



File Number TO-11-3705
TO-11-3706

IN THE MATTER OF
The ***HEALTH CARE CONSENT ACT***
S.O. 1996 c.2,
As amended

AND IN THE MATTER OF
AK
A PATIENT OF
YORK CENTRAL HOSPITAL
RICHMOND HILL, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

At the time of the Hearing, AK was an 81 year old man, who was separated from his wife and had one adult child. York Central Hospital (YCH) admitted AK “on September 2nd, 2011 with *Staph aureus* bacteremia following chemotherapy for metastatic squamous cell skin cancer” (Exhibit 5-Appendix B). He rapidly deteriorated and was placed in ICU on September 12th, where he was “dependent on Life support and mechanical ventilation...due to persistent multiorgan failure” (Exhibit 5-page 1). He remained in the ICU to the hearing date.

Dr. Dwosh found AK incapable of consenting to the following treatment plan:

1. AK be administered narcotic analgesia in a continuous fashion via IV pump or through subcutaneous infusion.

2. AK also receive other comfort medications that are appropriate for the withdrawal of life support interventions.
3. That AK be rapidly weaned off the ventilator and off the infusion of blood pressure medications to allow for a natural death without artificial life support interventions.
4. That no cardiopulmonary resuscitative interventions are undertaken in the event of the cessation of breathing or and arrest cardiac function.

PK was the son and substitute decision-maker of AK. PK would not consent to this plan of treatment and therefore, Dr. Dwosh applied to the Board to determine if that refusal was in accordance with the principles for giving or refusing consent to treatment as set out in The *Health Care Consent Act (HCCA)*.

DATES OF THE HEARING, DECISIONS AND REASONS

The hearing took place on November 30, 2011. The panel released its decisions on December 1, 2011. Ms Nnoli, on behalf of PK, requested written Reasons for Decision on December 2, 2011 which Reasons were released on December 6, 2011.

LEGISLATION CONSIDERED

The *Health Care Consent Act, 1996*, S.O. 1996 c.2, as amended including ss. 4(1), 20, 21, 37, and 37.1.

The *Consent and Capacity Board Rules of Practice*, including Rule 1.1, Rule 13.1 and Rule 13.2.

PANEL MEMBERS

Mr. B. Comiskey, Senior Lawyer-Presiding Member

Dr. P. Max, Psychiatrist Member

Mr. E. Campbell, Public Member

PARTIES

AK, the patient

Dr. H. Dwosh, the health practitioner who proposed the treatment
PK, the substitute decision maker

APPEARANCES

For AK, Ms G. Da Fonte, lawyer
For Dr. Dwosh, Ms K. Grace, lawyer
For PK, Ms C. Nnoli, lawyer

PRELIMINARY MATTERS

There was no written Power of Attorney for personal care. Since AK was separated from his wife, she could not be the substitute decision-maker (SDM) according to the *Health Care Consent Act (HCCA)*. PK was the only child of AK and therefore, pursuant to the *HCCA*, he was the SDM.

PK advised the panel that he wanted to bring a motion to the Board that the application of Dr. Dwosh be dismissed because of prior wishes of AK. PK argued that *Rule 13.1* of the *Consent and Capacity Board Rules of Practice* provided that a motion could be brought and in keeping with *Rule 1.1*, it was cost efficient and would avoid an unnecessary proceeding.

We advised PK that the hearing was a two-step process in that a determination had to be made by the panel as to the capacity of AK. If we found AK capable of consenting to his treatment, then the hearing would end and we would not have to decide such a motion. We proceeded to hear the evidence on the deemed capacity issue before considering his request to hear his motion.

THE EVIDENCE

The evidence at the hearing consisted of the oral testimony of Dr. Dwosh, PK, DK and ME, along with five exhibits:

1. Document brief of Dr. H. Dwosh (155 pages);
2. Further documents of Dr. Dwosh (54 pages);
3. Further documents of Dr. Dwosh (9 pages);
4. Document brief of PK (105 pages including letter of November 27, 2011);

5. Clinical Summary of Dr. H. Dwosh – November 22, 2011 (4 pages) with two appendices and letter from PK (Nov. 18/11) – (Total pages including summary-10).

INTRODUCTION

Dr. Dwosh proposed treatment for AK set out above under the heading “purpose of the hearing”. PK, SDM of AK, did not consent to the proposed treatment. The treatments proposed by Dr. Dwosh were all within the concept of palliative care and PK along with his family members were clearly in opposition to this concept and plan. Consequently, Dr. Dwosh brought a Form G application to the Board to determine if that refusal was in accordance with the principles for giving or refusing consent to treatment as set out in (*HCCA*). That application prompted a hearing under the Act to determine if the patient was capable of consenting to his own treatment.

