

16-5728-01
16-5728-02

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

AND IN THE MATTER OF

WA

A patient at
LONDON HEALTH SCIENCES CENTRE – UNIVERSITY HOSPITAL
LONDON, ONTARIO

REASONS FOR DECISION

PURPOSE OF THE HEARING

WA was a patient at London Health Sciences Centre – University Hospital, London, Ontario (“LHSC”), who had been found incapable of making decisions about his medical treatment. His son, GA, was his substitute decision-maker. Dr. Haddara, a member of WA’s treatment team, filed a Form D application under s. 35 of the *Health Care Consent Act* (“HCCA”), seeking directions from the Board about the applicability of a wish previously expressed by WA regarding his treatment. The Form D application triggered a mandatory review of WA’s capacity to make treatment decisions, under section 37.1 of the *HCCA* (the “deemed Form A treatment application”). The Board convened a hearing to decide both matters.

DATES OF THE HEARING, DECISIONS AND REASONS

The hearing took place on June 19 and 20, 2017 at LHSC, and the Board released its decisions the following day. At the hearing WA's counsel requested written Reasons for Decision, which were released on June 26, 2017 (contained in this document).

LEGISLATION CONSIDERED

The *Health Care Consent Act*, sections 1, 4, 5, 21 and 35.

PARTIES TO THE DEEMED FORM A (TREATMENT) APPLICATION

WA, the incapable person

Dr. David Leasa, health practitioner and capacity evaluator

PARTIES TO THE FORM D APPLICATION

WA, the incapable person

GA, WA's son and substitute decision-maker

Dr. Wael Haddara, the health practitioner representing WA's treatment team

PANEL MEMBER

Nina Lester, senior lawyer and presiding member, sitting alone

APPEARANCES

WA did not attend the hearing; he was represented by counsel, Mr. Philip Squire.

Dr. Leasa attended the hearing only to give oral evidence; Dr. Haddara attended the hearing on June 19; both doctors were represented by counsel, Mr. Brent Hodge.

GA attended the entire hearing and was represented by counsel, Ms. Nicola Circelli.

PRELIMINARY MATTERS

Determination of substitute decision-maker for purposes of hearing

Pursuant to a Power of Attorney for Personal Care dated October 20, 2012 (Exhibit 2), WA's two children, GA and HC, were named as WA's joint attorneys for personal care. However, on August 9, 2016, HC relinquished her role as attorney for personal care, by way of a signed letter (Exhibit 2). Ms. Circelli stated that HC had taken this step under duress, and she wished to be reinstated as an attorney for personal care for WA and, consequently, be named a party to the hearing. Ms. Circelli noted that HC and GA stood united in their views toward decision-making and their support of their father's wishes. I declined the request to name HC a party to the hearing. On the face of it, the letter by which HC had relinquished her role as attorney for personal care seemed valid – to question the cause and legitimacy of her act of relinquishment was beyond the scope of the hearing and the jurisdiction of the Board. I advised Ms. Circelli that she could call HC as a witness to the hearing, and that she could pursue other judicial avenues to determine whether HC could be reinstated as an attorney for personal care for WA.

Exclusion of Witnesses

Mr. Squire requested the exclusion of witnesses, which was granted. I pointed out that parties could not be excluded from any part of the hearing.

EVIDENCE

The evidence at the hearing consisted of the testimony of (in this order) Nurse Cathy Mawdsley, Dr. Leasa, GA, Dr. Haddara, JC (WA's grandson), and HC (WA's daughter, JC's mother, and GA's sister), and the following documents entered as Exhibits:

1. LHSC Consultation Note by Dr. Noureen Huda, November 19, 2016 and attached handwritten note by Dr. Leasa dated May 8, 2017
2. Power of Attorney for Personal Care signed by WA, October 20, 2012, with attached letter from HC relinquishing her role as attorney, August 9, 2016
3. LHSC Consultation Notes by:

Dr. Tariq and Dr. Teriaky, October 5, 2016
Dr. Schlachta, September 16, 2016
Dr. Adams and Dr. Jairath, September 11, 2016
Dr. Alotaibi, August 8, 2016
Dr. Schlachta, July 26, 2010

4. LHSC handwritten nursing notes by Nurse Mawdsley, dated between September 19–October 4, 2016
5. LHSC handwritten nursing note by Nurse Mawdsley, dated January 23-24, 2017
6. LHSC Ethics Consultation Note by R. Sibbald, January 24, 2017.

