be an ICU patient because he required that level of care, including suctioning every 2-3 hours. Dr. Demajo said E was in a persistent vegetative state based on the fact he was not responding or reacting to his environment. Neither mechanical ventilation nor CPR would change this prognosis. Dr. Demajo said that E lacked the capacity to make his own medical decisions. E lacked capacity because he was unable to understand and was unable to appreciate in terms of the legal test.

In addition, E could not communicate his desires or wishes. Dr. Demajo assessed E's capacity with respect to his treatment, found him incapable and went to E's wife M as substitute-decision maker for decisions. Dr. Demajo believed that because he was unable to set up a form of communication with E evidenced that he did not have the cognitive ability to understand the information that was relevant to his treatment or the consequences of any treatment decisions. Dr. Demajo noted that he could not get E's attention for him to learn or understand. Dr. Demajo described E's brain functioning as primitive not intellectual, that E was still breathing.

How does the health practitioner in this case assess capacity concerning any proposed treatment? Dr. Demajo's evidence noted that attempts have been made to establish communication with E without success. E was not able to either respond.

Dr. Demajo's opinion was that the inability to set up even a simple form of communication with E was evidence he did not have the cognitive ability to understand information about his treatment or the consequences of any treatment decisions. In his opinion E failed both parts of the two part test for treatment capacity as a result of cognitive impairment suffered from the brain injury. This cognitive impairment prevented E from being able to understand information relevant to his treatment and from being able to appreciate the reasonably foreseeable consequences of a decision or lack of decision about his treatment. In addition, there was no contradictory evidence suggesting E was capable with respect to his own treatment decisions. E's counsel in submissions took the position that the medical evidence established that her client was not capable with respect to his own treatment decisions.

What considerations did we need to examine to determine this issue on a balance of probabilities for each of the two parts of the test for capacity? We also had to remember that there was a presumption E was capable unless Dr. Demajo had reasonable grounds to believe that E was incapable (S4 (3) (HCCA)). Dr. Demajo had the onus of satisfying the Board on a balance of probabilities that E was incapable.

In terms of the first branch of the test for capacity and the Supreme Court of Canada's decision in *Starson* what considerations should be utilized to determine whether or not someone is incapable? The Supreme Court of Canada in *Starson* (paragraph 78) says that the ability to understand relevant information required that E had the cognitive ability to process, retain and understand the relevant information. We found there was no evidence E had such cognitive ability. Furthermore, the medical evidence which we found was not challenged or contradicted was such that E's ability was affected by his recent cardiac arrest and the consequences to him of the brain injury. In our further examination of the first branch of the test we examined the statutory phrase "relevant information".

*Starson* directs (paragraph 80) that "in practice the determination of capacity should begin with an inquiry into the patient's actual appreciation of the parameters of the decision being made:

- The nature and purpose of proposed treatment
- The foreseeable benefits and risks of treatment

- Alternative courses of action available
- Expected consequences of not receiving treatment”

We found E was unable to both communicate and understand that his recent cardiac had impaired his ability to understand information relevant to treatment decisions, in particular the treatment plan proposed by Dr. Demajo. We also found E was not able to understand information that is relevant to making a decision about the treatment proposed by Dr. Demajo. On the basis of this first part of the test, E was not capable with respect to the treatment proposed by Dr. Demajo or any other treatment.

***Did the evidence establish that E was unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision about the treatment in question?***

In Dr. Demajo’s opinion E failed this part of the test for the same reasons he failed the first part of the test for capacity.

*Neto v. Klukach*, [2004] O.J. No. 394, was a decision of Day, J. of the Ontario Superior Court of Justice dated February 10, 2004. In that decision, which was an appeal of a decision of this Board, the Court explained the second branch of the test for capacity (i.e. the ability to appreciate consequences) in light of *Starson*, as follows:

*The second branch assesses the ability to evaluate, not just understand, information. The patient must have an ability to appreciate the relevant information as it relates to him or her.*

Dr. Demajo said that in addition to failing the first branch of the test for capacity E also failed on the basis of his inability to appreciate the reasonably foreseeable consequences of a decision or lack of decision. He said E failed this second part of the two part capacity test for the same reasons he failed the first branch of the test. Dr. Demajo said E’s incapacity was a consequence of the effect on him of his dementia, recent cardiac arrest and brain injury.