This deemed capacity hearing was a condition precedent to the hearing under the Form G application.

THE LAW

The particular rules of the *Consent and Capacity Rules of Practice* relevant to PK’s motion are:

Rule 1.1 The purpose of these Rules is to provide a just, fair, accessible and understandable process for parties to proceedings before the Board. The Rules attempt to facilitate access to the Board; to promote respectful hearings; to promote consistency of process; to make proceedings less adversarial, where appropriate; to make proceedings as cost effective as possible for all those involved in Board proceedings and for the Board by ensuring the efficiency and timeliness of proceedings; to avoid unnecessary length and delay of proceedings; and to assist the Board in fulfilling its statutory mandate of delivering a just and fair determination of the matters which come before it.

Rule 13.1 “Motion” means a request for the Board's ruling, or decision on a particular issue at any stage within the proceeding or intended proceeding.

Rule 13.2 A motion may be made by a party to the proceeding, or by a person with an interest in the proceeding.

Capacity to Consent to Treatment

The issue before us was whether, at the time of the Hearing, AK was capable with respect to treatment. A person is presumed to be capable, and the onus is upon the health care practitioner to establish otherwise.

The test for capacity to consent to treatment is in S. 4(1) of the *Health Care Consent Act*:

“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.”

In *Starson v. Swayze*, [2003] SCC 32, released June 6, 2003, the Supreme Court of Canada held that the standard of proof for a finding of incapacity is a balance of probabilities.

Compliance with the Principles for Substitute Decision Making

The relevant sections of the *Health Care Consent Act* are as follows:

20. (1) If a person is incapable with respect to a treatment, consent may be given or refused on his or her behalf by a person described in one of the following paragraphs:
1. The incapable person's guardian of the person, if the guardian has authority to give or refuse consent to the treatment.
 2. The incapable person's attorney for personal care, if the power of attorney confers authority to give or refuse consent of the treatment.
 3. The incapable person's representative appointed by the Board under section 33, if the representative has authority to give or refuse consent of the treatment.
 4. The incapable person's spouse or partner.
 5. A child or parent of the incapable person, or the children's aid society or other person who was lawfully entitled to give or refuse consent of the treatment in the place of the parent. This paragraph does not include a parent who has only a right of access. If a children's aid society or other person is lawfully entitled to give or refuse consent to treatment in the place of a parent, this paragraph does not include the parent.
 6. A parent of the incapable person who has only a right of access.
 7. A brother or sister of the incapable person.
 8. Any other relative of the incapable person.
- (2) A person described in subsection (1) may give or refuse consent only if he or she,
- (a) is capable with respect to the treatment;
 - (b) is at least 16 years old, unless he or she is the incapable person's parent;
 - (c) is not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf;

(d) is available; and

(e) is willing to assume the responsibility of giving or refusing consent.

(3) A person described in a paragraph of subsection (1) may give or refuse consent only if no person described in an earlier paragraph meets the requirement of subsection (2).

(4) Despite subsection (3), a person described in a paragraph of subsection (1) who is present or has otherwise been contacted may give or refuse consent if he or she believes that no other person described in an earlier paragraph or the same paragraph exists, or that all those such a person exists, the person is not a person described in paragraph 1, 2 or 3 and would not object to him or her making a decision.

(5) If no person described in subsection (1) meets the requirements of subsection (2), the Public Guardian and Trustee shall make the decision to give or refuse consent.

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

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after obtaining 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 obtaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.

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

- (a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;
- (b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and
- (c) the following factors:
 1. Whether the treatment is likely to,
 - i. improve the incapable person's condition or well-being,
 - ii. prevent the incapable person's condition or well-being from deteriorating, or
 - iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
 2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
 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 determination as to whether the substitute decision-maker complied with section 21.

(2) The parties to the application are:

1. The health practitioner who proposed the treatment.
 2. The incapable person.
 3. The substitute decision-maker.
 4. Any other person whom the Board specifies.
- (3) In determining whether the substitute decision-maker complied with section 21, the Board may substitute its opinion for that of the substitute decision-maker.
- (4) If the Board determines that the substitute decision-maker did not comply with section 21, it may give him or her directions and, in doing so, shall apply section 21.
- (5) The Board shall specify the time within which its directions must be complied with.
- (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).
- (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.
- (6.2) If a subsequent substitute decision-maker knows the 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.
- (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.
- (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.

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.

ANALYSIS

Capacity to Consent to Treatment

In his clinical summary, Dr. Dwosh said on page 3 that he found AK incapable of consenting to treatment on November 7, 2011. The treatments to which he found AK incapable of consenting to are set out above under the title "Purpose of the Hearing". Dr. Dwosh said that AK was still incapable at the time of the hearing.