INTRODUCTION

WA was a 92-year old widowed man with two adult children, a son (GA) and a daughter (HC), and two grandsons, JC and AC. WA lived with GA until the current admission, and was relatively independent with his hygiene and activities of daily living. In 2010 WA had been diagnosed with a non-cancerous mass in his rectum. His physician had recommended surgery to remove the mass, which WA had refused. Due to this condition, WA had suffered from chronic diarrhea since 2010, progressively worsening, with several hospital admissions since 2014 for dehydration and electrolyte imbalance secondary to the diarrhea.

On June 21, 2017, WA was admitted to LHSC for suspected cardiac arrest, he stabilized in hospital, and was discharged on July 5. His diagnosis at the time was pneumonia, acute kidney injury (also known as renal failure), and diarrhea (Exhibit 3, Note of October 5, 2017). WA was readmitted on July 21, 2017 for confusion, nausea, reduced oral intake, and increased diarrhea. On July 23 WA was transferred to the intensive care unit (“ICU”) as he required intubation and mechanical ventilation to assist his breathing due to fluid in the lungs. His course in hospital had been complicated by multiple pneumonias requiring antibiotics, a stroke, a blood clot in his lung, and a rectal bleed which resolved with a switch of his blood thinning medication. He became dependent on kidney dialysis three times per week. Eventually WA required a tracheostomy for ongoing mechanical ventilation (intubation being a temporary measure). Following that, WA could not speak except for brief periods when a speaking valve was attached to his tracheostomy

tube and mechanical ventilation was suspended for as long as he could tolerate. The last time this was tolerated was in October 2016.

From July 23, 2016 until the date of the hearing, WA was declared incapable of making his own treatment decisions, with the exception of one brief period of approximately 10 days during September 2016. Under the authority of a Power of Attorney for Personal Care signed by WA on October 20, 2012 (“PAPC”), GA and HC were named as WA’s attorneys for personal care (“APCs”), whose authority included making treatment decisions for WA in the case of his incapacity. On August 9, 2016, HC relinquished her role as APC for WA, making GA sole APC and substitute decision-maker (“SDM”) for WA’s medical treatment. HC remained closely involved, however, in visiting her father and discussing treatment options with the medical team and GA.

In September 2016 the family and WA’s treatment team revisited the possibility of WA undergoing bowel surgery to potentially relieve his diarrhea. This was during the period of WA’s return to mental capacity. WA was ambivalent at first, but then consented to the surgery. However, his physicians determined that the required pre-operative tests were too risky, and surgery was ruled out (Exhibit 3, Note of October 5, 2016).

In October 2016, WA was stable enough to be transferred from the ICU to a general medical unit within LHSC, with ongoing mechanical ventilation and kidney dialysis. His condition worsened, however, and he was transferred back to the ICU in December. WA experienced delirium and was in and out of consciousness. By January 2017, the medical team was of the opinion that WA would never be able to wean off mechanical ventilation and was no longer responsive to external stimuli. They informed GA and HC that WA would never be able to go home, and that he was dying. In a family meeting on January 23, 2017, the treatment team reviewed with GA and HC the goals of care for WA. They recommended a switch from active treatment to palliation and letting nature take its course instead of prolonging WA’s “suffering” (Exhibit 5). GA refused consent to withdrawal of life support, insisting that the medical team continue to do everything possible to extend WA’s life. GA stated he was following his father’s own wish, which had been

clearly expressed while WA had been capable. GA felt he was bound, as SDM, to respect his father's wish, and was not at liberty to make any different decision.

