Consent and Capacity Board
Commission du consentement et de la capacité
Ontario

HA-12-5028
HA-12-5029

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

AND IN THE MATTER OF
AC
A patient at
Hamilton Health Sciences-Juravinski Hospital
HAMILTON, ONTARIO

REASONS FOR DECISION AND DISMISSAL

PURPOSE OF THE HEARING

A panel of the Board convened at the Hamilton Health Sciences-Juravinski Hospital at the request of Dr. Corey Sawchuk, a health practitioner. Dr. Sawchuk 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(s) in this case complied with Section 21 of the *Health Care Consent Act*, the principles for substitute decision-making, with respect to proposed treatment for AC. The proposed treatment was set out in a Plan of Treatment dated May, 2013 filed as an Exhibit.

An Application to the Board under Section 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 AC 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, DECISION, ORDER/ENDORSEMENT AND REASONS

The hearing took place on May 22, May 24, June 5, and June 12, 2013 with the Decision on the deemed application, Order/Endorsement dismissing the Form G application and Reasons for Decision and Dismissal being released on June 25, 2013.

LEGISLATION CONSIDERED

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

PARTIES

AC's Deemed Form A – Treatment Application
AC, patient
Dr. Sawchuk, health practitioner

Dr. Sawchuk's Form G – Treatment Application
Dr. Sawchuk, health practitioner
AC, patient
FC, AC's wife and substitute decision maker.
SC, AC's daughter and substitute decision maker.

AC did not attend the Hearing. Dr. Sawchuk attended the Hearing, gave oral testimony and filed documentary evidence.
FC attended the Hearing and gave oral testimony.
SC attended the Hearing, gave oral testimony and presented documentary evidence.

PANEL MEMBERS

Michael Newman, Vice-Chair, Presiding Lawyer Member
Beverley Hodgson, public member
David Boothby, public member

APPEARANCES

AC was represented at the Hearing by counsel, Mr. L. Dimitry
Dr. Sawchuk was represented at the Hearing by counsel, Ms. C. Clarke
SC was represented at the Hearing by counsel, Mr. M. Handelman and Mr. A. Procope
FC represented herself at the Hearing

PRELIMINARY MATTERS

Jurisdiction

The panel was advised that there had not been within the previous six months a determination by the Board of AC's capacity to consent to treatment. The panel was also advised that AC did not have a Guardian of the Person. He had a Power of Attorney for Personal Care, although it did not contain 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*. We determined that the Board had jurisdiction to continue with the Hearing.

Representation

FC clarified for the Board that she did not want legal representation and if given the opportunity she would not retain her own counsel. She was prepared to proceed unrepresented, indicating that she relied on her daughter SC and her other children.

Interpreter

An Italian interpreter (Campagna dialect) attended the entire Hearing process and interpreted the entire proceeding for FC and FC's evidence for the benefit of the Board, the other parties and observers.

THE EVIDENCE

The evidence at the Hearing consisted of the oral testimony of three witnesses, Dr. Sawchuk, FC, AC's wife and substitute decision maker and SC, AC's daughter and substitute decision maker and twelve Exhibits:

1. Dr. Sawchuk's Brief (consisting of Tabs 1-S)
2. Justice Crane's Superior Court Endorsement dated May 3, 2013
3. SC's Brief (entitled Application Record of the Applicant)
4. SC's Notice of Appeal dated May 6, 2013
5. Treatment Plan dated May, 2013
6. November 2012 Proposed Treatment Plan.
7. May 3, 2013 POST (2 pages) End of Life Care
8. CCAC Caregiver Recognition Awards (2), 2010
9. Two pictures (AC & SC)
10. Dr. Jones' note dated June 4, 2013
11. Release of Liability Waiver dated 03/09/2013
12. Dr. Sawchuk's Progress Note dated 20/05/2013

INTRODUCTION

AC was an 84 year old gentleman who was married to his wife FC. By his Power of Attorney for Personal Care dated February 9, 2002, AC appointed his wife FC and one of his three children, a daughter SC as his joint attorneys for personal care.

On August 22, 2011 AC was admitted to hospital as a result of complications associated with his feeding tube. By the first day of the Hearing AC had been in hospital receiving care in the Intensive Care Unit since August 2011, save for a five week period from December 2011 to January 2012. Medically, AC suffered from dementia and had numerous underlying medical issues, including end stage multi organ system failure, respiratory failure, kidney failure and required night time mechanical ventilation. As a result of his kidney failure AC received ongoing dialysis three times a week.

AC was immobile, did not initiate spontaneous movement, and was bed bound, dependent on a gastric tube for feeding and on other individuals for all activities of daily living and cleansing. Attempts at trying to set in place a plan to have AC return to his home under the care of his family have failed as AC could not tolerate any reduction in his care, in the view of the treating team. AC's family has been involved in every aspect of his care. Since November 2012 various treatment plans have been proposed to AC's substitute decision makers without consent being obtained. Presently, AC continued to be maintained on full treatment.