AK was not present at the hearing. Ms Da Fonte, on behalf of AK, said that she would not be

calling any evidence with respect to the issues before the Board.

At the time of the hearing, did AK have the ability to understand the information relevant to making a decision about the treatment proposed for him by Dr. Dwosh?

In his clinical summary at page 1 (Exhibit 5), Dr. Dwosh said that at the date of the hearing, AK was dependent on life support and mechanical ventilation in the ICU since September 12th, 2011 due to persistent multiorgan failure and that it was the unanimous opinion of all his treating physicians that AK was dying despite ongoing life support interventions in the ICU.

At page 4 of his summary, Dr. Dwosh said: “the patient is unable to talk or mouth words while on the ventilator due to his illness. All attempts at establishing a means of non-verbal conscious communication from the patient have been unsuccessful, including eye blinking, head nodding, hand squeezing, etc. The patient is unresponsive to simple verbal commands provided in Russian by a Russian-speaking nurse. When the patient is asked to open his eyes, move his limbs, or neck to command (with Russian-speaking nurse), he remains unresponsive.”

In his oral evidence, Dr. Dwosh said that AK did not have the cognitive functions to be aware of his surroundings or the treatment being proposed. Dr. Dwosh said that AK was unable to understand the risks and benefits of the proposed treatment because he was comatose. Dr. Dwosh said that AK had been comatose since he knew him. He said AK had never been aware of his surroundings nor was he purposeful in his responses.

On the basis of Dr. Dwosh’s clear, cogent and compelling evidence, we held that AK did not have the ability to understand the information relevant to the treatment proposed for him.

At the time of the hearing, did AK have the ability to appreciate the reasonably foreseeable consequences of making or not making a decision with respect to the treatment proposed for him?

For the same reasons, Dr. Dwosh said that AK did not have the ability to appreciate the reasonably foreseeable consequences of making or not making a decision about his treatment. He said that AK’s condition changed from the time he came under his care to the date of hearing, but not in a manner that would affect capacity. He said that AK deteriorated because at the time

of the hearing he was having ongoing seizures which required sedative medications that further impacted his ability to make treatment decisions.

We accepted Dr. Dwosh's clear evidence and held that AK did not have the ability to appreciate the reasonably foreseeable consequences of consenting to or refusing the treatment proposed for him. We held that AK was incapable of consenting to his own treatment pursuant to the provisions of section 4(1) of the *HCCA*.

PK's Motion

Once we held that AK was incapable, we listened to the argument of PK's lawyer with respect to his motion.

Ms Nnoli, lawyer for PK, argued that we ought to grant the motion to dismiss the Form G application of Dr. Dwosh because there was a prior wish expressed by AK, of which Dr. Dwosh was unaware.

Ms Grace, lawyer for Dr. Dwosh, argued that the prior wish of AK was an issue that would be at the heart of the application.

Ms Da Fonte, lawyer for AK, argued that the consideration of prior wishes was a part of the application criteria that the Board had to consider. She expressed concern that it was the first time that the issue was raised and that such a wish should have been raised long before the start of the hearing.

We deliberated on this matter. We held that we would hear all of the evidence from all parties on the issue of wishes along with the rest of the evidence respecting all the criteria concerning the application so that we could make a proper decision.

We proceeded to hear the evidence as to whether the refusal by PK to consent to the treatment proposed for AK was in accordance with the principles for giving or refusing consent pursuant to the *HCCA*.

AK's Clinical History

Dr. Dwosh said he was one of five full-time intensivists who worked as a team and who had all been involved in AK's care. He said that he had a specialty training in internal medicine and in intensive care medicine as did three of the other intensivists. He said that one of the physicians had specialty training in respiratory and critical care.

Appendix B, attached to the clinical summary of Dr. Dwosh, described the clinical history of AK. Dr. Dwosh said that AK was an 81-year-old man who was admitted to YCH on September 2, 2011 "with *Staph aureus* bacteremia following chemotherapy for metastatic squamous cell skin cancer." He said that AK had squamous cell cancer of his right ear with surgery in early 2009. The cancer recurred in his right face and skull in 2010, and he had a major surgical excision "involving his entire right ear, surrounding tissues and neck lymph nodes..." He had radiation therapy but he "was found to have recurrent metastatic cancer to his brain, lungs and bones in the summer of 2011 and was referred to Dr. Tweedale (York Central hospital, medical oncologist) for consideration of systemic chemotherapy for his metastatic disease." In her initial consultation of August 24, 2011, she indicated that his form of cancer was not curable. Dr. Dwosh said she raised concerns regarding AK's "ability to tolerate systemic chemotherapy because of his age, past history of heart disease, hypertension, and swallowing difficulties which made maintaining his nutritional status difficult and had ongoing problems of weight loss."