E was declared incapable with respect to the proposed treatment. Dr. Demajo then turned to E’s substitute decision-maker, his wife M to provide treatment decisions for E. M subsequently stepped aside as substitute

decision maker in favour of V. The treatment plan that Dr. Demajo proposed was no cardiopulmonary resuscitation including defibrillation and withdrawal or non re-institution of ventilator support.

The evidence we received supported the conclusions of Dr. Demajo, Dr. Hawryluck and the consulting neurologists that E was incapable with respect to the proposed treatment. E was unable to communicate and therefore lacked the ability to appreciate he was in fact suffering from manifestations of and the devastating consequences of his cardiac arrest and resulting brain injury. He was unable to evaluate information concerning the proposed treatment as it related to his own circumstances, a fact which rendered him incapable to make a decision concern his treatment.

The evidence to support a finding of incapacity was clear, cogent and compelling. E had no comprehension about his need for treatment because he was unable to communicate, concentrate or focus. E's lack of insight into his condition rendered him unable to appreciate the information relevant to making a decision and appreciate the consequences of a decision or lack of decision. As a result of his inability to recognize he suffered from the consequences of cardiac arrest and its devastating brain injury effects on him, E also lacked the ability to appreciate the consequences or a treatment decision. E therefore failed the second branch of the capacity test. He was incapable with respect to Dr. Demajo's treatment plan and with respect to any other treatment.

The legal consequence of E being incapable of making his own treatment decisions meant that consent may be given or refused on his behalf by a person described in Section 20 of the *Health Care Consent Act*. E as the incapable person did not have an attorney for personal care.

In a case where substitute decision-maker (SDM) consents to treatment on an incapable person's behalf and the health practitioner is of the opinion that the SDM did not comply with S21 (HCCA), the health practitioner may apply to the Board. This was the Form G application before us in this case. In determining whether the SDM complied with s.21, the Board may substitute its opinion for that of the substitute decision-maker. If the Board determines that the SDM did not comply with s.21, it may give him or her directions, applying s.21 (s.37 (4)). The Board is required to specify the time within which the direction must be complied with. If the SDM does not comply with the Board's directions within the time specified by the Board, he shall be deemed not to meet the requirements of ss.20 (2) (s.37 (6)). If under ss.(6), the SDM is deemed not to meet the requirements of ss.20(2), any subsequent SDM shall, subject to ss.(6.2) and (6.3),

comply with the directions given by the Board on the application within the time specified by the Board (s.37(6.1)).

In *Conway v. Jacques*, [2002] O.J. No. 2333 (Ont.C.A.), rev'g (2001), 32 Admin.L.R.(3d) 248 (S.C.J.), leave to appeal to S.C.C. refused [2002] S.C.C.A. No. 341, the respondent's treating psychiatrist brought an application to determine whether the SDM (the respondent's mother) complied with the statutory principles for substitute decision-making under the HCCA. The respondent, who was found guilty by reason of insanity for using a weapon while committing a sexual assault in 1984, had been detained in psychiatric facilities since that time. The respondent denied that he was mentally ill and refused to accept anti-psychotic medication. In 1996, the respondent was found incapable of giving or refusing consent to psychiatric medication. His SDM refused to consent to the recommended anti-psychotic medication on the basis that the respondent refused to consent to other anti-psychotic medication while capable. The CCB found that the SDM had not complied with s.21 of the HCCA and held that the wish expressed by the respondent while he was capable was not applicable to the circumstances because his condition had deteriorated and the medication now available was more effective and had fewer side effects. The Board concluded that the SDM, in making a decision about consent to treatment, must act in the respondent's best interests. The respondent and his SDM successfully appealed to the Superior Court, which held that the Board's decision was unreasonable given the respondent's consistent refusal to consent to anti-psychotic medical while capable of giving or refusing consent. The psychiatrist appealed to the Court of Appeal.