Over the course of the last number of months, AC's substitute decision makers and health practitioner have tried to find common ground with respect to AC's treatment. More recently, Plans of Treatment were proposed in November 2012, on April 11, 2013 and then finally the current plan before the Board dated May 2013. Efforts and discussions between Dr. Sawchuck, as AC's health practitioner and Most Responsible Physician (MRP) and AC's substitute decision makers were unsuccessful at resolving the issues between them. As a consequence, Dr. Sawchuk filed the current Form G Application before the Board.

THE LAW

General

When the Board is considering Dr. Sawchuk's Form G Application and the deemed treatment capacity application by AC, the onus is always on the health practitioner at a Board Hearing to prove his or her case. The standard of proof on any application under the *Health Care Consent Act, 1996* is proof on a balance of probabilities. The Board must consider all evidence properly before it. Hearsay evidence may be accepted and considered, but it must be carefully weighed. In order for the Board to find in favour of the health practitioner it must hear clear, cogent and compelling evidence in support of their case. An individual who has been found incapable with respect to treatment, here AC, did not have to prove anything to the Board.

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(1) 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.

Sections 10 and 11 of the *Health Care Consent Act* read as follows:

No treatment without consent

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

(a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or

(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).

Opinion of Board or court governs

(2) If the health practitioner is of the opinion that the person is incapable with respect to the treatment, but the person is found to be capable with respect to the treatment by the Board on an application for review of the health practitioner's finding, or by a court on an appeal of the Board's decision, the health practitioner shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless the person has given consent. 1996, c. 2, Sched. A, s. 10 (2).

Elements of consent

11. (1) The following are the elements required for consent to treatment:

1. The consent must relate to the treatment.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not be obtained through misrepresentation or fraud. 1996, c. 2, Sched. A, s. 11 (1).

Informed consent

(2) A consent to treatment is informed if, before giving it,

(a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and

(b) the person received responses to his or her requests for additional information about those matters. 1996, c. 2, Sched. A, s. 11 (2).

Same

(3) The matters referred to in subsection (2) are:

1. The nature of the treatment.
2. The expected benefits of the treatment.
3. The material risks of the treatment.
4. The material side effects of the treatment.
5. Alternative courses of action.
6. The likely consequences of not having the treatment. 1996, c. 2, Sched. A, s. 11 (3).

Express or implied

(4) Consent to treatment may be express or implied. 1996, c. 2, Sched. A, s. 11 (4).

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.

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.

Dr. Sawchuk, a health practitioner, critical care specialist, anestheologist and the Chief of the Critical Care Unit at Hamilton Health Sciences-Juravinski Hospital applied for a determination as to whether or not FC, AC's wife and SC, AC's daughter as AC's substitute decision makers complied with the principles for substitute decision making as set out in the *Health Care Consent Act* with respect to proposed treatment for

AC. Throughout our deliberations, we imposed the onus of proof upon Dr. Sawchuk. That onus was on a balance of probabilities.

By statute this type of application triggered an application by AC 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* (at times referred to as the HCCA). That legislation also sets out a scheme for identifying substitute decision makers (SDMs) for incapable persons. It also described how SDMs should make decisions and the available options should SDMs 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.

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.

Did the evidence establish that AC was unable to understand the information relevant to making a decision about the treatment in question? Did the evidence establish that AC was unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision about the treatment in question?

Dr. Sawchuk described AC as a lovely patient, but one who had been in the intensive care unit for over 16 months and who was dying. The doctor noted that AC had a 10 year history of dementia and that for much of that time through the extraordinary efforts and hard work of his wife and family had been provided with quality care in his home environment. Dr. Sawchuk said that although AC had been brought to hospital many times over the years, through the efforts of hospital staff and a close knit supportive family, a way had always been found to take AC home. However, as Dr. Sawchuk noted, AC's dementia has progressively worsened over time resulting in AC requiring more and more supports, which AC's family continued to work at providing or obtaining for him.

Dr. Sawchuk prepared and filed a clinical summary dated January 31, 2013. In oral evidence the doctor confirmed that as of the Hearing his clinical summary remained accurate. In his summary Dr. Sawchuk wrote:

> "AC is cognitively impaired. He has no ability to make any decisions. It appears that AC is unaware of his environment and is unable to recognize people."

According to Dr. Sawchuk AC was able to open his eyes spontaneously and blink but was unable to track, follow voice commands or speak. The doctor said that it did not appear that AC was in touch with his surroundings which the doctor said was consistent with AC's underlying dementia. The doctor's position was that AC was unable to understand information and was unable to appreciate the consequences of any treatments decisions. Insofar as AC's capacity to consent or refuse consent with respect to his own treatment decisions the evidence of AC's incapacity was unchallenged.

The doctor said that the inability to set up even a simple form of communication with AC was evidence he did not have the cognitive ability to understand information about his treatment or the consequences of any treatment decisions. According to Dr. Sawchuk AC failed both parts of the two part test for treatment capacity. In Dr. Sawchuk's opinion, AC's significant mental impairments limited his ability to understand

information and to appreciate reasonably foreseeable consequences. None of the other parties took issue with Dr. Sawchuk's opinion that AC was incapable with respect to his own treatment.