The LHSC medical team applied to the Board for directions with regard to WA's previously expressed wish (Form D application under the *HCCA*). The questions before the Board were whether WA had expressed a clear wish regarding the course of his treatment, whether the wish was applicable to the present circumstances, and whether WA had been capable when he had expressed the wish.

THE LAW

Capacity to Consent to Treatment

The Form D application for directions triggered a deemed Form A application (*HCCA* s. 37.1) requiring the Board to review the evidence regarding WA's alleged incapacity to consent to resuscitation and ongoing life sustaining treatments. In other words, before the Board could issue directions, the Board had to first be satisfied that WA continued to be incapable at the time of the hearing.

In any review of a finding of incapacity, the onus is always on the health practitioner to prove that, on the day of the hearing, the person is incapable of making treatment decisions according to the test set out in the *HCCA*. The standard of proof, as with any application under the *HCCA*, 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. The Board must be satisfied on the basis of clear, cogent and compelling evidence that the evaluator's onus has been discharged. There is no onus whatsoever on the person who is the subject of the application.

Under the *HCCA* s. 4(2), a person is presumed to be capable to consent to treatment and the onus to establish otherwise rests with the evaluator, in this case, Dr. Leasa. The test for capacity to consent to treatment is set forth in s. 4(1) of the *HCCA*, which states:

4.(1) Capacity. – *A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.*

4.(2) Presumption of capacity. – *A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services.*

In other words, a person will be found incapable of consenting to treatment if that person fails either part of the two-part test set out in s. 4(1).

Application for Directions

Section 35(1) of the *HCCA* allows a substitute decision-maker or a health practitioner to apply to the Board to seek directions or clarification if the incapable person previously expressed wish regarding treatment:

35.(1) Application for directions. – *A substitute decision-maker or a health practitioner who proposed a treatment may apply to the Board for directions if the incapable person expressed a wish with respect to the treatment, but,*

- (a) the wish is not clear;*
- (b) it is not clear whether the wish is applicable to the circumstances;*
- (c) it is not clear whether the wish was expressed while the incapable person was capable; or*
- (d) it is not clear whether the wish was expressed after the incapable person attained 16 years of age.*

(1.1) Notice to substitute decision-maker. – *A health practitioner who intends to apply for directions shall inform the substitute decision-maker of his or her intention before doing so.*

(2) Parties. – *The parties to the application are:*

- 1. The substitute decision-maker.*
- 2. The incapable person.*
- 3. The health practitioner who proposed the treatment.*
- 4. Any other person whom the Board specifies.*

(3) Directions. – *The Board may give directions and, in doing so, shall apply section 21.*

Section 21 of the *HCCA* sets out the principles by which substitute decision-makers may give or refuse to give consent to treatment on behalf of an incapable person:

21.(1) Principles for giving or refusing consent. – *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.*

(2) Best interests. – *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 quality of the incapable person’s condition or well-being,*
 - ii. *prevent the quality of 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.*

Section 21 refers to an incapable person's prior capable wish. Section 5 of the *HCCA* stipulates that such a wish can be expressed in many forms:

5.(1) Wishes. – *A person may, while capable, express wishes with respect to treatment, admission to a care facility or a personal assistance service.*

(2) Manner of expression. – *Wishes may be expressed in a power of attorney, in a form prescribed by the regulations, in any other written form, orally or in any other manner.*

(3) Later wishes prevail. – *Later wishes expressed while capable prevail over earlier wishes.*

Finally, in any analysis involving the *HCCA*, it is important to bear in mind the purposes of the legislation, encoded in section 1 of the Act:

1. Purposes. – *The purposes of this Act are,*

(a) to provide rules with respect to consent to treatment that apply consistently in all settings;

