Wills & Estates
Winter Term 2018

Lecture Notes No. 1

SUBSTITUTE DECISION-MAKING

- A substitute decision-maker is of three types: an "Attorney" under a "Continuing Power of Attorney", a court-appointed Guardian, or a "Statutory Guardian". All have the same obligations. All owe fiduciary obligations.

- In the case of a power of attorney granted by a capable person in respect of property management at large or specific transactions in particular while he or she remains capable, this is more a form of traditional agency.

- The *Substitute Decisions Act 1992* sits alongside the *Mental Health Act* and the *Health Care Consent Act 1996*. Both deal, in part, with who and when one person may make decisions for another who is incapable of doing so.

1. Capacity and Incapacity

Capacity is a legal construct and we presume that a person has capacity.

The *Substitute Decisions Act, 1992* provides:

> 6. A person is incapable of managing property if the person is not able to understand information that is relevant to making a decision in the management of his or her property, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.
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> …
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> 45. A person is incapable of personal care if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

Calvert (Litigation Guardian Of) v. Calvert
(1997), 32 O.R. (3d) 281 (Ontario S.C.J.)

Mr. and Mrs. Calvert were each married prior to their marriage to each other, and each had a child from the first marriage. They entered into a marriage contract before the marriage. Mr. Calvert came into considerable funds during the course of the marriage, although the couple continued to live frugally. Mrs. Calvert was later diagnosed with Alzheimer's Disease. Mrs. Calvert brought an action for divorce through her litigation guardian; Mr. Calvert defended on the basis that his wife lacked capacity to separate and divorce.

Benotto J.:

> 53 There are three levels of capacity that are relevant to this action: capacity to separate, capacity to divorce and capacity to instruct counsel in connection with the divorce.
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> 54 Separation is the simplest act, requiring the lowest level of understanding. A person has to know with whom he or she does or does not want to live. Divorce, while still simple, requires a bit more understanding. It requires the desire to remain separate and to be no longer married to one's spouse. It is the undoing of the contract of marriage.
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> 55 The contract of marriage has been described as the essence of simplicity, not requiring a high degree of intelligence to comprehend: Park, supra at 1427. If marriage is simple, divorce must be equally simple. The American Courts have recognized that the mental capacity required for divorce is the same as required for entering into marriage.
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> 56 There is a distinction between the decisions a person makes regarding personal matters such as where or with whom to live and decisions regarding financial matters. Financial matters require a higher level of understanding. The capacity to instruct counsel involves the ability to understand financial and legal issues. This puts it significantly higher on the competency hierarchy. It has been said that the highest level of capacity is that required to make a will. (I note that Mr. Bimbaum felt that, in August 1994, he would have taken instructions for a will but for Dr. Hogan's concern about her ability to instruct counsel.) While Mrs. Calvert may have lacked the ability to instruct counsel, that did not mean that she could not make the basic personal decision to separate and divorce.
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> 57 The courts are slow to take away a person's right to decide. This is reflected in the low threshold the courts have set for the determination of capacity. Persons have been held to have capacity who suffer from schizophrenia; delusions; and other serious mental problems. A person who suffers from a cognitive impairment is competent as long as the act in question takes place during a lucid interval.

2. Capacity to Grant a Continuing Power of Attorney

The *Substitute Decisions Act, 1992* provides:

> 8. (1) A person is capable of giving a continuing power of attorney if he or she,
>
> (a) knows what kind of property he or she has and its approximate value;
> (b) is aware of obligations owed to his or his or her dependants;
> (c) knows that the attorney will be able to do on the person's behalf anything in respect of property that the person could do if capable,

except make a will, subject to the conditions and restrictions set out in the power of attorney;

(d) knows that the attorney must account for his or her dealings with the person's property;

(e) knows that he or she may, if capable, revoke the continuing power of attorney;

(f) appreciates that unless the attorney manages the property prudently its value may decline; and

(g) appreciates the possibility that the attorney could misuse the authority given to him or her.

…

47. (1) A person is capable of giving a power of attorney for personal care if the person,

(a) has the ability to understand whether the proposed attorney has a genuine concern for the person's welfare; and

(b) appreciates that the person may need to have the proposed attorney make decisions for the person.

3. Formalities

See SDA, s.10 re execution and attestation requirements.