Dr. Dwosh reported that "on September 8th and 12th", the Critical Care Response Team (CCRT), was summoned to assess AK on the medical ward because-first, because of the patient falling from the chair while trying to get to the bathroom at which time a CT of the head did not show any sign of trauma, but did show lesions in the right temporal lobe and left occipital lobe, consistent with the previously known brain metastases. He was seen by CCRT on September 12th for decreased level of consciousness, respiratory distress, and poor oxygen levels with possible gastric aspiration following vomiting and a possible seizure episode. Following the assessment of the CCRT, AK was transferred to the ICU for emergent intubation arrest an ongoing hemodynamic support with adrenaline-type medications. During the following 10 weeks since his admission to the intensive care unit, AK has multiple complications relating to his underlying cancer and recurrent infections. He has remained dependent on the ventilator due to recurrent pneumonias and extensive lung metastases. As a result of the repeated courses of antibiotics which have been ordered to try and treat his recurrent infections, AK is now colonized with

multidrug resistant bacteria (aka. “SuperBugs”), which we have been unable to clear from his lungs and blood.” He went on to say that AK underwent a “tracheostomy and a percutaneous gastrostomy feeding tube insertion on October 6, 2011”. He said that attempts to wean AK from the ventilator were unsuccessful, and that “the amount of support that he requires from the ventilator, has increased over the course of his ICU stay. It is the unanimous opinion of the ICU physicians that have been caring for AK, that his underlying lung function will never improve sufficiently for AK to be able to successfully wean from the ventilator.”

Dr. Dwosh said that AK had repeated bleeding episodes from his stomach and repeated vomiting, with an inability to tolerate feeding into his stomach and bowels. He said that he was not a candidate for intravenous nutrition, due to his un-resolving infections and is widespread metastatic cancer. He said that in ICU, AK had a decreased level of consciousness that resulted in significant cognitive impairment. He said he has “episodes of rapid heart rate, rapid breathing, grimacing, and sweating that indicate discomfort and distress throughout the day. These events are usually associated with issues of personal care such as turning, suctioning the tracheostomy tube, and moving the patient.”

In his oral evidence, Dr. Dwosh referred to the CT scan results of November 6th found at part three of Exhibit 1. He said that it demonstrated extensive metastatic cancer in AK. It affected his liver, spleen, and involved all of his pelvic bones. There was destruction of his tailbone, a fracture of his femur and rib damage. It was visible on his forehead and his right hand. He said there was fluid around his lungs because of cancer cells in the space around the lungs. The tumour had invaded AK’s stomach, causing a blockage of the bowel and bleeding in the stomach.

At page 1(Exhibit 5), Dr. Dwosh described AK's health information as at the date of the hearing as follows: “He has disseminated cancer metastases, recurrent septic shock due to multi-drug-resistant bacteria, and has been dependent on life support and mechanical ventilation in the ICU since September 12th, 2011 due to persistent multiorgan failure. It is the unanimous opinion of all his treating physicians that AK is dying despite ongoing life support interventions in the ICU.”

Were there Prior Wishes applicable in the circumstances that AK, the Incapable Person, expressed while capable?

In his clinical summary at page 2, Dr. Dwosh said as follows: “There are no known previously expressed capable wishes that apply to the patient's current circumstance and the treatment plan proposed.” Further, he said: “we have repeatedly inquired as to the patient's values and beliefs, however, the SDM will only provide his own personal views and has refused to provide any information pertaining to the patient's own wishes despite repeated requests.” At page 3 of Appendix B, attached to Dr. Dwosh’s clinical summary, Dr. Dwosh said they had repeatedly inquired about any previously expressed wishes applicable to the circumstances that AK may have expressed when capable. He said that the ICU social worker had conversations with PK, who indicated that he and his father never had a discussion about end-of-life treatment issues. Dr. Dwosh said that he asked PK both verbally and in writing what AK’s “values and beliefs pertaining to end-of-life care may be.” He said PK “has provided only his own personal views and beliefs and refused to provide any information as to what the patient himself might have thought or had said.”

In his oral evidence, Dr. Dwosh said that in the three months that AK was in ICU, PK did not once express that his father had a prior wish with respect to treatment.

On the day of the hearing, PK presented to the Board and to counsel for his father and Dr. Dwosh a letter dated November 27, 2011 headed Jewish Russian Community Centre of Ontario and signed by Rabbi Zaltzman. This letter was delivered with Exhibit 4, being the document brief of PK. In part, Rabbi Zaltzman said that “It is not permitted to take any actions to stop the process of staying alive.” In the next paragraph, he said: “Active intervention may only be used to prolong life, but not to shorten it. This means that if a patient is already on life support machines, a person may not proactively turn off or detach those machines.” He went on to say: “These principles concern every Jewish person and every human life, and AK has always shared these principles.”