(b) to facilitate treatment, admission to care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters;

(c) to enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed and persons who are to receive personal assistance services by,

(i) allowing those who have been found to be incapable to apply to a tribunal for a review of the finding,

(ii) allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on their behalf concerning treatment, admission to a care facility or personal assistance services, and

(iii) requiring that wishes with respect to treatment, admission to a care facility or personal assistance services, expressed by persons while capable and after attaining 16 years of age, be adhered to;

- (d) to promote communication and understanding between health practitioners and their patients or clients;*
- (e) to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment, admission to a care facility or a personal assistance service; and*
- (f) to permit intervention by the Public Guardian and Trustee only as a last resort in decisions on behalf of incapable persons concerning treatment, admission to a care facility or personal assistance services.*

ANALYSIS

Capacity to Consent to The Proposed Treatment

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

The standing treatment WA was receiving at the time of the hearing was described as “resuscitation and ongoing life sustaining treatments”. The life sustaining treatments consisted of: mechanical ventilation administered through a tracheostomy, kidney dialysis three times per week, and feeding and hydration tubes. In addition, WA was being treated for a stage 4 bed ulcer at his coccyx (the most severe stage with a wound exposing the bone), chronic diarrhea due to the mass in his bowel, chronic fluid in his lungs requiring suction several times each day, and frequent lung infections requiring antibiotics. According to the evidence, WA was asleep most of the time, with brief periods of consciousness when his family visited.

Two members of WA’s medical treatment team testified about his lack of capacity for treatment. Nurse Mawdsley had regular supervision of WA in the ICU. She described how, several days before the hearing, she had tried to draw a response from WA by talking, then yelling in his ear, and applying mild pain for a response. WA gave no sign that he could hear or feel pain, although he winced when dark glasses were removed from his eyes due to photosensitivity. At times his legs moved spontaneously and his hands tugged at his tubes, but he rarely moved in response to a command. Nurse Mawdsley said that WA had been interactive in the fall of 2016, but since January 2017 he could no longer interact with his environment.

Dr. Leasa was one of WA's treating physicians (the ICU consisted of a team of physicians who rotated in assuming primary care of patients). Dr. Leasa stated that since January 2017 WA's condition had remained unchanged. Most of the time his eyes remained closed and he could not respond to simple commands like "move your thumb" or "stick out your tongue". The last time Dr. Leasa witnessed WA respond to such a command was on May 8. Dr. Leasa noted that while WA had been lucid back in September 2016, he had been able to converse about his conditions and the proposed treatments, and had been treated as capable for a period of about ten days. Since January, 2017 it was impossible to hold a conversation about anything with WA and he was certainly unable to understand medical information or appreciate the consequences of complex treatment decisions in his condition. It was not simply a matter of not being able to communicate; WA's brain function was severely compromised. None of the parties challenged Dr. Leasa's finding of incapacity.

I determined that in his current semi-conscious state, WA lacked the cognitive ability to understand information relevant to making decisions about his treatment and also unable to appreciate the consequences of any decision or lack of decision. As of the date of the hearing, I confirmed Dr. Leasa's finding that WA was incapable of consenting, or refusing consent, to any and all medical treatments.

Application for Directions

Having determined that WA was incapable with respect to treatment, I then considered Dr. Haddara's Form D application. The role of the Board in a Form D application was endorsed by Justice C. Brown of the Ontario Superior Court in the case of *Friedberg v. Korn* 2013 ONSC 960: "[61] The role of the Board in a Form D application is to determine whether there is a clear prior capable wish which is applicable in the circumstances. The Board is not to usurp the role of the substitute decision-maker and make a determination based on the best interests of the patient." I referred to the elements of a valid and enforceable wish outlined in *HCCA* s. 35.

Did the evidence establish that WA had expressed a clear wish regarding his medical care?

