



File Number LO-08-4507
LO-08-4506

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

AND IN THE MATTER OF
W
A RESIDENT OF
MOUNT FOREST, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

At the time of the Hearing, W was 4 years old (date of birth- November 18, 2004). W had a prenatal diagnosis of bilateral renal cystic dysplasia (abnormal development of the kidneys resulting in abnormal formation and subsequent abnormal function). Postnatal imaging confirmed that diagnosis.

Mrs. W and Mr. W were the parents and substitute decision-makers of W. As treatment for W, Dr. Grimmer proposed renal replacement therapy, including dialysis and kidney transplant.

W's parents would not consent to this plan of treatment and therefore, Dr. Grimmer 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 March 27, 2009. The panel released its decisions the morning of March 28, 2009. At the hearing, Mr. W requested written Reasons for Decision which Reasons were released on March 31, 2009.

LEGISLATION CONSIDERED

The *Health Care Consent Act, 1966*, S.O. 1996 c.2, as amended including ss. 4(1), 20, 21, 37, and 37.1.

PANEL MEMBERS

Mr. B. Comiskey, Senior Lawyer-Presiding Member
Dr. J. Pelletier, Psychiatrist Member
Ms J. Cutaita-Beales, Community Member

PARTIES

W, the patient
Mrs. W and Mr. W, the substitute decision makers
Dr. J. Grimmer, the health practitioner

APPEARANCES

For W, Ms D. Ewer, lawyer
Mr. W and Mrs. W chose to represent themselves.
For Dr. Grimmer, Ms J. Zamprogna-Balles, lawyer.

PRELIMINARY MATTERS

The panel was advised that Mr. and Mrs. W had one witness that they wished to call. Ms Ewer

and Ms Zamprogna-Balles sought an order excluding witnesses, which we granted after explaining to the parties the necessity to have independent evidence from the witness.

THE EVIDENCE

The evidence at the hearing consisted of the oral testimony of Dr. Grimmer, Mrs. W, Mr. W, Mr. U.W as well as four exhibits:

- 1–Clinical Summary– Dr. J. Grimmer- March 27, 2009;
- 2– Notes and Letter from Mr. U.W to Dr. Grimmer and hospital- March 2, 2009;
- 3 –Letter of agreement- treating team and parents-dated July 24, 2008 and signed September 5, 2008;
- 4 – Advanced medical directive- treating team and parents- dated July 25, 2006 and signed August 18, 2006 to August 23, 2006.

INTRODUCTION

W, a four-year-old child, was born with bilateral renal cystic dysplasia. Dr. Grimmer proposed renal replacement therapy for W. Mr. and Mrs. W, the parents and substitute decision-makers of W did not consent to the proposed treatment. Consequently, Dr. Grimmer brought a Form G application to the Board under the *HCCA* which prompted a hearing under the Act to determine if the patient was capable of consenting to her own treatment.

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

THE LAW

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

4. (1) 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.

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 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 compliant 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

Dr. Grimmer advised that she was a pediatric nephrologist. She said that she was a medical doctor with a specialty in pediatrics followed by a two-year clinical fellowship in pediatric nephrology. She said that nephrology deals with kidneys and their function. She said that W had been followed by her since her birth and cared for by two pediatric nephrology colleagues during two of her maternity leaves. As well, W had been followed by the entire multidisciplinary team. That team consisted of three pediatric nephrologists, a dietitian, a pharmacist, a social worker, a nurse practitioner and a dialysis nurse specialist.

Did W have the capacity to consent to her own treatment?

Dr. Grimmer said that she was directly involved in the care of W before she was born and immediately after birth when she was transferred from Mount Forest to London Health Sciences Centre (LHSC). In her clinical summary and orally, Dr. Grimmer said that W was a four year and three month old female. W had a diagnosis of bilateral renal cystic dysplasia (abnormal development of the kidneys resulting in abnormal formation and subsequent abnormal function). This developmental abnormality was not curable and required renal replacement therapy. Based on W's chronological and developmental age she said that W was not able to make an informed decision with respect to her treatment. In her clinical summary, Dr. Grimmer said: "At her age she has little concept of life, death, sickness or health. W would have no insight into foreseeable consequences of a decision or lack of decision." There was no evidence which contradicted Dr. Grimmer.