4. Capacity Assessment

Abrams v. Abrams
2008 CanLII 67884 (Ont. S.C.J.)

Strathy J.:

Analysis of the Issues

47 Before examining the issues and the submissions of counsel, some general observations are in order. First, the purpose of the SDA is to protect the vulnerable: See *Stickells Estate v. Fuller*, 24 E.T.R. (2d) 25, [1998] O.J. No. 2940 (Ont. Gen. Div.). **In *Phelan, Re*, 29 E.T.R. (2d) 82, [1999] O.J. No. 2465 (Ont. S.C.J.), Madam Justice Kitely said, at paragraphs 22-23:**

> **The Substitute Decisions Act is a very important legislative policy. It recognizes that persons may become temporarily or permanently incapable of managing their personal or financial affairs. It anticipates that family members or others will identify when an individual has lost such capacity. It includes significant evidentiary protections to ensure that declarations of incapacity are made after notice is given to all those affected or potentially affected by the declaration and after proof on a balance of probabilities has been advanced by professionals who attest to the incapacity. It requires**

> **that a plan of management be submitted to explain the expectations. It specifies ongoing accountability to the court for the implementation of the plan and the costs of so doing.**
>
> **The alternative to such a legislative framework is that incapable persons and their families might be taken advantage of by unscrupulous persons. The social values of protecting those who cannot protect themselves are of "superordinate importance".**

48 While Justice Kitely was making those observations in the context of a request for a sealing order, they highlight the nature and importance of proceedings of this kind. These proceedings are not a *lis* or private litigation in the traditional sense. The interests that these proceedings seek to balance are not the interest of litigants, but the interests of the person alleged to be incapable as against the interest and duty of the state to protect the vulnerable.

49 The SDA contains a number of provisions that indicate that the dignity, privacy and legal rights of the individual are to be assiduously protected. For example:

> (a) there is a presumption of capacity (section 2);
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> (b) a person whose capacity is in issue is entitled to legal representation (section 3);
>
> (c) a person alleged to be incapable is entitled to notice of the proceedings (ss. 27(4) and ss. 62(4));
>
> (d) the court must not appoint a guardian if it is satisfied that the need for decisions to be made can be met by an alternative course of action that is less restrictive of the person's decision making rights (ss. 22(3) and ss. 55(2));
>
> (e) in considering the choice of guardian for property or personal care, the court is to consider the wishes of the incapable person (cl. 24(5)(b) and cl. 57(3)(b));
>
> (f) subject to exceptions, a person has a right to refuse an assessment, other than an assessment ordered by the court (section 78).

50 In considering whether to order an assessment, whether on motion or on its own initiative, a court must balance the affected party's fundamental rights against the court's duty to protect the vulnerable. The appointment of an assessor to conduct what is essentially a psychiatric examination is a substantial intervention into the privacy and security of the individual. As Mr. Justice Pattillo said in *Flynn v. Flynn* (December 18, 2007), Doc. 03-66/07 (Ont. S.C.J.): "[a] capacity assessment is an intrusive and demeaning process."

51 There is little authority to guide me on the circumstances in which the court should order a further assessment where, as here, the individuals have voluntarily submitted to assessments by a qualified assessor. In *Forgione v. Forgione*, [2007] O.J. No. 2006 (Ont. S.C.J.), a second assessment was ordered where the first assessment had not been carried out by a qualified capacity assessor and the report that had been prepared was not in accordance with the Guidelines for Conducting Assessments of Capacity. There were, as well, serious questions about the capacity and vulnerability of the person to be assessed, none of which had been mentioned in the earlier report.

52 In *Mesesnel (Attorney of) v. Kumer*, [2000] O.J. No. 1897 (Ont. S.C.J.), Justice Greer ordered a second assessment. In that case, submissions were made by counsel on behalf of the affected individual, that he did not want to endure another assessment. It was argued that the person's autonomy should be respected, given his advanced age of 81 years. Justice Greer ordered the additional assessment on a number of grounds, including the failure of the first physician to do what he had been asked to do; personal criticisms of the attorney which raised suspicions of bias which tainted the doctor's reports; and failure to follow standard tests and procedures in the report. It is noteworthy that in that case the applicant had filed a letter from another physician, who was familiar with the person's health and mental status, setting out issues that were not properly explored in the first report.