We had to remember that there was a presumption AC was capable unless Dr. Sawchuk had reasonable grounds to believe that AC was incapable (S4 (3) (HCCA). Dr. Sawchuk had the onus of satisfying the Board on a balance of probabilities that AC was incapable.

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 that 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."

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) stated that at the ability to understand relevant information required that AC had the cognitive ability to process, retain and understand the relevant information. We found that AC lacked that cognitive ability. The medical evidence was such that AC's abilities to both understand relevant information and appreciate consequences were severely compromised by his significant mental impairments. In our further examination of the first branch of the test we examined the statutory phrase "relevant information".

Starson directed (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"

Dr. Sawchuk's evidence of AC's incapacity with respect to treatment was clear, cogent and compelling. We found AC was unable to communicate, understand or appreciate. He had no actual appreciation of the parameters of his treatment decisions. We agreed with Dr. Sawchuk's opinion that AC's significant mental impairments severely impaired any ability to understand information relevant to treatment decisions. We found AC was not able to understand information that is relevant to making a decision about any treatment proposed for him. On the basis of this first part of the test, AC was not capable with respect to any treatment proposed by Dr. Sawchuk.

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.

The unchallenged evidence we received supported the conclusions of Dr. Sawchuk that AC was also incapable with respect to his treatment on the basis of the second branch of the test. AC was unable to communicate or evaluate and therefore lacked the ability to appreciate he was in fact suffering from manifestations of and the devastating consequences of his significant mental impairments. AC's inability to evaluate information concerning the proposed treatment as it related to his own circumstances rendered him incapable to make a decision concern his treatment.

The evidence to support a finding of incapacity was clear, cogent and compelling. AC had no comprehension about his need for treatment because in his mental state he was unable to communicate, unable to follow voice commands, evaluate, concentrate or focus. In his longstanding current mental state AC lacked any insight into his condition which 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 progressively worsening dementia and its devastating effects on him, AC also lacked the ability to appreciate the consequences of any treatment decisions. We found AC was incapable with respect to all medical treatment.

Form G- Treatment Compliance Application

The legal consequence of AC 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*. AC as the incapable person had a Power of Attorney for Personal Care, appointing his wife FC and his daughter SC jointly as his attorneys for personal care and therefore his substitute decision makers. Here, FC deferred decision making to her daughter and joint attorney for personal care SC.

Where substitute decision makers (SDMs) consent to treatment on an incapable person's behalf and the health practitioner is of the opinion that the SDMs did not comply with s.21 (HCCA), the health practitioner may apply to the Board. This was the Form G application brought by Dr. Sawchuk in this case. In determining whether the SDMs complied with s.21, the Board may substitute its opinion for that of the substitute decision makers. If the Board determines that the SDMs did not comply with s.21, it may give them 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 SDMs do not comply with the Board's directions within the time specified by the Board, they shall be deemed not to meet the requirements of ss.20 (2) (s.37 (6)). If under ss.(6), the SDMs are 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)).

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 (l) 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".

In Dr. Sawchuk's view it had become extremely difficult to work with AC's substitute decision makers and family. SC's evidence disclosed that from the family's perspective they found it more and more difficult to work with hospital staff including Dr. Sawchuk. Clearly, both the health care team and AC's substitute decision makers had different views of what was in AC's best interests. However, all parties continued attempting to resolve their issues, which were aimed at having AC return home. By March 27, 2013 the Hearing of Dr. Sawchuk's Form G Application before another panel of this Board was adjourned on consent to facilitate the implementation of a Treatment Plan which would have seen AC returning home. That never

happened. By April 11, 2013 the previous proposal to have AC cared for at home had turned into Dr. Sawchuk's then proposed palliative Treatment Plan, which effectively would have seen according to the doctor, the withdrawal of all aggressive measures. That proposed Treatment Plan of April 11, 2013 was set out in Ms. Clarke's letter to Mr. Handelman dated April 11, 2013 (Tab N, Exhibit 1) which read as follows:

> "1. Care plan focuses on comfort including administration of narcotics and sedatives as needed recognizing that comfort medications may be associated with hypotension and clinical decline.
> 2. Blood pressure monitoring to decrease to every 4 hours. Discontinue ECUG monitoring but maintain continuous saturation monitor 24 hours a day.
> 3. No chest compressions or defibrillations at time of death
> 4. Discontinuation of intermittent Levophed infusions to support blood pressure.
> 5. Discontinue all procedures including IVs, and needle sticks for investigations, central lines, dialysis therapy and dialysis catheters. Leave current catheters and tubes in place until time of death.
> 6. Maintain pressure support ventilation as needed for comfort with hospital ventilator. Maintain oxygen support on ventilator to a maximum of 60 percent inspired oxygen.
> 7. Transfusions to maintain Hemoglobin above 80. In the event of a massive GI bleed or other event, no interventions or transfusions of blood products
> 8. No antibiotics for organisms cultured that have multi-resistance
> 9. Extend family visitation subject to individual code of conduct and acuity of patient condition.
> 10. With implementation of 1-10, continue with other dignified measures including feeds, IV fluids, wound care, routine bedside nursing, suction, trach care, as previously outlined."