On the basis of Dr. Grimmer's clear evidence, we held that it was impossible for W to have the ability to understand the information relevant to the treatment proposed for her, nor was it

possible for her to have the ability to appreciate the reasonably foreseeable consequences of consenting to or refusing the treatment proposed for her. The panel held that W was incapable of consenting to her own treatment pursuant to the provisions of section 4(1) of the *HCCA*.

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

W's Medical History, Status, Prognosis and the Treatment Plan

Dr. Grimmer filed as Exhibit 1 a clinical summary, which set out in great detail the medical history, current status, prognosis, proposed treatment and the risks and benefits of that treatment.

Dr. Grimmer, in her clinical summary and orally, gave clear, cogent and compelling evidence. She described W's medical condition and indicated that although W had renal dysfunction she had never required readmission to hospital since three weeks after her birth.

Dr. Grimmer said that outside of her renal abnormality, W had no other abnormalities.

Dr. Grimmer said that subsequent to release from hospital after her birth, W was followed by the pediatric nephrology clinic on an outpatient basis and by her family doctor. She was seen frequently in her first year, then every six weeks and at the time of the hearing every three months.

Dr. Grimmer said that there was a gradual decline in W's renal function. She said that the initial management of such chronic kidney disease is medical. When the renal function declined to approximately 15% of normal, renal replacement therapy (dialysis and kidney transplantation) was necessary. Dr. Grimmer last reviewed W prior to the hearing on February 24, 2009. At that time, W's estimated renal function was approximately 17% of normal. She said that it was best medical practice to initiate renal replacement therapy before absolute indications arise. In her clinical summary, Dr. Grimmer said that W "currently has no absolute indications for dialysis, but has several relative indications. Absolute indications for dialysis are for those conditions that will result in significant harm, including death, if they are not dealt with immediately. These include: fluid overload, acidosis and electrolyte abnormalities that could not be controlled

medically, and uremic complications (pericarditis and seizures). Relative indications are for abnormalities that result from poor renal function that cannot optimally be managed medically.”

Dr. Grimmer said that W had a huge number of relative indications. She said that her creatinine and urea levels were extremely elevated. In her summary she said: “while there are no known toxic effects of elevated creatinine, there are significant clinical effects of elevated urea (uremia) and other associated toxins. Manifestations of uremia include nausea, vomiting, anorexia, growth failure, peripheral neuropathy, and central nervous system abnormalities ranging from loss of concentration and lethargy to seizures, coma and death. Other complications include platelet dysfunction, resulting in an increased tendency to bleed, and pericardial disease (pericarditis and pericardial effusion). One of the most concerning effects of uremia in a young child is the neurodevelopmental effect. The neurologic findings can range from subtle deficits resulting in poor school performance to seizures and severe mental retardation.”

Dr. Grimmer said that she had no concerns for W’s nutrition as her family worked very hard to get adequate calories into her. She said that for growth failure, “growth hormone is given as a daily injection until growth is complete”. She said that growth hormone was very expensive and was in the range of \$15,000-\$25,000 per year. She said the cost was covered by OHIP for those who qualify and accept coverage. She said that Mr. and Mrs. W pay for all medical bills personally and do not subscribe to OHIP. She said they declined the use of growth hormone, “but I have supported that decision because there is no significant advantage to its use, other than increased height. W will continue to grow, although she will not achieve her full potential height”.

Dr. Grimmer said that the treating team was having difficulty “managing her calcium, phosphate and PTH (parathyroid)”. She said that difficulty managing those levels was a relative indication for starting dialysis. She said: “Poor management of calcium and phosphate balance in childhood is a significant contributor to increased cardiovascular disease seen in young adults who have had chronic kidney disease in childhood”.

In her prognosis, Dr. Grimmer said: “Without renal replacement therapy (dialysis and kidney transplant) W will certainly die. The risk of death is 100%”. She estimated that death would

occur within 1 to 5 years. She said that if she “were to become acutely unwell with any number of relatively common childhood illnesses (example: gastroenteritis, influenza etc.) it is possible that W would suffer an acute decline in her renal function, requiring immediate dialysis, or resulting in her death”.