The *HCCA* provides, in s. 5(2), that a person's wishes may be expressed in any manner, including orally. It is a matter for the Board to determine, based on evidence, whether a person expressed an unmistakable wish while still capable.

The testimony of three witnesses at the hearing: GA, HC, and JC, persuaded me that WA had expressed a clear, explicit wish prior to his admission to LHSC on July 21, 2016. These witnesses did not hear each other's evidence before testifying. Their separate accounts of WA's wish to be kept alive at any cost were remarkably similar.

GA testified first. He had lived with his father, WA, his entire life; for the past seventeen years just the two of them in an apartment. Even during WA's admission to LHSC, GA visited him every day for up to 8 hours. He probably knew WA better than anyone else in the world did. GA described how his father was fixated on staying on life support, making it clear that he wanted everything done, including CPR, to extend his life. WA said this to GA on many occasions, with persistence. He would often say things like (paraphrasing) "no matter what, you keep me alive, I want CPR, whatever it takes – you'd better remember!" GA would respond to WA "yes, Dad, I get it, I've got your back, I'll follow your wish".

HC had also lived with WA and GA during her adult life – the two of them had moved into her home with her husband and two children for approximately 12 years, until around year 2000, when WA and GA moved to their own place a five-minute's drive from HC. To this day they remained very close, seeing each other several times per week. HC gave a similar account to GA's: that WA had repeated on many occasions that he wanted every possible intervention to keep him alive (paraphrasing) "no matter how many tubes or needles, to the nth degree, I still want it." HC said the topic came up most often when one of WA's friends or acquaintances passed away, but on other occasions too. HC recalled the most recent such conversation which took place in July of 2016 in between his two admissions to LHSC. It was a family gathering in HC's back yard, and WA was so insistent that GA and HC eventually had to implore him to change the topic so as not to spoil the occasion. WA brought up the subject of his brother, George, who was hospitalized with a "do not resuscitate" ("DNR") order in his chart. WA

specifically said he did not want a DNR – ever, and made his children promise never to do that to him. He said he wanted “whatever it takes, until the very end”.

JC was WA’s grandson, an intelligent and articulate young man of 28 years old who was very close with his grandfather. JC recalled the family gathering in July 2016, when he heard WA say unequivocally that he did not want a DNR order placed on him. JC also described an earlier time, two years ago, when WA had been confused and delirious and reluctant to go to the hospital. JC and his mother persuaded WA to go with them to the hospital where he was treated for severe dehydration. Later, WA was very thankful for JC’s persistence, and told JC that he wanted to receive medical care to any extent possible to save his life.

Among GA, HC and JC there was some confusion about the precise date of the most recent conversation regarding end of life care. GA thought it had been in July 2015. HC believed it had been July 2016, on Canada Day, which was not possible as WA was discharged from hospital on July 5, 2016. JC recalled it had been a birthday celebration for him and WA (whose birthdays coincided in July) in mid-July 2016. I found that despite the variation in their recollection of the actual date of the event, their descriptions of the context and content of the discussion were detailed and very similar. They all remembered it had been July, in HC’s backyard, with the four of them plus HC’s other son and husband assembled for a family celebration. WA had just been discharged from hospital and was doing well at the time, but he perseverated on the subject of end of life care, wanting to make sure that his family well understood his wish to be given every form of life support available to extend his life for as long as possible. This was consistent with similar expressions he had made in the past, but seemed even more urgent to his audience this time.