The Court of Appeal held that the Board's decision that the respondent's wish was not applicable to the circumstances was reasonable in fact and law. The court stated (at para. 28):

“Substitute decision-making concerning medical treatment affects fundamental rights long recognized by the common law and now protected by the *Canadian Charter of Rights and Freedoms*. The right to decide whether to accept or refuse invasive medical treatment is fundamental to an individual's bodily integrity and personal autonomy”.

In *Conway* the Court of Appeal referred to the decision in *Fleming v. Reid* (1991), 4 O.R.(3d) 74 (C.A.) where the court struck down the legislation allowing the SDM to consent to treatment as being in the patient's best interests without regard to the patient's prior wishes and without a right to a hearing. The court noted that the HCCA was a response to this case. In the HCCA, the wishes of the patient are to be considered by the substitute decision-maker at two stages: 1) in acting in accordance with a prior capable

wish applicable to the circumstances pursuant to s.21 (1); and 2) in determining the incapable person's best interests pursuant to s.21 (2) where there is no prior capable wish applicable to the circumstances.

In reference to the first stage, the court agreed with the appeal judge that prior capable wishes are not to be applied mechanically or literally without regard to changes in circumstances. The court also noted that even wishes expressed in categorical or absolute terms must be interpreted in light of circumstances prevailing at the time the wish was expressed. In considering the second stage based on the best interests test under s.21(2), the court noted that it was only at this point that the HCCA allowed for consideration of the decision the patient would have made in light of changed circumstances. The court held that the lower court had not applied the correct test for determining whether a prior capable wish was applicable to the circumstances. The lower court held that the Board failed to consider whether the respondent would have consented to the anti-psychotic medication suggested by the doctor if he had been capable of giving or refusing consent. Sharpe J.A. stated (at para. 33):

“To require the substitute decision-maker or the Board to consider what the incapable person would have decided in light of changed circumstances would replace the two-stage test mandated by the Act with a different test that is not supportable under the language of the Act. Paul Conway's prior capable wish was either applicable to the circumstances or inapplicable to the circumstances. If a prior capable wish is not applicable to the circumstances, the question for the substitute decision-maker is not what the patient would have decided in light of the change but rather what is in the best interests of the patient.”

Sharpe J.A. found that it was open to the Board to conclude that the respondent's prior capable wish was not applicable to the circumstances. The Board considered that the respondent did occasionally consent to medication for his symptoms while capable of giving or refusing consent. The Board considered that the respondent's psychiatric condition deteriorated from the time he expressed his prior capable wish. The Board considered that the nature of the anti-psychotic medication had radically improved. In addition, the Board considered that the respondent's refusal to consent to chemical treatment was fuelled by his denial that he suffers from mental illness. The court noted that the respondent's SDM was not entitled to make a decision on the basis of the respondent's views of his own mental health and it was open to the Board to find that the SDM had failed to base her substitute decision refusing treatment on the best interests test under s.21(2) of the Act. Sharpe J.A. noted that the question before the court was not how the Court of Appeal would decide the issue but whether the Board's decision was unreasonable. Sharpe J.A. held that it was not

unreasonable for the Board to conclude that the respondent's prior capable wish was not applicable in the circumstances.

In *(M.)A. v. Benes* (1999), 46 O.R. (3d) 271 (C.A.), the Court of Appeal held that the Board did not have to defer to a decision of an SDM just because it was made in "good faith and was reasonable." The Board had the right to review a decision by the SDM in the absence of prior expressed wishes by the incapable person. The SDM refused treatment against the recommendation of the incapable person's physician and the physician then applied pursuant to s.37 for a review of the decision. The Board found that the SDM had not complied with s.21 of the HCCA and ordered that she consent to the recommended treatment. The SDM appealed arguing that s.37 was unconstitutional because it violated the incapable person's rights under s.7 of the *Charter*. For other reasons, the court held that the section was unconstitutional. The finding was appealed to the Court of Appeal by the Attorney General of Ontario. The SDM argued that as long as the SDM's decision was made in good faith and was reasonable, the CCB should defer to that decision. However, the Court of Appeal disagreed with this argument stating that the standard of "good faith and reasonableness" did not adequately protect the *Charter* interests of the incapable person.