In his evidence, PK said that his father's prior wish was consistent that he wanted his life to be continued in any circumstances and by any means and to not be artificially stopped. He referred to his father's admission to hospital on September 2, 2011. He said his father was put on “full

code” by Dr. Lee. PK said that his father being placed on full code supported his father's prior wish.

Dr. Dwosh, in his evidence said that “full code” meant that all resuscitative measures, including all matters to get the heart started again, were to be taken. In appendix B (Exhibit 5), Dr. Dwosh referred to AK’s admission to hospital by Dr. KC Lee for the administration of IV antibiotics. As to the discussion about full code status, Dr. Dwosh said: “At the time of admission, Dr. KC Lee discussed code status with AK’s son, PK, who indicated that he wanted his father to be ‘full code’. AK himself did not participate in the discussion of Code Status, as he is predominantly non-English speaking, nor did his son confer with him in Russian about the issue of Code Status at the time, according to Dr. KC Lee.”

PK, his son DK and his wife ME were all present in the hearing room for each other's evidence. PK said that his father's life must be maintained in any circumstance. He said that his father absolutely wanted to fight for life, no matter what. He said in Jewish law, life must be supported always. He said he spoke to Rabbi Zaltzman who called him two weeks prior to the hearing. He said that he told Rabbi Zaltzman that he had to consider ending the life of his father and the Rabbi told him that he should take into account Jewish law. He went on to say that it was his understanding that Rabbi Zaltzman personally knew his father. DK gave evidence and said that his grandfather told him the night before his major surgery on December 12, 2010 that “if anything happens, this is my life. Nobody can take it away from me. I would like to fight with any means possible.” PK went on to say that his grandfather always said to “make sure you tell them what my values and beliefs are.” ME gave evidence and said that she had known AK for 20 years. She said that after his first chemotherapy treatment, he told her that “if something happens, you have to tell them to do everything.”

Ms Da Fonte, lawyer for AK, in her submissions said that she looked with suspicion on the evidence of PK and his family members. She said that PK raised the issue at the hearing for the first time and had not said anything about prior wishes even when the hearing of this matter was adjourned by a panel of the CCB only a few days earlier. She said she viewed the evidence of the family members with suspicion and a great deal of caution and concern.

It was too convenient to have the letter of Rabbi Zaltzman produced on the morning of the hearing. Given the strong words by PK, DK and ME about AK's prior wishes, it was impossible to believe that over the three months that AK was in ICU not one word about any prior wish was said by any one of these people to the treating physicians or staff members who were treating AK. Dr. Dwosh gave evidence that PK disagreed with virtually every single procedure or step that the treating physicians wanted to take in caring for AK. We did not accept as credible the evidence of PK and his witnesses. We accepted the clear, cogent and compelling evidence of Dr. Dwosh and held as a fact that AK did not have a prior capable wish applicable in the circumstances.

We had to consider the SDM's belief as to what the patient would have wanted if he had been aware of the circumstances in which he found himself at the time of the hearing. What were AK's values and beliefs? PK said that both he and his father attended the Jewish community but we heard nothing with regard to AK's religious beliefs and practices. In our view there was insufficient evidence to uphold that he had those Jewish beliefs described in the letter of Rabbi Zaltzman. What the family believed was only one of the factors that the Panel had to consider. We looked at all the factors including what had been going on for the preceding three months for AK. There were multiple new complications since he came to the hospital on September 2, 2011. The evidence that came from PK and the other family members convinced us that their sole consideration was what they believed he would have wanted without giving consideration to section 21(2)(c) and the patient's true state. PK, his wife and son did not accept the medical opinion of the intensivists. If they couldn't accept or believe the expert physicians, then how could they possibly consider what AK would have wanted if he was aware of those expert medical opinions? In our view, under those circumstances, PK and the family members could not have known what AK would have wanted. On a balance of probabilities we held that there was insufficient evidence for us to ascribe values and beliefs to AK.

Section 21 Criteria for Best Interests

We had to determine whether PK was acting in the best interests of his father, as his substitute decision-maker.

We referred specifically to the House of Lords decision in *Airedale NHS Trust v. Bland*, [1993] 1 All ER 821, the leading decision on the issue of withdrawal of treatment for patients in a persistent or permanent vegetative state with no hope of recovery. *Airedale* involved a 17-year-old person in such a condition. Respecting best interests, there are several important considerations enunciated in that decision which one must consider.