53 In my view, in deciding whether to order an assessment in this case, particularly as there are existing assessments of Philip and Ida, I should consider and balance the following factors to determine whether, in all the circumstances, the public interest and the interests of Philip and Ida, require that an assessment take place and justify the intrusion into their privacy:

(a) the purpose of the SDA, as discussed above;

(b) the terms of section 79, namely:

(i) the person's capacity must be in issue; and

(ii) there are reasonable grounds to believe that the person is incapable;

(c) the nature and circumstances of the proceedings in which the issue is raised;

(d) the nature and quality of the evidence before the court as to the person's capacity and vulnerability to exploitation;

(e) if there has been a previous assessment, the qualifications of the assessor, the comprehensiveness of the report and the conclusions reached;

(f) whether there are flaws on the previous report, evidence of bias or lack of objectivity, a failure to consider relevant evidence, the consideration of irrelevant evidence and the application of the proper criteria;

> **(g) whether the assessment will be necessary in order to decide the issue before the court;**
>
> **(h) whether any harm will be done if an assessment does not take place;**
>
> **(i) whether there is any urgency to the assessment; and**
>
> **(j) the wishes of the person sought to be examined, taking into account his or her capacity.**

Vanier v. Vanier
2017 ONCA 561 (Ont. C.A.)

This was a contested guardianship case in relation to a 90 year-old lady. The litigants were her two sons and the issues included the validity of a Continuing Power of Attorney made in favour of one son replacing an existing CPOAP naming the two sons jointly and severally. The donor participated in the proceedings to defend the CPOAP. One son alleged that the CPOAP was procured by undue influence. Thus the question became the standard applicable to the application of undue influence to the making of such documents. That is, whether the *inter vivos* approach (looking to presumptions to shift the burden to the party defending the document in certain cases) or the testamentary approach (requiring the party alleging undue influence to provide it) applied. After noting that the issue was presented improperly for the first time on appeal, Epstein J.A. held:

> [38] Raymond submits that the test relied upon by the motion judge, set out above - the test for "testamentary undue influence" - is not the appropriate test for the granting of a power of attorney. The test the motion judge ought to have used is the test for inter vivos equitable undue influence, either actual or presumed. The effect of the inter vivos test would be to shift the onus to Pierre to prove that Rita signed the 2015 CPOAP, willingly and without undue influence.
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> [39] **Raymond relies on the decision of the House of Lords in *Royal Bank of Scotland v. Etridge (No. 2)*, [2001] UKHL 44, that explains how equity identifies two forms of unacceptable conduct in the context of inter vivos transactions. One involves overt acts of improper pressure or coercion (actual undue influence). The other arises out of a relationship between two people, where one acquires a measure of influence or ascendancy over another, of which the ascendant person takes unfair advantage. The law has long recognized the need to prevent abuse of influence in these "relationship" cases despite the absence of evidence of overt acts of persuasive conduct (presumed undue influence).**
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> …
>
> [50] However, I need not decide whether it is in the interests of justice for this issue to be dealt with, as the inter vivos equitable undue influence test has no application on the facts of this case. **As noted by the House of Lords in *Eltridge*, at paras. 21-22, there are two prerequisites to the**

evidential shift in the burden of proof from the complainant (Raymond, arguing on behalf of Rita) to the other party (Pierre). First, the complainant reposed trust and confidence in the other party. Second, the transaction is not readily explicable by the parties' relationship. This second part of the test has been held by the House of Lords to mean that the evidence must support a finding that the transaction is "immoderate and irrational".

[51] In oral argument, Pierre candidly conceded the first part of the test, in other words that Rita reposed trust and confidence in him. However, he submits that Raymond cannot meet the second part, in other words show that the 2015 CPOAP was "immoderate and irrational".

[52] I agree. There is nothing "immoderate or irrational" about the 2015 CPOAP. The record supports a finding that Rita's decision to give the power of attorney to one son over the other was an emotionally difficult but totally rational decision. Rita was very clear in what she said to the police and to Ms. Silverston, none of which evidence was challenged. She knew her money was out of reach. She needed her funds to pay basic expenses such as rent. She understood that Raymond was interfering with her access to the fund and that the solution had to lie with Pierre.