The court made this decision based on the following reasons: the SDM is not always chosen by the incapable person (sometimes authority is conferred by statute) so the SDM might not always know the incapable person's beliefs, values, and non-binding wishes any better than the Board; the "best interests" test involves more than looking at the values, beliefs, and non-binding wishes of the incapable person (the effects of proposed treatments must be considered and this may be best dealt with by a medical expert – the job of the CCB is to resolve tension between the SDM and the medical expert); the HCCA does not require an SDM to follow particular procedural guidelines in making a decision under s.21 but the Board must follow procedural guidelines. The CCB was able to substitute its decision to authorize treatment for the SDM's decision to refuse treatment, even though the SDM was acting in good faith.

The Board found that V was a person who gives or refuses consent on behalf of E, an incapable person. V was obliged to follow the principles set out in Section 21 of the *Health Care Consent Act*.

### **No previously expressed wishes applicable to E's Circumstances**

Section 21(1) of the *Health Care Consent Act* has been previously set out. The evidence of both Dr. Demajo and V was such that they were not aware of any specific document, discussion or wish expressed by E while capable or otherwise that was applicable to his current circumstances. We carefully considered the evidence.

V described a number of events in which he said his father expressed an opinion about situations. For example, V said there was one time he and his father were watching the Portuguese news and a story came on about a husband seeking permission to “unplug” his wife. V recalled that his father became angry that the husband was seeking to end his wife’s life. According to V, his father said the husband should be “shot” for what he was trying to do. On another occasions V recalled E’s mother being diagnosed with a terminal head illness and E sought out treatments for her, even taking her to Portugal to look for more aggressive treatments.

V said his father’s motto was “where there is life, there is hope” that his father was a fighter. V said his father regularly sought out medical attention for his ailments such as diabetes and high blood pressure. E even went to Portugal to look for different or better treatments.

V also described E as a religious person. While not attending church every day like his wife, E attended outdoor religious processions. V recalled E taking the family to visit Fatima, a spiritual and religious sanctuary in Portugal. V said his father believed in miracles. V also said that quality of life was important to his father, to get up, go outside and move around. V said it was only his opinion that his father wanted to fight for his life, saying “how can I speak for the mouth of someone else, I can only give an opinion.” At one point V testified that he wanted the hospital to do what was best for his father, that the doctors should determine what was best. Later in his evidence V said only God could make the decision of what was in his father’s best interests, that only God could decide the quality of his father’s life. V wanted his father to have a regular death, and that would occur when God called him. V said the doctor’s machines were instruments of God, just as the doctors were instruments of God.

While there was some evidence that E valued life in general there was absolutely no evidence of his prior consideration of the affects of severe brain injury on him. We noted the Compassionate Care Form signed by M in March 2006 for transfer of E to an acute care hospital with cardiopulmonary resuscitation, but found

that this was not evidence of a prior capable wish by E. Nor was it evidence that could be given much weight in the consideration of the issue of best interests.

As Justice Sharpe said at paragraph 31 in *Conway v. Jacques*, cited above,

“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”.

Any comments attributable to E were not precise and lacked particularly. There was no evidence of statements meant that he should be kept alive despite any levels of pain, loss of autonomy or personal dignity. We found that as at the Hearing E had not previously expressed a wish applicable to his circumstances, for end of life care.

We found no evidence E had his current circumstances in mind. Holding that his beliefs such as in miracles were prior capable wishes applicable to his devastating current circumstances would be too mechanical or literal application of any words with complete disregard for changes in his circumstances.

We therefore found that V did not know of a wish applicable to the circumstances that E expressed while capable and after attaining sixteen years of age. V was obliged to act in E’s best interests as defined in S.21 (2) of the *Health Care Consent Act*. That meant that in deciding what E’s best interests are, V as the person who gives or refuses consent on his behalf shall take into consideration the factors set out in S. 21(2).