At page 872, Lord Goff stated as follows:

“The truth is that, in the course of their work, doctors frequently have to make decisions which may affect the continued survival of their patients, and are in reality far more experienced in matters of this kind than are the judges. It is nevertheless the function of the judges to state the legal principles upon which the lawfulness of the actions of doctors depend; but in the end the decisions to be made in individual cases must rest with the doctors themselves.”

Certainly in this matter, the expert physicians clearly supported the view that palliative care and withdrawal of life support was the correct course of treatment for AK.

The House of Lords said that the extent of pain that the incapable person was likely to be suffering was one consideration but there were other considerations that were relevant to the patient's best interests.

At page 846, Lord Sloss said as follows:

“The quality of life has already been recognized as a factor and placed in the equation to allow a life not to be prolonged and any costs (...) To limit the quality of life to extreme pain is to take a demeaning view of a human being. There must be something more for the humanity of the person of a PVS patient. He remains a person and not an object of concern.”

At page 848, he added the following:

“[The incompetent patient] has the right to be respected. Consequently he has a right to avoid unnecessary humiliation and the degrading invasion of his body for no good purpose. (...)

The considerations as to the quality of life of Mr. Bland now and in the future in this extreme situation are in my opinion rightly to be placed on the other side of the critical equation from the general principle of the sanctity and inviolability of life. In this appeal those factors which include the reality of Mr. Bland's existence outweigh the abstract requirement to preserve life (...). The duty of the doctors towards a PVS patient at the extreme end of the spectrum does not extend to prolonging his life at all costs.”

At page 853 Lord Justice Hoffman said that Mr. Bland “is alive but has no life at all.” In concluding that life support should be withdrawn he said: “we would be showing more respect to him as an individual than by keeping him alive.”

At page 870 Lord Goff said:

“I cannot see that medical treatment is appropriate or requisite simply to prolong a patient's life when such treatment has no therapeutic purpose of any kind, as where it is futile because the patient is unconscious and there is no prospect of any improvement in his condition. It is reasonable also that account should be taken of the invasiveness of the treatment and of the indignity to which as the present case shows, a person has to be subjected if his life is prolonged by artificial means, which must cause considerable distress to his family - a stress which reflects not only their own feelings but their perception of the situation of their relative who was being kept alive. But in the end, in a case such as the present, it is the futility of the treatment which justifies its termination.”

In the matter before the panel, AK was in just that situation. Dr. Dwosh gave evidence that AK had no chance of being off life-support. He said that it was his view that “the ventilator was not prolonging life, but prolonged the dying process.”

He suffered from pain. In appendix B of the clinical summary, Dr. Dwosh said: “Frequently, AK has episodes of rapid heart rate, rapid breathing, grimacing and sweating that indicate discomfort and distress throughout the day. These events are usually associated with issues of personal care such as turning, suctioning the tracheostomy tube, and moving the patient. Despite these repeated observations, documentations and explanations to the patient's SDM, his SDM has refused to consent to the routine administration of narcotic analgesics and other comfort medications to the patient to alleviate such symptoms. As such, the ICU care team has had to resort to applying section 27 of the HCCA ‘emergency treatment despite refusal’ by the SDM, to administer comfort medications when severe suffering is observed. Repeated attempts to address the issues of ongoing patient suffering, inappropriate level of intervention for the patient dying of metastatic cancer, and implementing a treatment plan that addresses AK’s end-of-life care needs have been met with hostile and often threatening opposition from the patient's SDM. All attempts and conflict resolution, including 2nd opinions, outside consultations, mediation with the hospital's Patient Relations Dept., referral to the hospital's Ethicist, offers to transfer the patient to a different healthcare facility have all been repeatedly rebuffed by the SDM for AK.” Dr. Dwosh, in his oral evidence, confirmed the various attempts that he made with PK in an attempt

to obtain a satisfactory plan of treatment and care for his patient, AK. At the hearing, both PK and his son DK gave evidence that they would be prepared to allow narcotic medication to be administered to AK only if it was proven by the doctors that AK required it. In a question from the panel, after posing it in many ways to get an answer from PK, PK finally admitted that if he had a fractured leg that was not in the cast and if he attempted to move that it would cause pain. Asked if he would get medication to relieve the pain, he said yes. In our view, PK's position with respect to administering narcotic analgesia to his father was not at all realistic.