[53] Moreover, far from being "immoderate", the 2015 CPOAP conferred little, if any, benefit on Pierre. He was left with the same power as he had under the 2013 CPOAP. The minor "benefit", if one could call it that, is that the 2015 CPOAP protected Pierre from the stress and inconvenience of Raymond's being in a position to interfere with Rita's finances.

[54] For these reasons, I am of the view that the motion judge was fully justified in applying the testamentary undue influence test.

[55] I add, that even if the inter vivos equitable undue influence test were applicable, the record does not support a finding of undue influence.

[Emphasis added.]

While Epstein J.A. did not rule out the use of the *inter vivos* approach, it would appear that the normal disposition of the issue will be through the proof of actual undue influence. One expects that the issue will return before the Court of Appeal sooner rather than later.

5. Court-Appointed Guardians and POA Litigation

Chu v. Chang
2010 ONSC 294 (Ont. S.C.J.)

Read this case for the depth of the factual analysis by which the Court determines whether a guardianship should be terminated and the need for an accounting.

6. Personal Care

Rasouli (Litigation Guardian Of) v. Sunnybrook Health Sciences Centre
[2013] 3 SCR 341 (S.C.C.)

McLachlin C.J.C.

> **G. Resolving Disagreements Over Withdrawal of Life Support**
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> 77 Having rejected the physicians' arguments, it follows that the consent regime imposed by the HCCA applies in this case. I earlier outlined that regime. At this point, it may be useful to discuss in greater depth the role of the substitute decision-maker, health practitioners and the Board in cases like this.
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> **78 To recap, the HCCA** [Health Care Consent Act] **is a carefully tailored statute. It deals with patients capable of consent and patients who no longer have the power to consent. It seeks to maintain the value of patient autonomy — the right to decide for oneself — insofar as this is possible. This is reflected in the consent-based structure of the Act. If the patient is capable, she has the right to consent or refuse consent to medical treatment: s. 10(1)(a). If the patient is incapable, the HCCA transfers the right of consent to a substitute decision-maker, often next of kin (s. 10(1)(b)), who is required to act in accordance with the patient's declared applicable wishes or failing that, the patient's best interests: s. 21. Finally, it provides that a physician may challenge a substitute decision-maker's consent decision by application to the Board: ss. 35 to 37. The physician may make submissions to the Board regarding the medical condition and interests of the patient. If the Board finds that the substitute decision-maker did not comply with the HCCA, it may overrule the substitute decision-maker and substitute its own opinion in accordance with the statute: s. 37(3). To be clear, this means that, even in life-ending situations, the Board may require that consent to withdrawal of life support be granted.**
>
> 79 Under the HCCA, the substitute decision-maker does not have carte blanche to give or refuse consent. He or she must comply with the requirements of s. 21 of the Act, which contemplates two situations. The first is where the substitute decision-maker knows of a prior expressed wish by the patient which is applicable to the circumstances. The second is where

there is no such wish, in which case the substitute decision-maker "shall act in the incapable person's best interests".

(1) Prior Expressed Wishes

80 If the substitute decision-maker knows of a prior wish regarding treatment that the patient expressed when capable and over 16 years old, and that is applicable in the circumstances, the wish must be followed: s. 21(1). This reflects the patient's autonomy interest, insofar as it is possible.

81 While the HCCA gives primacy to the prior wishes of the patient, such wishes are only binding if they are applicable to the patient's current circumstances. This qualification is no mere technicality. As the Ontario Court of Appeal held in *Conway v. Jacques* (2002), 59 O.R. (3d) 737 (Ont. C.A.), at para. 31:

> **... 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.**

82 Needless to say, where an incapable patient has expressed a prior wish that life support not be withdrawn, the intended meaning and scope of the wish must be carefully considered: see Fleming, at p. 94. The question is whether, when the wish was expressed, the patient intended its application in the circumstances that the patient now faces: see *Conway*, at para. 33; *Scardoni*, at para. 74. Changes in the patient's condition, prognosis, and treatment options may all bear on the applicability of a prior wish: Conway, at paras. 37-38. For example, had Mr. Rasouli expressed a prior wish regarding life support, his substitute decision-maker would have to consider whether, when the wish was expressed, Mr. Rasouli intended the wish to apply if he were in a permanent vegetative state, with recovery extremely improbable according to medical evidence, and facing the health complications associated with long-term provision of life support.

