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

TO 07-1423, 1424

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

AND IN THE MATTER OF
**Mrs. D.H.**
A Patient at
St. Michael's Hospital
Toronto, Ontario

# REASONS FOR DECISION

## PURPOSE OF THE HEARING

Mrs. D.H. was a voluntary psychiatric patient at this facility. She was medically stable and ready for discharge but her Attorney for Personal Care and her attending physician were both concerned that she was unsafe living alone in her own home. Mrs. D.H.'s Power of Attorney expressed a wish regarding her living arrangements that, they were concerned, interfered with Mrs. D.H.'s admission to a care facility, which was her physician's recommendation. Ms T.C. therefore applied to the Board for directions to determine whether the wish expressed in Mrs. D.H.'s Power of Attorney was a capable wish applicable to her circumstances (the Form D Application) and in the alternative to depart from the wish (the Form E Application).

Applications like this usually trigger a "deemed Hearing," which requires the Board to review the finding of incapacity. However, as Mrs. D.H.'s capacity to make her own admission decision was reviewed by the Board and the finding confirmed within the six months preceding Hearing, the deemed Hearing was unnecessary. (*Health Care Consent Act*, s. 54.1)

DATE OF THE HEARING

July 31st, 2007

PARTIES

Mrs. D.H., the incapable person
Ms T.C., the Applicant
Ms Edith Lo, on behalf of Toronto Central Community Care Access, the person responsible for authorizing admission to a care facility.

PANEL MEMBERS

Mr. M. Handelman, Vice Chair, Senior Lawyer Member

APPEARANCES

For Mrs. D.H., Ms A. Sultan, Lawyer
For Ms T.C., Ms. K. Whaley, Lawyer

RECORD

(a) Form D under The *Health Care Consent Act*, the Application for Directions;
(b) Form E under The *Health Care Consent Act*, the Application to Depart from Wishes;
(c) The Notice of Hearing respecting the Form D Application, and;
(d) The Notice of Hearing respecting the Form E Application.

EXHIBITS

1. Ms Whalley's document brief, on behalf of Ms T.C..
2. Ms Sultan's document brief, on behalf of Mrs. D.H..
3. Two letters from Mr. M. Moses, the solicitor who prepared Mrs. D.H.'s Power of Attorney for Personal Care.

THE EVIDENCE

These people gave evidence at the Hearing:

- Dr. D. Robertson, Mrs. D.H.'s attending physician and the evaluator who found Mrs. D.H. incapable of consenting to admission to a care facility;
- Ms T.C., the Applicant, and;
- Mr. M. Moses, the solicitor who prepared Mrs. D.H.'s Power of Attorney for Personal Care.

At the time of this Hearing, Mrs. D.H. was 67 year old. She was divorced and retired from teaching. Mrs. D.H. had a forty year history of mental disorder that, when treated, did not interfere significantly with her career or social interactions. However, when untreated, Mrs. D.H.'s disorder resulted in her becoming suspicious, distrustful and paranoid.

The Board reviewed the finding that Mrs. D.H. was incapable of consenting on her own behalf to admission to a care facility at the same time the Board reviewed a finding that Mrs. D.H. was incapable of managing her property. That Hearing took place on June 11th, 2007. The Board upheld both findings of incapacity. In his Reasons for Decision [Board file TO-07-0754] the presiding Member quoted at length from a clinical summary Mrs. D.H.'s attending physician prepared for that Hearing and at page 18 of his Reasons accepted that evidence, neatly summarizing Mrs. D.H.'s condition and situation:

> Mrs. D.H. suffered from mental disorder and medical problems for many years. She had functioned successfully for most of that time though it appeared her situation deteriorated over the past 10 years. She had hospitalizations in 2002, 2005 and again in 2007. As reported by her daughter and shown in the clinical record, Mrs. D.H. had borderline functioning since 2002 and efforts to provide support in the community for her met with lessening degrees of success.

> This decline was in Drs. Robertson's and Nguyen's view a direct result of Mrs. D.H.'s schizophrenia. The mental disorder caused her thinking to be disordered and disorganized and impaired her executive decision-making abilities. Her capacity to problem solve was greatly diminished.
> (Mrs. D.H.'s) condition was greatly exacerbated by the paranoid delusions which accompanied her psychosis. Mrs. D.H. was distrustful of almost everyone who came in contact with her including care givers, her own staff/servants, the pharmacist, the concierge and superintendent at her building and the people at the bank. If such persons were not stealing from her, they were trying to poison her. This led her to decline assistance, refuse to cooperate with discharge plans and medication regimens and withdraw from others.
> Mrs. D.H. needed a structured setting where she would receive assistance with her medications and care needs. This was established by the fact she had improved in the hospital setting with attenuation of her psychosis, improved behaviour and communication and better control of her medical conditions via medication and diet.
> ...
> Mrs. D.H. was oblivious to the extent of her care needs. She was largely non-compliant with her medication regimen, failed to eat properly and maintain her diabetic diet and placed herself at great risk... The seriousness of the risk was illustrated by the incident where she changed the locks to her apartment and the daughter required police assistance to gain entry, only to find Mrs. D.H. in a deplorable state.