### **Best Interests**

The Board examined Section 21(2) in the context of the evidence and considered each provision of the section with the evidence below. The Board applied the factors set out in s. 21 (2) of the *Health Care Consent Act* to E’s circumstances to determine his best interests. The absence of previously expressed capable wishes applicable to E's circumstances as at the Hearing meant we had to determine consent based upon E's best interests, in light of Justice Sharpe's observations in this regard at paragraph 33 in *Conway v Jacques*. It did not mean we would determine what E would do in those circumstances. We also noted that

E's values and beliefs were only one of the factors to be considered in assessing his best interests. We were in a better position than V to determine E's best interests as recognized by the Court of Appeal in *Benes*.

### **Values and Beliefs**

In ascertaining that E made no prior capable wish applicable to the circumstances the Board had closely examined the evidence. We have already found that there was no evidence before us as to E's desires if he found himself in the condition the Board found him in. Without repeating ourselves we heard V express E's values and beliefs when he sought out treatment for himself, his mother and showed his faith by attending church and Fatima. However, when specifically asked about his father's value and beliefs, we found V's evidence vague. He stated that E fought for his life and gave us examples. However, the examples provided little insight into what E's values and beliefs would be if he was capable.

In terms of V's assertion that his father was religious man and believed in God, the evidence was not clear, cogent and compelling as to how those beliefs would have affected his wishes and desires in his current circumstances. However, on a number of occasions in giving evidence V was unable to say what his father would have wanted. He was clear that his mother wanted all treatment to continue. However, when asked whether that is what his father would have wanted he responded with "exactly, maybe". There was no clear evidence as to what E's views were concerning mechanical ventilation and CPR.

To the panel E valued life prior to his admission to hospital. E's quality of life had already been impacted by dementia and his other medical ailments. V said his father called him regularly. V took his father for walks even when he required assistance. V testified that based on his father's values and beliefs, his father would wish to fight for his life.

V was asked about E's values and beliefs that he knew E held when capable and believes he would still act on if capable. V said his father would have wanted everything done that was possible to do because he was a fighter. V said to his father that life meant "hope". We found the very limited evidence of E's values and beliefs.

b) Wishes – We could not find there were any wishes expressed by E with respect to the proposed treatment that are not required to be followed under paragraph 1 of subsection (1).

This provision was not applicable to the case before the Board.

- 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.
    - iv. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
    - v. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
    - vi. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

As was set out by Justice Cullity in *Scardoni v Hawryluck* [2004] O.J. No 300 (paras 45-50) well-being is broader than simply life but incorporates concepts of quality of life, dignity and pain.

V who was close with his father has demanded that his father be treated. However according to the clear cogent and compelling medical evidence these treatments will cause E to continue suffering pain and loss of dignity including bed sores, infections and invasive medical treatments. The potential benefit of mechanical ventilation and CPR, may cause some delay as to when E will die without ever recovering to a neurological condition to allow him to interact with the world. However we found any potential benefits are outweighed by the burden of the treatment, including pain, discomfort and loss of dignity. The risk of harm from life-sustaining treatment and the possibility of a less intrusive treatment are not factors on the evidence before the Board.

V testified that he understood that the medical team's opinion that it was not in E's best interests to continue to reinstate mechanical ventilation or offer CPR. From both the health records including the notes of January 2, 2009 and V's oral testimony he wanted the medical team to do what was best for his father. At the Hearing V was asked to explain what he meant. V indicated that what was best would be to administer all treatments, including dialysis, despite there being no medical indication for same. V said God had provided

these instruments to doctors so they could be used. V also said that if God then still wanted to see his father die, his father was “in God’s hands” and it was “for God to decide”. In the end when asked whether he believed continuing mechanical ventilation was in his father’s best interests, V said he could not really answer the question.

V said that it was too early to consent to Dr. Demajo’s treatment plan. He believed that Dr. Demajo was minimizing E’s recovery potential, that his father was not being afforded the standard 6-12 month recover time typically given in these circumstances to fully assess improvement/prognosis. V believed that the proposed treatment plan for E will result in accelerating his father’s demise. V believed his father made mild improvements that maintaining full medical intervention was prudent and likely to reduce the extent or rate at which E’s condition was likely to deteriorate.