Dr. Dwosh said PK was fixated with the issue of pain medication, as well as two other areas of care for AK. PK requested a plastic surgeon be consulted with respect to the tumours on the patient's right hand and fingers. Dr. O Grady, a plastic surgeon provided a consultation report dated October 20, 2011 (Exhibit 1, section a, page 19). In it he gave his opinion that AK was not a surgical candidate. At page 23 of the same exhibit, Dr. O Grady provided a further consultation report dated October 20, 2011. In it he advised that PK had insisted on seeing him in the evening and had him paged in the hospital, which Dr. O Grady found "most unusual". He said: "I explained to his son several times that given his father's entire clinical picture, that any surgery to remove a small cutaneous metastases on his fingertips when he has other cutaneous metastases, as well as lung and liver metastases is absolutely of no benefit to him. In addition, such a wound on his fingers would be extremely painful, as the lesions were 1 cm in diameter and I was very unlikely to get these primarily closed. The fingertips have a huge concentration of nerve endings and this would be uncomfortable to his father." He went on to say: "Secondly, given his cancer status, his immune system is compromised and his ability to heal is significantly decreased...He further went on to state that I was not doing anything because his father was not worth the time or expense. I very emphatically stated that this was not the case. I have not offered him surgery because there is no surgical benefit to his father... He insisted several times that I do this and, quite frankly, I found him argumentative. He simply would not listen to any reason."

Another area of concern for Dr. Dwosh were the demands made by PK respecting nutrition. Dr. Dwosh said that PK wanted the medical team to introduce intravenous nutrition. Dr. Dwosh said he told him that he would not do so because it was of no benefit to AK. He had a tumour blocking his bowels, which caused AK to vomit. Even though this difficulty was explained to PK, he concluded that his father was not tolerating food because he was constipated and wanted

laxatives introduced. This step was contra-indicated. His physical condition was going to continue to deteriorate. There was no prospect that there would be any improvement in his condition. He would never recover. The artificial means by which he was being kept alive had no therapeutic purpose of any kind. As Lord Goff said; "... it is the futility of the treatment which justifies its termination."

At page 839-840 Sir Thomas Bingham said:

"While the respect accorded to human life always raises a presumption in favour of prolonging it, that presumption is not irrebuttable. Mere prolongation of the life of a PVS patient such as Mr. Bland, with no hope of any recovery, is not necessarily in his best interests, if indeed such prolongation is in his interests at all. In making an objective judgment of Mr. Bland's best interests, account can be taken not only of pain and suffering which prolonged feeding and medication might cause but also wider, less tangible considerations.

(...)

I cannot conceive what benefit his continued existence could be thought to give him. It might be different where it possible to hope that, if he lived long enough, means might be found to restore some part of his faculties, but no grounds have been suggested for cherishing such a hope and the physiological findings appear to preclude it. It is of course true that pain and suffering, which may (if the foregoing reasoning is sound) weigh in the balance against the presumption in favour of life, are here to be ignored because of Mr. Bland's insensible condition. An objective assessment of Mr. Bland's best interests, viewed through his eyes, would in my opinion give weight to the constant invasions and humiliations to which his inert body is subject (...)."

Hope is exactly what PK and the family had. Having heard the evidence of Dr. Dwosh, it was clear to us that the family's hope was not at all realistic. AK would not recover. Dr. Dwosh, in his oral evidence, said that the purpose of treatment for AK was to optimize his quality of life, his well-being in the broadest sense, his own dignity and welfare. He said that to do unnecessary and not useful interventions was an indignity to AK's life.

Lord Sloss at page 847 referred to a passage from the American case of *Re Conroy (1985) 98 NJ 321 at 398-399*, wherein that court stated:

"The medical and nursing treatment of individuals in extremis and suffering from these conditions entails the constant and extensive handling and manipulation of the body. At some point, such a course of treatment upon the insensate patient is bound to touch the sensibilities of even the most detached observer. Eventually, pervasive bodily intrusions, even for the best motives, will rouse feelings akin to humiliation and mortification for the helpless patient. When cherished values of human dignity and personal privacy, which belong to every person living or dying, are sufficiently transgressed by what is being done to the individual, we should be ready to say: enough."

The foregoing quote from *Re Conroy* was cited with approval by a panel of this Board, in the decision of *EJG (2007) CanLII 44704 (ON C.C.B.)* at page 22.

We could not be blind to the constant invasions and humiliations suffered by AK. In this matter, PK was adamant that he wanted AK to live by any artificial means and obviously in the hope that there would be recovery. He could not acknowledge the predictive likelihood that AK would not recover, as expressed by Dr. Dwosh and supported by the other treating physicians. PK put his own views ahead of the expert opinions of AK's treating physicians. In our opinion, PK was totally wrong.

During the course of the hearing, we heard evidence from Dr. Dwosh, PK, DK and ME. We had an opportunity to observe the way in which the witnesses gave their evidence. Dr. Dwosh gave his evidence in a clear, cogent and compelling manner. PK almost never gave a direct answer to any question, either by his own lawyer, any of the other lawyers or the panel members. In spite of many requests, he refused to answer questions with either yes or no and insisted on giving an explanation despite the fact his answer had nothing to do with the question.