That "deplorable state" resulted in Mrs. D.H.'s current admission to this facility, which began April 11th 2007. The only reason Mrs. D.H. remained in hospital was that she wished to return home whilst her daughter and treatment team thought that was unsafe. The reference in the first paragraph of this quote to the lessening degrees of success supporting Mrs. D.H. in the community was the result of Mrs. D.H.'s paranoia. She could afford to hire people to assist her in the community but she became suspicious of them. None of the people she hired lasted longer than a month. Ms T.C. and Dr. Robertson concluded that if Mrs. D.H. returned to her home this cycle would repeat.

Mrs. D.H.'s daughter was her substitute decision-maker on the authority of Mrs. D.H.'s Power of Attorney for Personal Care. Mrs. D.H. named Ms T.C. and Ms T.C.'s brother her Attorneys, but Ms T.C.'s brother could not be found and was therefore unavailable to give or refuse consent to the admission. That left Ms T.C. to consent, which she wanted to do.

However, Ms T.C.'s decision had to be in accordance with the principles for consenting set out in s. 42 of The *Health Care Consent Act*, set out below. The first principle is the obligation, unless it is impossible to respect the wish, of giving or refusing consent in accordance with any previously expressed capable wishes applicable to the circumstances. The problem was the "Conditions and Restrictions" section of Mrs. D.H.'s Power of Attorney for Personal Care, which Mrs. D.H. executed on May 24th, 2006. The section read,

a. This power of attorney for personal care does not provide any authority to my attorney(s) to place me in any mental home/institution nor in any mental ward of any hospital or similar institution.
b. Should I have any illness, including but not limited to any mental illness, then this power of attorney does authorize my children as my attorneys to hire someone to attend to my needs at my residence, during such illness.

Mr. Moses prepared this Power of Attorney for Personal Care. He first met Mrs. D.H. in February 2005, when she attended at his office without an appointment to discuss a will. Ms T.C. was with her. Mr. Moses thought Mrs. D.H. "seemed a bit strange," but was aware of her finances and situation and knew what she wanted.

Mrs. D.H. returned to Mr. Moses' office a few days later. Though he believed Mrs. D.H. to be capable of executing a testamentary document, he suggested Mrs. D.H. obtain an opinion as to her capacity from a physician in case someone subsequently challenged the will, but Mrs. D.H. did not want to do that. Some time shortly after her second appointment, or possibly during it, Mrs. D.H. executed a will and Powers of Attorney for Property and Personal Care.

Mrs. D.H. returned to Mr. Moses' office on January 11th 2006. She wanted to change her Power of Attorney for Personal Care. She told Mr. Moses she had been detained in a mental institution and did not want that to happen again. In the months following that visit, Mrs. D.H. instructed Mr. Moses to make various changes to her Power of Attorney. As noted, she executed it on May 24th 2006. Mr. Moses drafted the provisions set out above. He said that in doing so he followed Mrs. D.H.'s wishes and intent.

Mr. Moses said Mrs. D.H. was clear in what she wanted in her Power of Attorney. However, his notes did not indicate and he could not remember if a nursing home or care facility came into the discussion—and Dr. Robertson said Mrs. D.H. would have to be on the locked ward of such a facility. However, Mr. Moses said that if Mrs. D.H. had used the term "nursing home," he would have put that term into the document as well. He could not recall if use of the word "similar institution" was intended to cover the locked wards of care facilities, but did recall that Mrs. D.H. did not wish to be locked up again.

Ms T.C. recognized her mother's Chinese tradition of caring for the elderly at home, a value that was important to Mrs. D.H.. However, there was also evidence that Mrs. D.H. previously contemplated admission to a care facility in the broadest sense of the phrase. She and Ms T.C. went to Boston some years earlier, in part to look at nursing homes, but Mrs. D.H. could not find one she liked. Mrs. D.H. did have a connection to Boston—she had some friends there from her university days in that city.

Mr. Moses took detailed notes of his interviews with Mrs. D.H.. He was also alert to the issue of her capacity since (in his words) she "seemed a bit strange." Mr. Moses concluded that Mrs. D.H. was aware, knew her circumstances and knew what she was doing. Her intent was clear and Mr. Moses thought Mrs. D.H.'s level of awareness had not changed in the year since they first met. Mr. Moses said in evidence that he specifically addressed Mrs. D.H.'s capacity to execute a will and powers of attorney for personal care, but did not address her capacity to make a treatment or admission decision—and in fact was not aware of the test for capacity to make an admission decision.