V in his evidence said that no matter how poor his father’s prognosis he wanted intervention to be offered and provided. He said this notwithstanding his belief that the interventions would cause his father pain and his father was unlikely to ever be able to interact with his family or the world.

The totality of the medical evidence, from the three consulting neurologists, and the two ICU doctors, Dr. Hawryluck and Dr. Demajo was that mechanical ventilation and CPR might keep E alive for some period of time longer than if these treatments were withdrawn or withhold. However in their opinions E’s underlying condition and well-being could not be improved by the treatments with his neurological condition permanent and devastating. In short, all medical evidence indicated there was no prospect for recovery.

The medical evidence was clear that after twelve months there would unlikely be any further improvement from a brain injury (including brain trauma) and most recovery happened in the first six months. However, the medical evidence also was that in the circumstances of this case of E’s anoxic brain injury and irreversible brain damage, if there has been no meaningful recovery shown by four months time, the likelihood of meaningful recovery was essentially non-existent.

V reported, contrary to Dr. Demajo’s evidence that E grimaces often in response to stimuli, especially when a tube was placed down his throat. V also said his father has jerked his arm when V rubbed it. V was questioned about M’s reports that her husband has expelled tears and tracked her. V said his mother was old

and not understanding that the tears were from eye drops. He said he was not sure what to make of his mother's other reports, but he did not believe them to be true.

V testified that he was aware of his father's medical condition and that he had not seen improvements where there were none. However, V believed it to be in E's best interests for Dr. Demajo to maintain a treatment plan that included full medical intervention. He believed that the benefit of the current treatment outweighed its risk of harm to E. The medical evidence received was that full medical intervention would prolong the dying process, not restore neurologic functions, would cause E pain and suffering, that life support measures could lead to other damage i.e. central line and bladder infections, sacral ulcers and drug use damage to the organs. It was clear to the Board that on the evidence there was never a full meeting of the minds between E's family and the treating team, regardless of what the hospital records reflect in that regard. Despite communication challenges for the medical team and a very distressed family, it appeared to the Board that E was provided with all necessary treatment throughout.

We had some difficulty in terms of relevance with V's comments that a husband seeking to "unplug" his wife should be "shot". It was unclear from the evidence which particular case V was referencing. If the case was the Terry Schiavo case, as Dr. Demajo's counsel pointed out, there were a number of distinguishing factors between that case and E's case before the Board including the ages of the two persons and that in the Schiavo case the proposed withdrawal of treatment was withdrawal of a feeding type, something not currently proposed for E.

With respect to V's evidence that E searched for assistance for his mother's head illness, Dr. Demajo's counsel argued that the nature and extent of the illness and ability for it to be treated or improved was unknown based on the evidence. We agreed.

The statement attributed to E "where there's life, there's hope" was not sufficient as a prior expressed capable wish applicable to the circumstances. The statement could be considered as a factor in determining best interests, along with other evidence that was relevant to E's best interest.

We were unable to conclude that V's evidence was sufficient on a balance of probabilities that E would have desired CPR and ventilation support in the circumstances in which he found himself at the time of the Hearing.

There was no cogent evidence that E responded to sounds. The medical evidence was that E's response to pain was a primitive, nerve-based response and there was no other medical evidence to contradict this point. We preferred the clear, cogent and compelling medical evidence.

From the evidence there was no reasonable hope of permanent restoration of respiratory function in E, simply temporary ability to breathe without the support of the respirator and with continuing suctioning. As has been evidenced during his admission, E, even if weaned, would continue to cycle on and off the respirator because of his permanently poor neurological condition.

As to the suggestion that E responded to external stimuli, the evidence in support of this amounted to hearsay from M which was not believed by her son V and some evidence from V which was not supported by the medical evidence. We preferred the clear medical evidence to the contrary.

Insofar as submissions by E's counsel as to whether the proposed treatment plan related to "hospital administrative and staffing needs" and not the patient's best interests, there was no evidence to support such a submission.