83 A prior wish need not identify every possible future development in order to be applicable: Scardoni, at para. 74; S. (K.M.), Re [2007 CarswellOnt 4883 (Ont. Cons. & Capacity Bd.)], 2007 CanLII 29956. However, a wish that is unclear, vague, or lacks precision may be held inapplicable to the circumstances. On this basis, the Board has found there were no prior wishes relating to life supportP applicable to the existing circumstances in numerous cases: D. (D.), Re [2013 CarswellOnt 4211 (Ont. Cons. & Capacity Bd.)], 2013 CanLII 18799; P. (D.), Re [2010 CarswellOnt 7848 (Ont. Cons. & Capacity Bd.)]; B. (E.), Re [2007 CarswellOnt 745 (Ont. Cons. & Capacity Bd.)], 2006 CanLII 46624; G, Re; E., Re [2009 CarswellOnt 3258 (Ont. Cons. & Capacity Bd.)], 2009 CanLII 28625; J. (H.), Re [2003 CarswellOnt 8244 (Ont. Cons. & Capacity Bd.)], 2003 CanLII 49837. I have been unable to locate any case in which there was a prior

expressed wish opposing withdrawal of life support that was held to be applicable and therefore binding in the circumstances.

84 If it is unclear whether a prior wish is applicable, the substitute decision-maker or physician may seek directions from the Board: s. 35. Alternately, if the substitute decision-maker acts on a prior wish that the physician believes is not applicable, the physician may challenge the consent decision before the Board: s. 37. The physician's submissions on the patient's condition, prognosis, and any adverse effects of maintaining life support will be relevant to the Board's assessment of applicability.

85 In addition, either the substitute decision-maker or physician may apply to the Board for permission to depart from prior wishes to refuse treatment: s. 36. The Board may grant permission where it is satisfied that the incapable person, if capable, would probably give consent because of improvement in the likely result of the treatment since the wish was expressed: s. 36(3).

86 I note that the HCCA also provides that the substitute decision-maker is not required to comply with an expressed prior wish if "it is impossible to comply with the wish": s. 21(1)2. This is not raised on the facts of this appeal, and I consider it no further.

(2) The Best Interests of the Patient

87 If the substitute decision-maker is not aware of an expressed prior wish of the patient or if the wish is not applicable to the circumstances, the substitute decision-maker must make her consent decision based on the best interests of the patient, according to the criteria set out in s. 21(2). These criteria include the medical implications of treatment for the patient, the patient's well-being, the patient's values, and any prior expressed wishes that were not binding on the substitute decision-maker. This legislative articulation of the best interests of the patient aims at advancing the values that underpin the HCCA: enhancing patient autonomy and ensuring appropriate medical treatment.

88 The substitute decision-maker is not at liberty to ignore any of the factors within the best interests analysis, or substitute her own view as to what is in the best interests of the patient. She must take an objective view of the matter, having regard to all the factors set out, and decide accordingly. This is clear from the mandatory wording of the opening portion of s. 21(2): the decision-maker "shall take into consideration" the listed factors. The need for an objective inquiry based on the listed factors is reinforced by s. 37, which allows the decision of the substitute decision-maker to be challenged by the attending physician and set aside by the Board, if the decision-maker did not comply with s. 21. The intent of the statute is to obtain a decision that, viewed objectively, is in the best interests of the incapable person.

89 The first consideration under s. 21(2), heavily relied on by Ms. Salasel in this case, concerns the values and beliefs of the incapable person. Section 21(2)(a) provides that the substitute decision-maker must consider the values and beliefs that the incapable person held when capable and that the substitute decision-maker believes that the incapable person would still act on if capable. Here, Ms. Salasel argues that sustaining life as long as possible accords with the religious beliefs of Mr. Rasouli, and that as a result he would not have consented to the removal of life support.

90 The second consideration relates to known wishes of the incapable person that were not binding on the substitute decision-maker under s. 21(1)1. For example, wishes expressed when a person was under the age of 16 or when incapable do not bind a substitute decision-maker, but must be taken into consideration in this stage of the best interests analysis.