We agreed with the evidence of Dr. Dwosh. In appendix B at page 4 (Exhibit 5), Dr. Dwosh summed up the matter appropriately. He said: "In the absence of a previously expressed wish made by the patient either when capable or incapable, we have developed the current treatment plan based on what is the patient's best interests. Since AK has exhausted all oncologic treatment options, whether they be surgical, radiation or chemotherapeutic - his overall condition will inexorably deteriorate regardless of whether the amount of life support interventions is maintained or increased. In essence, AK is dying. Continued administration of life support interventions adds to his burden of suffering at the end-of-life and in our view is a detriment to his well-being..."

We were referred to a number of cases and two of those cases are apropos to the issue of "well-being". In *Scardoni v. Hawryluk, 2004 CanLII 34326, 69 O.R. (3d) 700 (ON SC)*, an appeal from a decision of this Board, Justice Cullity, at paragraphs 45 through 50 of his decision, agreed with the Board's interpretation of "well-being" and referred to page 20 of its Reasons for Decision.

The Board said the following: “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.” In considering the quote from the *Scardoni* decision, Justice Cullity referred to another case cited as *Janzen v. Janzen (2002)*, 44 E.T.R. (2d) 217 (S.C.J.), ‘in which the interpretation of section 21(2) of the Act was considered in the context of competing applications for an appointment as an incapable person’s Guardian of the person’, Aitken J 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. Janzen's quality of life. I consider the concept of ‘well-being’ a very broad concept, which encompasses many considerations, including quality of life. Many of the interventions contemplated as being necessary to prolong Mr. Janzen’s life involve procedures that could be painful or uncomfortable for Mr. Janzen. Maria Janzen's guardianship plan focuses on keeping Mr. Janzen comfortable and pain-free. I find that this focus will improve his overall well-being.”

There was no hope that AK would have any recovery and in fact would get worse. He had cancerous tumours throughout his body with absolutely no hope or chance of recovering. No doubt the family desired to have AK recover and go home but in our view that view was not in any way realistic. The family members did not view his situation objectively nor were they able to put themselves into his position. The true conflict was the mistrust the family had for the medical team. The issue of the best interests for AK and the quality of the patient’s life was subverted by the family’s actions. After weeks in hospital hooked up to tubes and machines, after suffering from irreversible metastatic cancerous tumours, after suffering from pain, after suffering several bouts of recurrent septic shock, after suffering from continuous seizures, after losing his cognitive ability, after being in a state where recovery was not possible, after suffering from many fractures of his spinal column and his femur, after suffering from the invasion of personal privacy, after suffering human indignities, it was time for the family to say “enough”. In our minds, there was no disputing the clear, cogent and compelling evidence of Dr. Dwosh. We agreed with Dr. Dwosh that AK should be allowed to die with dignity and that the treatment for AK, in his best interests, would be the treatment proposed by Dr. Dwosh.

It was clear to us, having taken into consideration all of the evidence, that PK was not acting in accordance with the best interests of AK as set out in the section 21 criteria.

The lawyers for Dr. Dwosh and AK asked us to order that not only should PK be removed as SDM but that we should hold that neither DK nor ME should be the SDM and that we should appoint the Public Guardian and Trustee (PG&T) as SDM. We did not have the jurisdiction within this proceeding to make such an order.

RESULT

The Board held that AK was incapable with respect to the treatment proposed for him, as set out in the treatment plan below.

We granted Dr. Dwosh's application and determined that the refusal of accepting Dr. Dwosh's treatment plan for AK was not done in accordance with the principles for giving or refusing consent to treatment as set out in *The Health Care Consent Act (HCCA)*. We directed PK to consent to the proposed treatment plan, namely:

1. AK be administered narcotic analgesia in a continuous fashion via IV pump or through subcutaneous infusion.
2. AK also receive other comfort medications that are appropriate for the withdrawal of life support interventions.
3. That AK be rapidly weaned off the ventilator and off the infusion of blood pressure medications to allow for a natural death without artificial life support interventions.
4. That no cardiopulmonary resuscitative interventions are undertaken in the event of the cessation of breathing or and arrest cardiac function.

We delivered the decisions to the parties by fax on December 1, 2011. We gave PK until 12:00 noon, December 2, 2011 to consent to the treatment in accordance with our decision. The decision clearly sets out that if the substitute decision maker fails to comply with the Board's directions within the time specified, that he shall be deemed not to meet the requirements for substitute decision-making as set out in section 20 (2) of the Act and Dr. Dwosh can then seek consent in accordance with our decision from the next ranking substitute decision-maker as set

out in section 20.

Dated at Chatham, Ontario this 6th day of December, 2011.

Bernard Comiskey, Presiding Member