V's comments that his father would have wanted everything done that was possible to do were not specific to his current life situation. We found the comments not to be prior capable wishes applicable to the circumstances. If they are put forward as values, we found them to be quite vague to be values. They were certainly not directory.

Dr. Demajo's proposed treatment plan was no cardiopulmonary resuscitation including defibrillation and withdrawal or non re-institution of ventilator support. His plan was supported by Dr. Hawryluck. Dr. Demajo's unchallenged medical evidence was that E had no realistic chance of recovery. E's dire situation was noted by all neurologists in their consultations. All medical evidence and opinions concurred with each other. We accepted them and found them to be factual. The plan recognized that well-being involved more than just living, that there were qualitative aspects to it. This plan was the minimally invasive approach to the devastating consequences forced on E. If, during the process of withdrawing the ventilator E could not sustain his breathing adequately, he would be treated with medications to provide optimal palliative care to prevent discomfort. The risk of the proposed treatment was that, if E was unable to breathe adequately, he would die during or shortly after the life support is withdrawn. However, according to the only medical

evidence and opinions we received and accepted, full medical intervention will not improve the overall quality of E's life nor lessen the disability associated with having had the severe neurological damage.

The question for us was whether it was in E's best interests to be kept alive by these means of prolonging or extending his life with full medical interventions and the likely risk of infections and pain, without hope of recovery? In other words in determining the S.21(2)(c) considerations including E's well-being in this case we had to consider the invasiveness of the interventions required to extend E's life, and that these would not, according to the medical evidence improve E's current condition.

As the Court of Appeal set out (paragraph 45) in *Benes* values, beliefs and non-binding wishes are not the only elements of the best interests test. The likely affect of the proposed treatment is a key element as well. What impact would Dr. Demajo's plan have upon E's "condition or well-being?" That term is used in paragraph 21(2) (c) 2 of the Act, "Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment."

In *Scardoni v. Hawryluck*, 2004 CanLII 34326 (ON S.C.), an appeal from a Decision of this Board, Justice Cullity analyzed how the Board interpreted "well-being." The Board's used this definition:

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. (Quoted from Paragraph 45 of Justice Cullity's Judgment)

Justice Cullity approved of that approach, though he reversed the Board's decision on other grounds. In this case before us we found "condition" refers to a person's overall health which can involve many factors. We also found that "well-being" has a broad meaning to an incapable person's overall situation and quality of life.

Dr. Demajo said that this case was about deciding what quality of life meant and that was an individual matter differing from person to person. In our view E's well-being included consideration of his dignity and quality in his life. Full life support would be more detrimental than beneficial in terms of well-being. Put another way not only were the treatment provisions of full life support, not in E's best interests, they were not in his interest at all. On the evidence we found that full life support, ongoing hospitalization of E and likely

infections will not improve the overall quality of E's life nor lessen the disability associated with having cardiac arrest and severe neurological damage, the brain damage. Full care of E would extend life. How was that in E's best or any interest given his current state after suffering the anoxic brain injury? V based his objection to the proposed treatment on hope and faith in God. However, the legal requirement required consideration of E's "best interests". In addition there were no medical opinions in opposition to the treatment plan.

We also noted the words of the Court of Appeal in *Benes* at paragraph 45 that the S.D.M. is not likely to have special knowledge about the possible effects of medical treatment and thus, as a general rule, must rely on the expertise of the treating health practitioner.

We found that the evidence supported findings that E will remain brain damaged, unable to communicate and completely dependent for his care needs. Furthermore, we agreed with the clear, cogent, and compelling medical evidence that the treatment plan of Dr. Demajo was in E's best interests.

We knew from the medical evidence that the impact of the treatment plan upon E's condition was not necessarily that he would die, as he had previously been weaned from the ventilator. Did well-being to E's life simply mean quantity of life and not quality of life? Everyone eventually dies. So the risk is not whether E dies, but when and how he dies and what transpires in the interim. These are some of the factors that must be considered in determining well-being.