Clinical records filed and the evidence revealed that any communication between the treating team and AC's substitute decision makers and family continued to deteriorate. Following further attempts at resolution of issues concerning proposed treatment for AC, on April 30, 2013, Dr. Sawchuk as AC's most responsible physician, placed a Physician's Order on AC's chart which read as follows:

> "ICU attending and MRP
> starting at 9:00 a.m.
> May 2, 2013
> No chest Compression
> No Defibrillation"

Dr. Sawchuk subsequently amended his order to be effective from May 3, 2013. In this same short time period between the end of April and early May 2013 SC applied to Superior Court for an interim injunction to prevent the doctor's order from being implemented. On May 3, 2013 Justice Crane dismissed the application. That dismissal was then appealed by SC to the Court of Appeal. By early May 2013, the April 2013 Treatment Plan proposed for AC changed to the May 2013 Proposed Treatment Plan, currently before the Board set out in detail as follows:

"Goals of Treatment Plan:

AC has ongoing decline since admission into the ICU in January, 2012. He requires clinical care within ICU. He is unable to go home unless a palliative plan incorporating active withdrawal of dialysis and Norepinephrine and subsequent imminent death is accepted by the family.

As the family does not consent to withdrawal of therapy, he must remain in ICU. In hospital, the ICU team will do what is medically reasonable and clinically indicated to maintain AC in a comfortable and dignified manner, providing him with treatments that contribute to his overall well-being and best interests recognizing he has ongoing clinical decline and will eventually pass away in the ICU.

Respiratory Status

- Trach
- Atelectasis
- Aspiration
- Suctioning
- Pleural Effusion
- Therapeutic use of oxygen

Goal: To maintain current respiratory status and provide supportive interventions

- Ventilation - As part of his clinical decline, mechanical ventilation has become a necessity of life on this hospital admission for Mr. A.C. and it is almost certainly not possible that he will be completely liberated from his support. Mechanical ventilation will be provided for the purpose of rest at fixed intervals on a daily basis as well as during any periods of instability.
    - Ventilator management will be provided exclusively by the health professionals knowledgeable in this domain.
    - Family not to remove, adjust, or otherwise interfere, with ventilator Mechanical ventilation to be provided between approximately 2200 - 0600 hrs. and throughout the day to keep Mr. A.C. comfortable V determined by the physician.
    - Ventilator settings to be determined by the physician in discussion with the RRT.
    - There had been plans in place to train the family to facilitate home mechanical ventilation. As Mr. AC has had many episodes of clinical instability unfortunately it now seems improbable he is a candidate for home mechanical ventilation. In the event that Mr AC has a prolonged period of clinical stability (approximately four weeks) this option will be revisited.
- Tracheotomy - Long term
    - Routine trach care to be provided at appropriate times as per RRT/nurses' clinical judgment.
- Inexsufflation
    - 4 /day and pm: schedule and timing to be determined by RRT and nursing
- Oral Care and Suctioning
    - Routine oral hygiene will be provided by the RN/RRT staff

- Oxygen Flow
    - Supplemental oxygen will be provided to maintain appropriate oxygen saturation levels as determined by the physicians. Ventilator requirements for oxygen and mechanical support will be kept to a reasonable non-toxic range no greater than Fi02 of 0.6 and PEEP of 15.
    - Changes only performed by health professional, based on his or her clinical assessment.

Cardiac Function

- Previous episodes of heart failure
- Controlling heart rate and Blood Pressure

Goal: to maintain appropriate hemodynamic status.

AC has atrial fibrillation with frequent episodes of tachycardia (rapid ventricular response) as well as episodes of bradycardia and pauses. Consequently, he has evidence of right ventricular dysfunction (dilatation and systolic dysfunction).

- Monitoring Fluid Intake
    - To be reassessed and adjusted based on clinical status and Dialysis Pressure Plan (see "Urinary Function" below)
- Monitoring Heart Rate
    - Monitor pulse by continuous oximetry
    - Monitor for response to interventions, treatments and medications Interventions for heart rate to be determined by MD team.
- Blood pressure

Support with inotropes will be maintained with Norepinephrine in the dosage range (0-0.2ug/kg/min) to non-invasive blood pressure measurements SBP>85mmHg.