As to Mrs. D.H.'s capacity, Dr. Robertson testified that Mrs. D.H. remained incapable of making an admission decision. He doubted she would subsequently become capable. I asked Dr. Robertson if he thought Mrs. D.H. would have been capable of making an admission decision in May 2006, which was nearly a year before he first met her. Dr. Robertson was, quite fairly, reluctant to project Mrs. D.H.'s capacity historically. However, he said that from reading Mrs. D.H.'s medical records and based upon his experience as a psychiatrist and his observations during Mrs. D.H.'s more than three months of current hospitalization, he would be "quite surprised" if Mrs. D.H. was capable of making an admission decision in May 2006.

THE LAW

The extracts below are from The *Health Care Consent Act*

> 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.

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

4.(3) A person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission or the personal assistance service, as the case may be.

42.(1) A person who gives or refuses consent on an incapable person's behalf to his or her admission to a care facility 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.

42.(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 admission to a care facility that are not required to be followed under paragraph 1 of subsection (1) ; and

(c) the following factors:

1. Whether admission to the care facility is likely to,

i. improve the quality of the incapable person's life,

ii. prevent the quality of the incapable person's life from deteriorating, or

iii. reduce the extent to which, or the rate at which, the quality of the incapable person's life is likely to deteriorate.

2. Whether the quality of the incapable person's life is likely to improve, remain the same or deteriorate without admission to the care facility.

3. Whether the benefit the incapable person is expected to obtain from admission to the care facility outweighs the risk of negative consequences to him or her.

4. Whether a course of action that is less restrictive than admission to the care facility is available and is appropriate in the circumstances.

52.(1) A substitute-decision maker or the person responsible for authorizing admissions to a care facility may apply to the Board for directions if the incapable person expressed a wish with respect to his or her admission to the care facility, 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.

52.(1.1) If the person responsible for authorizing admissions to the care facility intends to apply for directions, the person shall inform the substitute decision–maker of his or her intention before doing so.

52.(2) The parties to the application are:
1.The substitute decision-maker.
2.The incapable person.
3.The person responsible for authorizing admissions to the care facility.
4.Any other person whom the Board specifies.

52.(3) The Board may give directions and, in doing so, shall apply section 42.

53. (1) If a substitute decision–maker is required by paragraph 1 of subsection 42 (1) to refuse consent to the incapable person's admission to a care facility because of a wish expressed by the incapable person while capable and after attaining 16 years of age,

(a) the substitute decision–maker may apply to the Board for permission to consent to the admission despite the wish; or

(b) the person responsible for authorizing admissions to the care facility may apply to the Board to obtain permission for the substitute decision–maker to consent to the admission despite the wish.

53.(3) The Board may give the substitute decision-maker permission to consent to the admission despite the wish if it is satisfied that the incapable person, if capable, would probably give consent because the likely result of the admission is significantly better than would have been anticipated in comparable circumstances at the time the wish was expressed

This provision, respecting capacity to execute a Power of Attorney for Personal Care, is from The *Substitute Decisions Act*:

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.

(2) A power of attorney for personal care is valid if, at the time it was executed, the grantor was capable of giving it even if the grantor is incapable of personal care. 1992, c. 30, s. 47 (2).

(3) A person is capable of revoking a power of attorney for personal care if he or she is capable of giving one.

(4) Instructions contained in a power of attorney for personal care with respect to a decision the attorney is authorized to make are valid if, at the time the power of attorney was executed, the grantor had the capacity to make the decision.

Note s. 47(4) recognizes that a person may be capable of executing a Power of Attorney for Personal Care and may express instructions in it, but the instructions are only valid if the person was capable to make that decision at the time of executing the document. That is because a different, perhaps more stringent, capacity test applies to making health care decisions than to executing a Power of Attorney for Personal Care.

ANALYSIS

None of the witnesses' credibility was challenged and I had no difficulty accepting all of the evidence given. Simply put, the issue was whether Mrs. D.H. expressed a capable wish applicable to her circumstances and if so, whether to direct Ms T.C. to depart from it.

Mrs. D.H.'s circumstances were equally straightforward. She was a voluntary patient in a psychiatric facility who wanted to go home, but whose physician and Attorney believed she was unsafe at home. I agreed with them. Mrs. D.H.'s recent history preceding her current hospitalization was the best predictor of what was likely to happen if she returned to her home. While Mrs. D.H. could afford the levels of home care she required, she was likely to hire and fire staff quickly as she became suspicious of them—suspicions founded in the paranoia created by the mental disorder from which she suffered. Mrs. D.H. was unlikely to take medication either for schizophrenia or diabetes were she at home, would change the locks on her door and not answer her telephone. At some point along this trail of deteriorating mental and physical condition, Mrs. D.H.'s daughter was likely again going to have to engage the assistance of police officers to break into Mrs. D.H.'s home and get her back to this or another psychiatric facility.