Mr. Hodge, on behalf of the treatment team, raised a number of counter-arguments to point out that WA’s wish was either not clear, or inconsistent with previous decisions by WA. He noted the report of a family meeting that had taken place on November 19, 2016 (documented in Exhibit 1) which recorded HC as saying that “no clear discussion ever took place by their dad”. In questioning about that comment, HC emphatically denied she had ever said that; the author of the note was mistaken. HC repeated that her father had always been clear and consistent,

repeating his wish numerous times, and she was never in doubt about his wish for ongoing life support. HC did admit that, at that meeting on November 19, 2016, she was persuaded to favour palliation rather than life extension for WA; that part of the report was accurate. At the hearing, HC stated she had felt tremendous pressure from hospital staff to agree to palliative care, and was having an emotional “melt down” at that meeting. This was also why she had removed herself as APC on August 9, 2016, because she felt harassed by the medical team. When she saw that GA was going to stand his ground on maintaining life support for WA, including potential CPR, HC walked out of the meeting saying she no longer wanted to be involved in decision-making, she found it too stressful, and was content to let GA make the decisions. At the hearing HC said that on November 19 she was persuaded by the treatment team that palliative care may have been in WA’s “best interests” although she knew in her heart that this was not what WA would want. HC confirmed that she and GA were always in complete agreement as to their father’s wish for ongoing treatment, but in November the team had convinced her that best interests should trump WA’s wishes, and that was reflected in the clinical note.

Mr. Hodge raised the fact that WA had refused potentially life-saving surgery in 2010, and had hesitated when surgery had been proposed again to him in 2016. HC explained WA’s reluctance to have surgery in 2010: he had had a bad experience with back surgery some years before that and was very reluctant to undergo surgery again for a condition in his colon which was not presented to him as life-threatening at the time, but more of a nuisance factor, resulting in chronic diarrhea. WA felt that the risk of surgery outweighed the burden of living with his condition, a reasonable and capable decision that did not contradict his current directive. In September 2016 the situation was much different. WA’s medical team explained that without surgery he would never go home, and with surgery there was only a chance he would go home, and both options carried the risk of death. WA did not decline the surgery, he said “I don’t know” and needed time to think about it. Between September 19 to 30 the matter was raised several times with WA and he could not decide (Exhibit 4) despite being told it was urgent. According to GA, during the weekend following September 30, WA decided to have the surgery, as reflected in a consultation note dated October 5, 2016 (Exhibit 3), however the medical team then decided that the required pre-operative tests carried too much risk, and the proposed surgery was abandoned.

I did not find that WA's hesitation about surgery contradicted his wish to "have everything done" to save his life. He was told that the surgery itself carried a significant risk of death, and the status quo would also result in eventual death, and he was weighing out the lesser of evils. He still wanted to live, and did not know where to place his bet. Eventually he decided in favour of surgery, but it was then taken away as an option. In both cases of proposed surgery (2010 and 2016) WA's actions did not diminish the strength or validity of his expressed wish to remain on life support. I did not find any inconsistency.

Mr. Hodge submitted that within the PAPC document signed by WA (Exhibit 2), the clause entitled "Instructions, Conditions and Restrictions" was left blank. This was the space in which a grantor would ordinarily specify what kinds of decisions he would want made on his behalf in case of incapacity. Mr. Hodge argued that the fact that WA left it blank showed ambivalence on his part, that he wished such decisions to be left within the discretion of his APCs. HC and GA both explained that WA did not think he needed to fill in that clause as long as he instructed his children as to his wishes. He did not engage a lawyer or notary to help create the PAPC, but did it all himself. In fairness to WA, the PAPC form states right underneath the title of the clause: "This part may be left blank". Ms. Circelli pointed out that if WA had written something in that space, it would have stated exactly as he had instructed his children: that he wanted everything possible done to extend his life.

In the case of *Friedberg v. Korn* (cited above) the incapable person had signed a PAPC with an end of life clause specifying she should "not be kept alive by artificial or heroic measures" and yet the Court overruled this stated wish on the basis that the surrounding evidence showed she did not understand or agree with what she had signed, nor did it accord with her deeply-held religious beliefs. The Court supported Mrs. Friedberg's substitute decision-maker's refusal to consent to withdrawal of life support despite an ostensibly contrary wish documented in her PAPC. This case is significant for the principle that even a wish written into a signed PAPC can be superseded by extrinsic evidence to the contrary. Applying this logic to WA's case, positive evidence of an expressed wish could overcome the lack of an end of life clause in a PAPC. As long as GA satisfied the evidentiary burden of proving that his father had expressed a wish to

extend his life using all available means, it was irrelevant that the clause had been omitted from the PAPC.