Skin Integrity

- Skin breakdown

over coccyx, heels

- Care provided with appropriate products to protect skin
- Monitor for skin breakdown as part of routine nursing care
- Pressure Ulcers — Coccyx, heels
    - Dressing changes will be performed as recommended by the skin and wound care clinicians and as needed by nursing staff.
    - Family will be asked to leave during dressing changes and pressure ulcer treatment.
- Consults by Skin and Wound Clinician as needed
- Monitor trach site and J-tube site and change trach and J-tube dressing as per hospital policy and as deemed necessary in clinical judgment of health professionals
- Continue use of therapeutic surface
- Re-position every 2-4 hours
    - To be performed only by health professionals and as deemed necessary in nursing clinical judgment

Nutritional Status
• J-Tube

- Nutrition will be provided as per consultation with dietitian.
- Feeds will be administered and monitored according to Hospital policy via J- tube.
  - Feeds to be administered by nursing staff, as per physician orders.
- Response to feeds will be monitored by residual volumes as well as bowel movements
- Incontinence Briefs to be used and changed by hospital staff

Urinary Function
• acute renal failure
• incontinence

Goal: To provide appropriate renal support. Mr. A.C. has been deemed to have end-stage kidney disease and is, consequently, dialysis-depending according to Nephrology consult service.

- Haemodialysis
  - Dialysis to be carried out by St. Joseph's Healthcare dialysis team every Monday, Wednesday and Friday. Time to be determined by St. Joseph's Healthcare dialysis team, in consultation with HHSC treatment team.

Contact Isolation

- Appropriate surveillance for infections will be provided by the health professionals.
- MRSA/VRE precautions
- Peripheral IV
  - Ongoing assessment based on clinical need
- Isolation and hand washing procedure
  - All staff AND family members to adhere to hand washing and isolation procedures
  - Family members to wear gloves when having any contact with the patient or with body fluids
- Anti-infective treatments will determined according to clinical judgment of the physician, in consultation with Infectious Disease consultants
  - New fever >38°C
  - Leukocytosis> 12
  - Laboratory identification of microbes

Mobility
• Deconditoned-unable to
Safely stand pivot transfer
To chair
• Ventilated

- Mr. A.C. NOT to be moved or transferred without proper equipment and a health care professional present. No exceptions.
  - This is necessary to prevent injuries to patient, family and staff.

- Any equipment will be provided by healthcare practitioners as deemed necessary. transfer to chair
- Mobility dependent on AC's condition or status.
- Mobility options (due to condition and ventilatory status):
  - Bed rest
  - Placing bed in cardiac chair position
  - Sitting up at edge of bed as tolerated
  - To be mobilized only if heart rate less than 130 bpm and not on norepinephrine.
  - Options to be reassessed and determined by health professionals based on clinical condition
- Exercise and Physiotherapy
  - Family to continue to participate with passive range of motion exercise, as directed by physiotherapist
  - Physical therapy to be provided as patient able to tolerate and as case load and staffing permit

Cognitive Function

- History of dementia
- At risk for delirium

- Rest encouraged at appropriate intervals, especially at night
  - Allow periods of rest during day after activities to optimize function
- Monitor for delirium - ICU Confusion Assessment Method
- Interaction and Stimulation
  - Encouraged during the day using visual and auditory aids

Medication Administration

- All medications to be administered by health professionals as appropriate and directed by ICU physicians' on-call as needed to address the issue at hand and fulfill the objective of the treatment plan.

Nursing Care/Activities of Daily Living

Routine daily care is to be carried out as nurses deem necessary in their clinical of Daily Living judgment and in accordance with the other aspects of the treatment plan set out above.
In particular, the nurses will do the following each day:

- Staffing — goal is to provide 2:1 nursing care
- Turning — will occur every 2 to 4 hours
- Bathing — the nurse will provide a sponge bath daily and as needed
- Monitoring fluid intake and output with a view to keeping the fluid intake at an appropriate level
- Dressing changes — to be performed by nursing staff only
- Medication dispensing — only by nursing staff