The proposed treatment for W was renal replacement therapy (dialysis and kidney transplant). She said that dialysis in the pediatric population was generally used as a bridge to transplantation. She said that if a living donor was available, dialysis could be avoided entirely. The workup for such a transplant would take about 6 to 9 months. If a living donor was not available, then W would be placed on a deceased donor list and in the interim she would be started on dialysis. With respect to timing, Dr. Grimmer said that she would initiate dialysis within the next couple of months of the hearing date and then seek a transplant. She referred to the procedure as a preemptive transplant as she said they never want to wait until the last minute.

In her summary, Dr. Grimmer described the two forms of dialysis that were available. She said: “one is peritoneal dialysis and the other is hemodialysis. Peritoneal dialysis is a home therapy and is the modality that I would recommend for W, if dialysis were required. The procedure involves the surgical insertion of a catheter in the abdominal cavity. Fluid is placed in the peritoneal space. Waste products and fluid diffuse into the fluid in the peritoneal space and are then removed. This is an overnight therapy with an automated cycler that fills and drains the abdomen approximately every hour. The patient is asleep for the majority of the therapy. It is completed in about eight to ten hours, overnight, and some fluid is left in the abdomen during the day. The daily time commitment for parents to complete the peritoneal dialysis is approximately 1.5-2 hours in preparation time.” Dr. Grimmer described in detail the complications with peritoneal dialysis with the most common complication being infection. She said the family members are trained in the hospital for approximately one week. She said that “occasionally, peritonitis will necessitate removal of the catheter and a switch to hemodialysis while the infection is treated. Hemodialysis can only be done in London.” She said it required that the patient be hospitalized.

In her summary she said: “The five-year survival of pediatric patients (age 0 to 10 years) that undergo renal transplantation is 97 to 99% for living related donor transplantation and 90 to 97%

for those who receive a kidney from a deceased donor. Morbidity and mortality rates are higher in children younger than W as dialysis and transplantation is technically more difficult and very young children.” She said that the mortality or death rate for an older child is much less than 5% but a younger child from 0 to 4 years is about 30%. She defined morbidity as being complications from a transplant such as infections. She said that an average transplanted kidney would last 10 to 12 years and that a person transplanted in childhood would require subsequent transplants during their life. She said that her life expectancy was into her late 30s or 40s. She said that since W’s disease was renal dysplasia that she was considered an ideal case for transplant. In her summary she said: “... dysplasia does not ‘come back’ in the transplanted kidney, and the bladder is normal and used to high urine volumes.”

Dr. Grimmer said that all members of the team were unanimous that the best course of treatment for W was transplantation and dialysis. She said that she consulted with Dr. Geary, the head of the pediatric nephrology department at Sick Children’s Hospital in Toronto. He said that it was absolutely in the best interests of this child to undergo renal therapy rather than death. We accepted Dr. Grimmer’s uncontradicted evidence.

The Position of the Parents

Mr. W said that they did not feel it was in the best interests for W’s quality of life to pursue dialysis and transplant. He said her best interests were to be with her family if possible. He said that the risks and transplant does not look like a very good idea to him although they appreciated the medical help. He thought it was better for her to be kept at home. He said they didn’t have OHIP and that all expenses were coming out of their pockets with the help of his community. He said that he chose not to have OHIP coverage. He said that they would rather let her die innocent than put her through the hospitalizations and medications. He said a transplant every 10 to 12 years was not his idea of a good quality of life. He said that they were not ready to see her die but they were not ready for her to receive a transplant. He said he was concerned about the burden. He said that they had five children and were expecting another child. He said that W was the middle child.

When he was asked if he would have a problem with a child with diabetes who had to be constantly checked and daily check her blood pressure, he said that would not be a problem. He

said that he had a brother who had a child with diabetes and was aware of that situation. He was asked if they would be able to handle a child with a cancerous tumour and the follow-up that went with that issue and he said that they could do that. He said that in the situation involving his daughter W that there would be a burden of going to appointments and taking care of the dialysis at home. He said they would be able to learn how to do it but it would be excessive and disruptive. He also said that he was told by the dialysis nurse that if he didn't have \$350,000 and \$15,000 to stay in Toronto that he would be unable to have the transplant. He said that was a burden.