In considering all of the evidence put forward at the hearing, I found as fact that WA had expressed a clear wish to have every possible medical intervention and means of life support applied to extend his life as long as possible. The testimony of the three family members was most persuasive in this regard.

Did the evidence establish that WA had been capable when he had expressed his wish?

There was no evidence to suggest that WA had been incapable in July 2016 when he had proclaimed his wish to use every means to extend his life. Section 4(2) of the *HCCA* sets out the presumption that a person is capable unless found incapable. Section 15 of the *HCCA* recognizes that capacity can fluctuate over time. JC testified that when WA was discharged from LHSC in July 2016, he was back to his old self until he deteriorated again later in July. Furthermore, the three family members all testified that the wish WA vehemently expressed in July 2016 was merely a repetition of sentiments he had expressed repeatedly in the past. There was no reason to doubt that WA had been capable to consent to treatment when he had expressed his wish.

Did the evidence establish that WA's wish was applicable to the current circumstances?

Having established that WA had expressed a wish, while capable, regarding his ongoing treatment, I turned to the question of whether his wish was applicable to his circumstances at the time of the hearing.

Mr. Hodge's submission was that WA's wish was not applicable to his current circumstances because at the time he had expressed his wish, WA could not have foreseen all of the invasive mechanisms that were now in place to keep him alive. His wish had been expressed as an abstract concept without knowledge of the specific measures that would be needed to satisfy his

wish. When he last expressed his wish in July 2016, WA could not have contemplated the particular circumstances of his condition in June 2017, nor the fact that there was no hope of recovering his independence. Dr. Leasa stated his belief that if WA could speak now, he would not want to remain on life support because he was suffering inhumanely with no potential benefits from treatment. Dr. Leasa said that WA was in the process of dying, and they were only prolonging his death, rather than providing any meaningful life. WA could never be weaned off the ventilator and would never go home. He could not even have the speaking valve inserted for anymore due to the risk involved. Dr. Leasa believed that GA and HC were pinning their hopes on a miraculous recovery by WA, but this was unrealistic. WA would remain unable to communicate or interact with his environment until his death. Dr. Leasa felt that nobody would ever want to prolong their dying days in this manner, therefore WA's earlier stated wish could not be considered applicable to these circumstances. Dr. Leasa's proposed treatment was to stop dialysis and other life sustaining measures, to not perform CPR in case of cardiac arrest, to sustain breathing for comfort, ensure that WA was free of pain, and let nature take its course.

The testimony of the three family members challenged Dr. Leasa's opinion. They all believed that WA was still able to interact with them through facial expressions and minor gestures. They believed that WA expressed pleasure when family visited him, particularly his grandsons. They did not believe that WA experienced pain or suffering in his current state, and that he still derived some pleasure from living. The three family members concurred that if WA were able to express himself now, he would still repeat his wish to have everything done to extend his life. GA described his father as a "fighter" with an indomitable spirit to live, and he felt that WA had not given up on life even despite his circumstances; he could see it in WA's expression. GA stated that WA's will to live was not dependent on the hope of recovery or of going home. WA wanted to stay alive for the sake of life itself, and for sharing more precious moments with his family.

Ms. Circelli argued that in most cases when a person states a wish regarding end of life, the person has no idea what the circumstances will be. PAPC documents are often signed many years before a person takes ill or loses their capacity, and yet they are still honoured and

enforced. By its very nature, an end of life wish can rarely be specific to the precise circumstances that will arise.