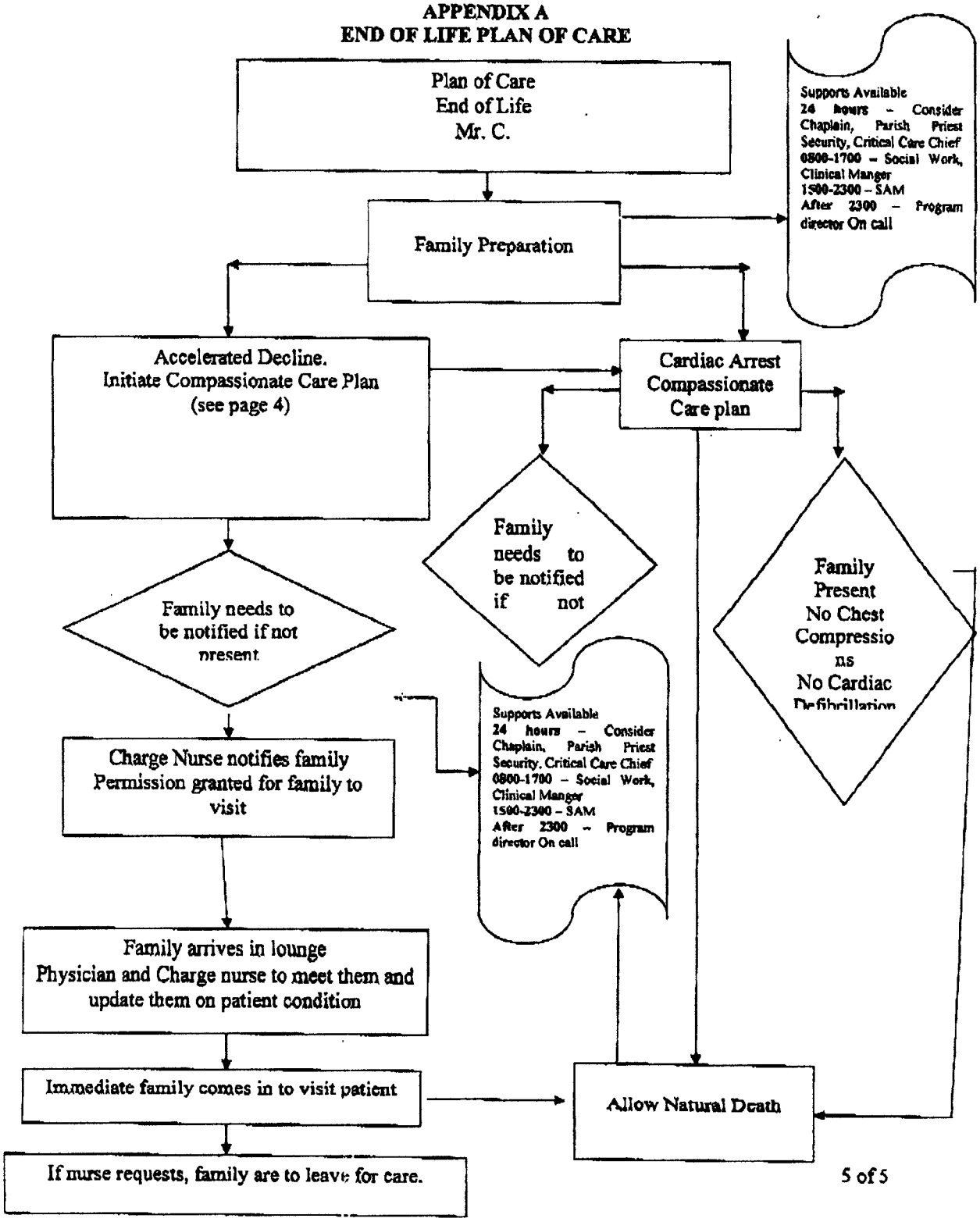
• Monitoring will be adjusted to allow patient to rest Vital Signs for Blood Pressure at night every 4 hours, Saturation monitoring and pulse rate by oximetry to be continuous. Electrocardiographic monitoring will be discontinued.
• Arterial blood gas sampling will no longer be offered to assess carbon dioxide levels and a non-invasive measurement will be utilized as an alternative
• Blood tests will continue to be drawn for the purpose of routine dialysis management

Decline in Clinical Status

• Mr. A.C.'s condition is expected to further decline, as he has throughout his hospital stay, despite all of the interventions outlined above.
• If Mr. A.C.'s condition deteriorates and it is the medical team's assessment that he is in critical condition, the team will notify Silvana and the family will be permitted to attend at the bedside outside of established visiting hours, to the extent that this does not interfere with patient care.
• If Mr. A.C. suffers accelerated decline defined as cardiorespiratory instability secondary to Shock, Sepsis secondary to organisms with multiresistant antibiotic profiles, GI Bleed requiring massive transfusion of blood products, increasing ventilator support with inspired oxygen levels greater than 60%, PEEP greater that 15,, or a cardiac arrest, the End of Life Plan of Care is to be implemented, as set out in Appendix A.
    • In the event of a cardiac arrest, the patient and family will be provided comfort and compassionate support.
    • Chest compressions and defibrillation will only prolong the dying process and not provide for a compassionate, caring environment at an inevitable time of death for this patient and, therefore, will not be offered.
    • Doses of Inotropic support will be maintained within AHA ranges as set out in the management of Shock guidelines from this society
    • Transfusion of blood products will be limited to maintenance of Hemoglobin greater than 75
• Initiation of massive transfusion for a massive bleed will not be offered and will be treated as a terminal event. Procedures such as endoscopy or surgery will not be offered as therapies
• Increasing ventilator requirements for oxygen and mechanical support will be kept to a reasonable non-toxic range no greater than Fi02 of 0.6 and PEEP of 15. Levels of support beyond this will not be offered.
• Central Venous Access is difficult and in the event of the inevitable loss of the subcutaneously tunneled dialysis catheter a reasonable attempt will be made to replace the line but cannot be guaranteed given the patients long term ICU status.

Treatment Plan – : , May, 2013

APPENDIX A
END OF LIFE PLAN OF CARE



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According to Dr. Sawchuk the May 2013 proposed Treatment Plan contained both current and palliative components, in the doctor's view as, an attempt to incorporate the family's concerns about AC's treatment. However the substitute decision makers did not consent to the May 2013 proposed Treatment Plan.