91 Third, in addition to considering the values and beliefs of the patient and any relevant wishes, s. 21(2)(c) requires that the substitute decision-maker consider four factors that relate to the impact of the treatment on the patient's condition, well-being, and health. This stage of the best interests analysis focuses on the medical implications of the proposed treatment for the patient. The attending physician's view of what would medically benefit the patient must be taken into account.

92 The first factor asks whether receiving the treatment is likely to improve the patient's condition or well-being, prevent deterioration of the person's condition or well-being, or reduce the extent or rate of the deterioration of the person's condition or well-being: s. 21(2)(c)1. In this case, the inquiry must determine whether removing life support would improve, prevent deterioration of, or reduce the extent or rate of deterioration of, Mr. Rasouli's condition or well-being. The physicians argue that artificially prolonging Mr. Rasouli's life will lead to health complications such as bedsores, respiratory infections, and organ failure — a scenario that can be avoided if life support is removed. On the other hand, Ms. Salasel argues that new evidence and evaluation suggest that Mr. Rasouli's condition may improve in the future, militating against removal of life support.

93 The second factor requires the substitute decision-maker to consider whether, in the absence of the proposed treatment, the incapable person's condition or well-being is likely to improve, remain the same or deteriorate: s. 21(2)(c)2. In this case, the inquiry is into the likely medical outcomes for Mr. Rasouli if life support is not withdrawn. The decision-maker must cast her mind into the future and ask what the patient's condition will be in one year, five years, or ten years.

94 The third factor requires the substitute decision-maker to consider risks of harm associated with the treatment and weigh whether the benefits from the treatment will outweigh those risks: s. 21(2)(c)3. This factor is particularly important in cases where the substitute decision-maker must decide whether to go ahead with a risky procedure, like

high-risk surgery, that while offering some hope, could worsen the patient's situation. In this case, the substitute decision-maker must consider the benefits of removing life support, such as avoidance of protracted physical deterioration from bedsores, infections and organ deterioration ultimately leading to death, against the risks, which quite plainly are the hastening of death and the loss of whatever chance of recovery Mr. Rasouli has according to medical evidence.

95 The fourth factor requires the substitute decision-maker to consider alternative courses of treatment — whether less intrusive or restrictive treatment would be as beneficial as the treatment proposed: s. 21(2)(c)4. In a case such as this, the question is whether maintaining life support would be less intrusive or restrictive than its withdrawal, and if so, whether maintaining life support would be more beneficial to the patient than withdrawal.

96 As I see it, this review of s. 21(2) reveals that although a patient's beliefs and prior expressed wishes are mandatory considerations, there is no doubt that the medical implications of a proposed treatment will bear significant weight in the analysis.

97 Where physicians and substitute decision-makers disagree about whether withdrawal of life support would be in the best interests of the patient, the HCCA provides the procedure for resolving this conflict. Under s. 37, the health care practitioner may apply to the Board to have the decision of the substitute decision-maker set aside on the ground that it is not in the best interests of the incapable person, having regard to the factors set out in s. 21(2) of the Act. This is an important avenue of recourse for physicians who believe that life support can no longer be ethically administered because it is not in the best interests of the patient to do so. The Board must duly consider the physician's professional opinion and submissions on what would be of medical benefit to the patient.

98 If the Board agrees that the substitute decision-maker did not act in the best interests of the patient, it may substitute its own opinion for that of the substitute decision-maker: s. 37(3). Alternatively, if the Board concludes that the substitute decision-maker did act in the best interests of the patient, it can affirm the decision of the substitute decision-maker. In making these determinations, the Board must objectively apply the same criteria that substitute decision-makers are required to consider under s. 21. The Board is well placed to make a determination of whether treatment is in the best interests of the patient, in light of the statutory objectives of enhancing patient autonomy and ensuring appropriate medical care. This was observed by the Ontario Court of Appeal in M. (A.) v. Benes (1999), 46 O.R. (3d) 271 (Ont. C.A.):

A case will come before the Board only when the health practitioner disagrees with the S.D.M.'s application of the best interests test under s. 21(2). The Board will then have before it two parties who disagree about the application of s. 21: the S.D.M., who may have better knowledge than the

health practitioner about the incapable person's values, beliefs and non-binding wishes; and the health practitioner, who is the expert on the likely medical outcomes of the proposed treatment. The disagreement between the S.D.M. and the health practitioner potentially creates tension and the Act recognizes this by providing for a neutral expert board to resolve the disagreement. Indeed, after hearing submissions from all parties, the Board is likely better placed than either the S.D.M. or the health practitioner to decide what is in the incapable person's best interests. [para. 46]

99 The Board must apply a standard of correctness in reviewing the decision of the substitute decision-maker: Benes, at para. 36; Scardoni, at para. 36. The wording of s. 37, which provides for full representation and gives the Board the right to substitute its decision for that of the substitute decision-maker, indicates that the Board must consider the matter de novo. The critical nature of the interests at stake support the Board's obligation to review the decision of the substitute decision-maker on a correctness standard.