Mrs. W gave evidence. She said that she agreed with her husband who as leader of the home takes care of finances. She said she was sure it would be a big burden and to some extent the community would have to bear that burden. She said it didn't look like a small price to her. Asked what she meant, she replied that it was the whole procedure and how it might affect the rest of the family.

Mr. U. W, the father of Mr. W, gave evidence and relied on letters he sent to the hospital that were marked as exhibit number two. He said they as a family were living the Bible and disagreed with what was in W's best interests. He said that transplant every 10 to 12 years was a major concern as it would make life more difficult. When asked why they didn't have OHIP coverage, he said that they felt it was biblical to pay their own way for the hospital and medications and not rely on social assistance. Asked the basis for the family's refusal for transplant, he said part of it was because they had no guarantee of the result either way. He said there was no guarantee either way of the side effects. He said the transplant was only good for 10 to 12 years and asked how many she might need. He said in "these types of situations there can be no comparison as to life on earth and life in heaven". He said the transplants were not against their beliefs. He said: "under the best of circumstances, life after death is better". He said that they had talked as a family about the situation numerous times and had always been in agreement as far as he knew. He said they talked to different personnel in the community who felt that it was a hard decision but that they would support the family's decision.

He was asked if there was a provision in their religious beliefs to accept OHIP in big bill situations. He replied that he hoped the medical community could reduce the costs on the basis

of principle. Asked again if the community might allow someone to accept OHIP, he replied: “it might happen someday- in the meantime, relying on God to help us... realistic that God cannot help us pay bills.” He said that such expensive treatment was definitely a community effort. He said they would go to the officials of the church who would pay 75% of the costs. He said that it would need a consensus of the community to allow someone to get OHIP and he was not going to ask the community to make such an exception. He said life in heaven was better.

Section 21 Criteria for Best Interests

In her clinical summary, Dr. Grimmer said that there were no treatment alternatives.

Dr. Grimmer gave evidence that the treatment they proposed for W would improve her condition or well-being, would prevent her condition or well-being from deteriorating, and would reduce the extent to which or the rate at which W's condition or well-being was likely to deteriorate. In her summary she said that “at a minimum, renal replacement therapy will prevent death. There are several advantages, outside of avoiding death, from renal replacement therapy. There will be improvement in one's health including nutrition, growth, neurocognitive development and an overall sense of well-being or quality of life. Renal replacement therapy will also help to prevent several complications that result from untreated chronic kidney disease, most significantly long-term cardiovascular disease (this is inevitable in all patients with chronic kidney disease, but optimal management with transplantation helps to decrease the risk), and central nervous system and neurodevelopmental abnormalities.” She went on to say: “W's function is at such a low level that a relatively minor childhood illness could result in serious complications, including death.” “... at W's current age, with the reduced risk of morbidity and mortality, renal replacement therapy is considered the standard of care in developed countries for a child with end-stage kidney disease. Dialysis would be used as a bridge until transplant.”

She said that, without the proposed treatment, W's condition or well-being “... will not improve and will continue to deteriorate overtime, eventually resulting in death.” In her oral evidence, Dr. Grimmer said that “without treatment, death was a certainty.” She said that in the end, W would have a lot of suffering. She said that they would try to deal with that suffering but it could be long drawn-out suffering.

Dr. Grimmer said that the benefit that she would receive from the treatment outweighed the risk of harm to her. In her clinical summary, she said: "The outcome without renal replacement therapy is certain death. The optimal therapy is renal transplantation. As described above, both dialysis and transplantation have potential risk but, in my professional opinion, the benefits far outweigh the potential risks."

She said: "there is no other less restrictive, or less intrusive, treatment available".

We accepted her expert opinion and agreed with her.