In WA's case in fact he did have an idea of his circumstances when he last expressed his wish in July 2016. WA knew he had an intestinal obstruction causing chronic diarrhea as far back as 2010. He had been in and out of hospital several times since 2014 for dehydration and infections. In his admission of June 21-July 5, 2016 WA had been diagnosed with acute renal failure and pneumonia in addition to his ongoing diarrhea. He was 91 years old with a variety of serious medical conditions, and a fairly good idea that his health was failing fast. With that knowledge, he drummed it into his family members that he did not want a DNR order, and he wanted everything done to keep him alive as long as possible: "all the tubes and needles" as he put it.

GA and HC were questioned closely on their interpretation of WA's stated wish. They were asked if they believed their father's wish would include mechanical ventilation, kidney dialysis, feeding by tube, and care for a stage 4 bedsore. They both answered without hesitation that their father's wish encompassed all of these interventions, plus CPR to revive him in case of heart failure.

As Ms. Circelli noted, WA expressed his wish in contemplation of his failing health and anticipation of the very mechanisms that were now sustaining his life. I agreed with Ms. Circelli that WA knew enough about his impending condition when he last expressed his wish, and the wish was expressed with enough specificity, so as to be considered applicable to the circumstances he was in at the time of the hearing. I was satisfied by the evidence that the treatment he was currently receiving in the hospital was close to what WA had envisioned when he had expressed his wish. It was theoretically possible that at some point in the future WA's circumstances might change so drastically that his wish would no longer be applicable, but that was hypothetical and speculative. As of the time of the hearing, I found that WA's expressed wish was applicable to his current circumstances.

Conclusion

While deliberating I gave due regard to the Court of Appeal case of *Conway v. Jacques* 2002 ONCA 2333 which sets out the principle [at para. 31] 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.” The *Conway* case is distinguishable from this case on the facts, in that Mr. Conway’s condition had grown much worse than when he had expressed his wish for no treatment, and the treatment itself had improved so as to be incomparable to the previous treatment he had tried and rejected. As well, Mr. Conway’s prior capable wish was based on his erroneous belief that he did not suffer from mental illness.

In the case of WA, I was persuaded that WA’s wish as expressed to his family members in July 2016 and numerous times previously, was indeed applicable to his circumstances on the day of the hearing. He last uttered his wish in contemplation of his worsening health and a recent two-week hospital admission which began with suspected cardiac arrest. He compared himself to his brother George, who had requested a DNR, saying he (WA) did not want that. Therefore, I found that the reasoning in *Conway* was not applicable to this case.

I considered the purposes of the *HCCA* as set out in s.1. Among those purposes are: “to enhance the autonomy of persons for whom treatment is proposed”; “allowing incapable persons to request that a representative of their choice make decisions on their behalf concerning treatment”; “requiring that wishes with respect to treatment expressed by persons while capable be adhered to”; and “to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about treatment”. Section 21 of the *HCCA* provides force to the autonomy of individuals by making it clear that an incapable person’s prior capable wish is given paramount consideration, even above the person’s best interests, as they may be perceived by others. GA and HC poignantly said that if they were to consider WA’s best interests they might possibly make different decisions, but they felt bound to respect and honour WA’s clearly expressed capable wish, which was precisely their legal obligation under the *HCCA*. The whole

purpose of s. 21 of the *HCCA* is to give a voice to an incapable person by exploring what the person previously said they would want under the circumstances. Only if such a wish is not discernible, does the analysis move to considering the person's best interests. As I found that WA had expressed a wish while capable that was applicable to the circumstances, an inquiry into his best interests was moot.

RESULT

1. I found that WA was incapable to consent to the treatments in question.
2. I determined that, prior to being found incapable, WA had clearly expressed a wish to consent to resuscitation and ongoing life sustaining treatments.
3. I determined that WA's prior capable wish was applicable to his present circumstances.
4. I directed GA, as WA's attorney for personal care, to continue consenting to resuscitation and ongoing life sustaining treatments for WA.

Dated: June 26, 2017

Nina Lester

Nina Lester, Presiding Member