In terms of how the proposed Treatment Plan came to be developed, Dr. Sawchuk said that every patient required a Treatment Plan. However, the doctor noted that these plans were not static, that they evolve as the condition of a patient changes, that they could not be rigid. The doctor noted that the last two pages of the Proposed Treatment Plan for AC contained provisions entitled Decline in Clinical Status and Appendix A, End of Life Plan of Care. The doctor said the focus of care at that time in the event of rapid decline in AC's condition would be as set out in the proposed plan. The doctor also said the focus of the proposed plan was AC's best interest but without providing everything that the family wanted and believed was in AC's best interests.

The Board noted on examining the May 2013 proposed Treatment Plan that it contained a number of categories as follows: Respiratory Status, Cardiac Functions, Skin Integrity, Nutritional Status, Urinary Function, Contact Isolation, Mobility, Cognitive Function, Medication Administration, Nursing Care/Activities of Daily Living and Decline in Clinical Status, and an Appendix A, End of Life Plan of Care. As set out above each heading contained details including Goals and subheadings.

On May 20, 2013 Dr. Sawchuk placed a Progress Note on AC's chart, which progress note referenced the May 2013 proposed Treatment Plan being placed in the chart. The progress note read in part as follows:

> "The family (Jenny) demanded that AC be put on the ventilator.
>
> His clinical status is unchanged and he is comfortable....
>
> The breathing pattern is normal.
>
> The clinical decision is to leave him on the ventilator at night and to do what is reasonable provided he is comfortable to keep him on the ventilator during the day.
>
> This approach was accepted at other times by the SDM.
> The goals to treatment plan proposed take this into considerations and as such I am going to place a copy of the treatment plan on the chart for all of us to refer to and to assist with day to day management by the medical team.
>
> The family does not acknowledge or accept the plan but as his care requirements are complex I believe as his MRP that we must have something to follow.

Plan to continue with dialysis today...."

What bears repeating at this point was that the Purposes of the *Health Care Consent Act* ("HCCA") are set out at its very beginning. These included 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. The Board took this to include substitute decision makers who make decisions on behalf of incapable persons.

The HCCA provided that subject to an emergency situation arising in limited circumstances treatment cannot be given without the requisite consent having been obtained. That consent can only be obtained by the health practitioner from either a patient, if capable or if incapable, from the patient's substitute decision maker(s) (S10, HCCA)

The HCCA codified the common law principle of requiring that consent be informed (S11 HCCA). In that regard, consent must relate to the treatment, be informed and given voluntarily without being obtained through misrepresentation or fraud (S11 (1) HCCA). As well as the information about the treatment which must be given whenever treatment is proposed (S11 (2) HCCA), where consent of an SDM is sought on behalf of an incapable person, as here, the health practitioner is also required to provide certain information about the law. The Ontario Court of Appeal has interpreted the requirement to obtain consent "in accordance with this Act" as imposing a statutory obligation on health practitioners to ensure that SDM's understand the criteria specified in Section 21 of the HCCA when deciding whether consent for a proposed treatment should be given or refused (M (A) v. Benes 46 O.R. (3d), 271 (Ont C.A) at paras 18, 19, 20 and 21).

M.(A). v. Benes, was a 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.

> "[18] Assuming, however, that Sutherland J. had jurisdiction to consider the notice issue, counsel for the Attorney General submits, correctly in our view, that properly construed, s. 10(1)(b) of the Act imposes a statutory obligation on health

practitioners to ensure that S.D.M.'s understand the criteria specified in s. 21 of the Act when deciding whether consent to a proposed treatment should be given or refused. That provision reads:

> 10. (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,
>
> ...
>
> (b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act.
>
> [Emphasis added.]

[19] For reasons which need not be detailed, Sutherland J. refused to interpret s. 10(1)(b) in the manner suggested by the Attorney General. In short, he construed the words "in accordance with this Act" narrowly and restrictively and found that they did not impose a statutory obligation on health practitioners to ensure that S.D.M.'s understand the requirements of s. 21 of the Act.

[20] With respect, we are of the view that Sutherland J. erred in his approach to the interpretation of s. 10(1)(b). In particular, he incorrectly applied the principles of statutory interpretation to the words "in accordance with this Act."

[21] The first of those principles is found in Rizzo v. Rizzo Shoes Limited (R.E.), 1998 CanLII 837 (SCC), [1998] 1 S.C.R. 27, where, at paragraph 21, Iacobucci J. adopted the following passage from Driedger's Construction of Statutes (2 ed.1983):

> Today there is only one principle or approach, namely, the words of an Act are to be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament.
>
> At paragraph 22 of the same decision, Iacobucci J. went on to state that every Act shall receive "such fair, large and liberal construction and interpretation" as will best attain the objects of the Act.