Ms Zamproga-Balles, on behalf of Dr. Grimmer, referred us to a Supreme Court of Canada case, *B. (R) v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 S.C.R. 315 and in particular a passage at page 11 by the majority of the members which reads as follows: "A parent's freedom of religion, guaranteed under s.2(a) of the *Charter*, does not include the imposition of religious practices which threaten the safety, health or life of the child. Although the freedom of belief may be broad, the freedom to act upon those beliefs is considerably narrower, as it is subject to such limitations as are necessary to protect the fundamental rights and freedoms of others. Since S.B. has never expressed any agreement with the Jehovah's Witness faith or any religion, there is an impeachment on her freedom of conscience, which arguably includes the right to live long enough to make one's own reasoned choice about the religion one wishes to follow as well as the right not to hold a religious belief. 'Freedom of religion' should not encompass activity that so categorically negates the 'freedom of conscience' of another."

She also referred to a decision of the Board cited as *L (Re)* 2008 CanLII 46902 (ON C.C.B.) which referred to and relied on a case at page 12 of that decision cited as *E.J.G. (Re)*, 2007 CanLII 44704 (ON C.C.B.). In that case, the parents of a child, who was in a vegetative state from oxygen deprivation at birth, refused to allow the health care team to wean the child from his ventilator and allow him to die. Mr. M. Handelman, the chair of the panel, at page 16 of that decision, said as follows:

"Unrelenting faith in divine intervention may be Mrs. G and Mr. G's belief. They were entitled to give primary importance to that faith in making their own treatment decisions but they made

EJG's treatment (decision) based only upon their beliefs, not his. EJG did not have any values or beliefs."

She said that the Board could not ascribe beliefs of the parents to the child. She carefully reviewed s. 21 of the *HCCA* and asked us to find on all of the evidence that Mr. and Mrs. W were not acting in the best interests of W.

Ms Ewer, on behalf of W, said that she concurred with Ms Zamprogna-Balles and referred us to the quote from the case of EJG in the case of L. She submitted that the parents as substitute decision-makers were not acting in the child's best interests, although she acknowledged that there was no doubt that they cared for their child. She said that W did not have values and beliefs. They cannot be ascribed to her by her parents. She said that Dr. Grimmer had proved her case and she added that there is a presumption in favour of prolonging life.

While we had empathy for Mr. W and Mrs. W, the parents, for their beliefs, and the care and devotion that they had given their child, we held that they were not acting, in this instance, in the best interests of their child. In our view, there was no evidence that contradicted the evidence of Dr. Grimmer. Her evidence was clear, cogent and compelling. Without renal transplant therapy, there was 100% certainty that W would die. To allow a child to remain at home to die when there was a 97 to 99% chance that she would survive a kidney transplant from a family donor was not acting in the best interests of the child W. The family's belief that it was better to let her die as an innocent child because they viewed life to be better in heaven than on earth was not a belief that they could impose upon W. It was clear to us from the cases cited by the lawyers for Dr. Grimmer and W, that the parents could not ascribe their views to the child W. This four year old child did not have any values and beliefs. The patient's best interests were served by accepting and adhering to the treatment plan proposed by Dr. Grimmer.

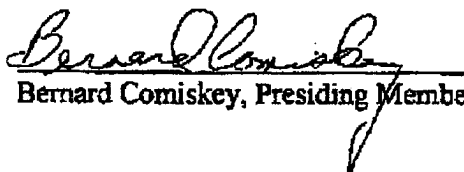
RESULT

The Board held that W was incapable with respect to the treatment proposed for her.

We granted Dr. Grimmer's application and determined that the refusal of accepting Dr. Grimmer's treatment plan for W 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 Mr. and Mrs. W to consent to the proposed treatment plan, namely: renal replacement therapy , including but not limited to kidney transplant and dialysis, for the child W.

We delivered the decisions to the parties by fax in the morning on Saturday, March 28, 2009. We gave Mr. and Mrs. W until 1:00 p.m. on Monday, March 30, 2009 to consent to the treatment in accordance with our decision. The decision clearly sets out that if they fail to comply with the Board's directions within the time specified, that they shall be deemed not to meet the requirements for substitute decision-making as set out in section 20 (2) of the Act and Dr. Grimmer 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 31st day of March, 2009.


Bernard Comiskey, Presiding Member