Dr. Demajo's treatment plan was less intrusive than full life support and the likely infections. These were important factors to consider. To the extent that "well-being" includes considerations of E's dignity and potential for improvement in the quality of his life, we believed Dr. Demajo's plan was more beneficial. The Board found therefore, that E has not complied with s. 21 of the *Health Care Consent Act* as he did not support the recommended treatment plan.

We found that full life support would not provide E with comfort or dignity in an extended state. He would be subject to pain and discomfort, likely infections, ulcers and bed sores, all complications of the underlying process according to Dr. Demajo, without any gain to his well-being. We found that the quality of E's life will further deteriorate. We concluded that it was more important to die a comfortable dignified death.

We found the benefit E was expected to obtain from the proposed treatment outweighed the risk of negative consequences to him. E's dignity and independence will be respected and he will not likely linger or suffer. We found that the alternative full medical care was treatment that was not a course of action that is less restrictive than the proposed treatment with likely surgical interventions, and likely infections and is not appropriate in the circumstances.

Counsel for E relied on the recent Ontario Superior Court decision in *Barbulov v. Cirone* (Crt File No. 03-012/09) as support for the proposition that the concept of well-being did not include the concept of quality of life. We reviewed the decision. It did not appear that the decision in *Scardoni v. Hawryluck* was brought to Mr. Justice Brown's attention. It was unclear the precise meaning of the passage cited by counsel for V. It appeared Mr. Justice Brown wished to make clear that simply because a patient would never recover a quality of life did not mean that questions of dignity in death were not important. The proposed treatment plan in this case does not undermine E's dignity in dying. Well-being included consideration of a person's dignity and sanctity in all stages of life. There was no proposal not to provide other care or supports to E including palliative care. Notably, in the *Barbulov* case, the Court confirmed as reasonable the Consent and Capacity Board's decision to require the patient's substitute decision maker to consent to the withholding of CPR and the non-reinstitution of ventilatory support.

As the decisions in *Barbulov* and *Scardoni* make clear, it is not open to the family to propose a treatment plan. Treatment plans are proposed by physicians and must be consented to by the substitute decision maker if they are in the patient's best interests. It is not sufficient for the consent or withholding of consent to be reasonable, it must be correct. While V's withholding of consent may be reasonable, E's best interests were the issue and required that consent be given to the treatment plan proposed by Dr. Demajo.

These are extremely difficult cases. In considering the evidence and law the panel believed on a balance of probabilities that our decision was reasonably supported by the evidence. We also found that E's best interests would be served by following Dr. Demajo's treatment plan. V was clearly motivated by his commitment, love and support for his father and was clearly acting in good faith. However, his father's condition was devastating.

As Justice Aitken in Janzen cited in the Scardoni decision above said:

“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 (*sic*) quality of life. I consider the concept of "well-being" a very broad concept which encompasses many considerations, including quality of life. Many of the interventions contemplated as being necessary to prolong Mr. Janzen's life involve procedures that could be painful or uncomfortable for Mr. Janzen. 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.”

Both Dr. Demajo and Dr. Hawryluck gave evidence that the recommended treatment plan proposed for E was the plan considering E's well-being. It was clearly less intrusive than full medical intervention. We accepted their expert opinions and agreed with them. We also found that no cardiopulmonary resuscitation including defibrillation and withdrawal or non re-institution of ventilator support would be the best way to respect the factors set out in paragraph 21(2) of the HCCA relevant to E's best interests. We found that E's well-being and dignity were thereby respected.

## RESULT

We confirmed Dr. Demajo's finding that E was incapable of giving or refusing consent to no cardiopulmonary resuscitation including defibrillation and withdrawal or non re-institution of ventilator support. We also determined that V as substitute decision maker for E has not complied with the principles for substitute decision making set out in the *Health Care Consent Act* and directed him to comply with the treatment plan of Dr. Demajo of no cardiopulmonary resuscitation including defibrillation and withdrawal or non re-institution of ventilator support. The substitute decision maker was directed to comply with the Board's direction by 5:00 p.m. Monday May 4, 2009.

**Dated: May 13, 2009**

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**Michael Newman**  
**Presiding Lawyer Member**