100 The legislature has given the Board the final responsibility to decide these matters. This is not to say that the courts have no role to play. Board decisions are subject to judicial review. This mechanism for court oversight ensures that the Board acts within its mandate and in accordance with the Constitution.

101 Over the past 17 years, the Board has developed a strong track record in handling precisely the issue raised in this case.

102 In some cases, the Board has upheld the decisions of substitute decision-makers to refuse withdrawal of life support as being in the best interests of the patient: W. (D.), Re [2011 CarswellOnt 2312 (Ont. Cons. & Capacity Bd.)], 2011 CanLII 18217; S. (S.), Re [2011 CarswellOnt 816 (Ont. Cons. & Capacity Bd.)], 2011 CanLII 5000; P. (D.), Re. In others, it has reversed the decision of the substitute decision-maker and required consent to be given for the withdrawal of life support: K. (A.), Re; G. (E.J.), Re; N., Re, 2009 CarswellOnt 4748 (Ont. Cons. & Capacity Bd.). The particular facts of each case determine whether withdrawal of life support is in the best interests of the patient.

103 Bringing its expertise to the issue, the Board's decisions may be expected to bring consistency and certainty to the application of the statute, thereby providing essential guidance to both substitute decision-makers and health care providers in this difficult area of the law.

…

I. Summary

116 I conclude that the following steps apply under the HCCA in a case such as this, where the substitute decision-maker and the medical health care providers disagree on whether life support should be discontinued.

1. The health practitioner determines whether in his view continuance of life support is medically indicated for the patient;

2. If the health practitioner determines that continuance of life support is no longer medically indicated for the patient, he advises the patient's substitute decision-maker and seeks her consent to withdraw the treatment;

3. The substitute decision-maker gives or refuses consent in accordance with the applicable prior wishes of the incapable person, or in the absence of such wishes on the basis of the best interests of the patient, having regard to the specified factors in s. 21(2) of the HCCA;

4. If the substitute decision-maker consents, the health practitioner withdraws life support;

5. If the substitute decision-maker refuses consent to withdrawal of life support, the health practitioner may challenge the substitute decision-maker's refusal by applying to the Consent and Capacity Board: s. 37;

6. If the Board finds that the refusal to provide consent to the withdrawal of life support was not in accordance with the requirements of the HCCA, it may substitute its own decision for that of the substitute decision-maker, and permit withdrawal of life support.

III. Conclusion

117 Applying the HCCA in the manner just discussed, we arrive at the following conclusions.

118 The appellant physicians, having determined that in their view Mr. Rasouli should be removed from life support, were obliged to seek Ms. Salasel's consent to the withdrawal. Since Mr. Rasouli had not expressed a wish within the meaning of s. 21(1)1, Ms. Salasel was required to determine whether removal of life support was in Mr. Rasouli's best interests, having regard to the factors set out in s. 21(2) of the Act.

119 If the appellant physicians do not agree that maintaining life support for Mr. Rasouli is in his best interests, their recourse is to apply to the Board for a determination as provided by s. 37(1) of the HCCA.

120 When the application is brought, it will be for the Board to determine whether Ms. Salasel's refusal to provide consent to the withdrawal of life support was in Mr. Rasouli's best interests, within the meaning of s. 21(2) of the HCCA. If the Board is of the opinion it was not, it may substitute its decision for that of Ms. Salasel, and clear the way for removal of Mr. Rasouli's life support.

121 It follows that I would dismiss the appeal. I would also dismiss the motions to adduce fresh evidence on the appeal to this Court, without prejudice to the Board receiving any evidence it deems relevant on the hearing before it.

122 This being a matter of public interest, I would not award costs.