In *Benes* 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 Board found the wording of Dr. Sawchuk's proposed May 2013 Treatment Plan contained many provisions that were vague, uncertain, overbroad, even speculative as to their implementation. The proposed plan contained some treatments for example; in the Decline in Clinical Status, Medication Administration and Nutritional Status sections that were vague and may (emphasis ours) only be provided after certain triggering events took place. The triggering events were unclear, vague and overbroad and did not permit the substitute decision makers to be informed and involved in decision making at the time the doctor was to determine compliance with the principles of substitute decision making. Some elements set out in the proposed Treatment Plan that were triggers or proposed means of treatment were undefined. For example, Dr. Sawchuk relied in hospital policies which he did not know the specifics of or present in evidence. Therefore, it was inconceivable that a SDM could apply currently the principles of substitute decision making with respect to those aspects of the Plan.

More specifically:

(1) under Skin Integrity "monitor track site and j-tube site and change track and j-tube dressing as per hospital policy and as deemed necessary in clinical judgment of health professionals".
(2) under Nutritional Status "feed will be administered and monitored according to hospital policy via j-tube".

There was no evidence Dr. Sawchuk knew these policies or shared them with SC, nor were the policies in evidence before the Board.

(3) Medication Administration "all medications to be administered by health professional as appropriate and directed by ICU physicians' on-call as needed to address the issue at hand and fulfil the objective of the treatment plan".

Again, this was vague and uncertain and no evidence was presented to inform the Board on what this meant.

(4) Under Decline in Clinical Status the proposed plan read in part:

> "• Mr. A.C.'s condition is expected to further decline, as he has throughout his hospital stay, despite all of the interventions outlined above.
> • If Mr. A.C.'s condition deteriorates and it is the medical team's assessment that he is in critical condition, the team will notify Silvana and the family will be permitted to attend at the bedside outside of established visiting hours, to the extent that this does not interfere with patient care.
> • If Mr. A.C. suffers accelerated decline defined as cardiorespiratory instability secondary to Shock, Sepsis secondary to organisms with multiresistant antibiotic profiles, GI Bleed requiring massive transfusion of blood products, increasing ventilator support with inspired oxygen levels greater than 60%, PEEP greater that 15 or a cardiac arrest, the End of Life Plan of Care is to be implemented, as set out in Appendix A."

Various provisions of the Decline in Clinical Status in the proposed plan started with the word "if". Clearly there were triggering mechanisms and these provisions were dependent on those triggering mechanisms occurring. As Chief, Dr. Sawchuk was unable to advise the Board on what the hospital's End of Life Policy was. How could the SDM make an informed decision without at least being informed in advance on these policies? How could SC as substitute decision maker consider the issue of consenting or refusing treatment on behalf of her father unless she was fully informed with respect to the proposed Treatment Plan? The End of Life provisions of the Proposed Treatment Plan were vague and uncertain as were other parts of the plan previously referred to as to their meaning, timing and implementation. There was more detail in the specific April 11, 2013 Palliative Plan Treatment, no longer proposed.

We reviewed the Board decision in SS (LO-12-3553) referred to in submissions, where the physician's proposed treatment plan was as follows:

> "to a discontinuation of dialysis, to a do not resuscitate order, to provide comfort measures only and to diconsitnue active care".

Similarly in the Board Decision DD (TO-12-4633/4634) the proposed treatment plan was as follows:

> "DD would be removed from mechanical ventilation, be provided oxygen non-invasively as required, not escalating organ support should he deteriorate (not starving dialysis and performing cardiopulmonary resuscitation if he should suffer a cardiac or respiratory arrest) and instead focus upon a palliative care plan."

Again this proposed plan of treatment was neither vague nor uncertain and was proposed for implementation immediately, not at some future undetermined date.

Dr. Sawchuk said that a palliative care approach set out in the End of Life provisions of the May 2013 proposed Treatment Plan would be in AC's best interests, if AC deteriorated, but that AC had not reached that stage. The doctor's oral testimony and documentary evidence included that AC's condition could worsen. We found that what Dr. Sawchuk was saying was that a palliative care approach to AC's treatment would be in AC's best interests if he deteriorated and was in critical condition. However, according to the clear, cogent and compelling medical evidence he was not yet in that critical condition.

Dr. Sawchuk's proposed May 2013 Plan of Treatment contained future proposed treatment, but it was unclear whether aspects of the proposed plan were based on AC's current or future health condition. More importantly, the wording of Section 21(2) of the HCCA spoke of what a person's best interest "are", in other words was written in the present tense, and it did not include what best interests will be or would be in the future. Dr. Sawchuk could not satisfy the Board on a balance of probabilities that the SDMs had not complied with the principles for substitute decision making as the SDMs could not apply the principles for substitute decision making because of the unclear, vague and overbroad wording and nature of the proposed May 2013 Treatment Plan.

RESULT

We found AC not capable with respect to all medical treatment. We also dismissed the Form G application.

Dated: June 25, 2013

Michael Newman, Vice-Chair
Presiding Member