Mrs. D.H.'s physician and Attorney concluded that she would best be protected by admission to the locked section of a care facility. Did Mrs. D.H.'s wish as expressed in her Power of Attorney for Personal Care apply to these circumstances and was it a capable wish?

> This power of attorney for personal care does not provide any authority to my attorney(s) to place me in any mental home/institution nor in any mental ward of any hospital or similar institution.

According to Mr. Moses, Mrs. D.H.'s concern was being locked up. Her concern arose from having been "locked up" in a psychiatric unit and that is what she expressed to Mr. Moses in instructing him to draft the document. It would have been impossible for Mr. Moses and Mrs. D.H. to specify every possible "institution" in which Mrs. D.H. might have been detained and in my view the phrase "similar institution" has to be read to include the locked unit of a care facility. As Justice Sharpe wrote in *Conway v. Jacques*, 2002 CanLII 41558 (ON C.A.), (2002), 59 O.R. (3d) 737,

> However, I agree with the appeal judge that prior capable wishes are not to be applied mechanically or literally without regard to relevant changes in circumstances. Even wishes expressed in categorical or absolute terms must be interpreted in light of the circumstances prevailing at the time the wish was expressed.

The change in Mrs. D.H.'s circumstances was that the proposal was to "detain" her in a care facility rather than in a psychiatric facility. But, I think that from Mrs. D.H.'s perspective, there was no difference between the two. It was clear from the second Condition she expressed in her Power of Attorney that she wanted to be at home rather than at any facility.

I therefore concluded that the wish Mrs. D.H. expressed in her Power of Attorney was applicable to her circumstances as at the time of this Hearing. However, I also concluded the wish was not expressed while Mrs. D.H. was capable.

Throughout his meetings with Mrs. D.H., Mr. Moses concerned himself with her capacity to execute a will and powers of attorney, rather than with her capacity to make treatment or admission decisions, which is a different, more stringent standard. Based upon his own evidence, Mr. Moses was unaware of the test for capacity to make an admission decision. He could not have assessed it.

I am aware that capacity is both issue and time specific (a person may be capable at one time but incapable at another, capable with respect to some health care decisions but incapable with respect to others). It is difficult to project backwards to determine whether a person was previously incapable and Dr. Robertson recognized this difficulty in his evidence—he did not know Mrs. D.H. when she executed the Power of Attorney and did not meet her until almost a year later.

Nonetheless, Dr. Robertson said he would have been "surprised" were Mrs. D.H. capable of making an admission decision in the spring of 2006. The motivation for the addition of the provisions in her Power of Attorney was he concern about being "locked up," without a complimentary ability to consider the consequences of being at home. Mrs. D.H.'s illness was chronic, with a delusional component that she did not recognize. Had Mrs. D.H. been capable of making an admission decision in the spring of 2006, I think her Power of Attorney would have contained a very different instruction.

Mrs. D.H.'s desire was not to be locked up. However, since she did not recognize she endured paranoid delusions about her family and caregivers, she lacked the ability to recognize the consequences of her decision to remain in her own home. She could not anticipate what, in fact, happened to her after she executed her Power of Attorney. What happened to Mrs. D.H. was that her mental and physical condition deteriorated to the point that her daughter had to obtain police assistance to break down her door and extract her from "deplorable" living conditions, that she stopped treating her diabetes and schizophrenia thereby putting both mental and physical health at serious risk.

I therefore held that Mrs. D.H.'s instruction contained in her Power of Attorney for Personal Care was not a capable wish. There was no evidence Mrs. D.H. expressed the same wish at a time she was capable. That resolved Ms T.C.'s Form D application.

However, on the authority of s. 42(2)(b), Ms T.C. still had to consider Mrs. D.H.'s incapable wishes as one of the factors in determining whether to consent to her mother's admission to a care facility. And Ms T.C.'s Form E application, to depart from Mrs. D.H.'s capable wishes remained outstanding.

I could have dismissed Ms T.C.'s Form E application as "moot" once I held Mrs. D.H. had not expressed a capable wish applicable to her circumstances. However, the purpose of these applications was to obtain certainty about Mrs. D.H.'s future care, to ensure that all parties acted decisively, ethically and legally. As well, in case I was wrong in my conclusion that Mrs. D.H. was incapable when she expressed her wish not to be in a locked facility or in case she expressed that wish at another time when capable, I concluded the parties were entitled to certainty without the need for a further application to the Board.

The likely result of Mrs. D.H.'s admission to a care facility was that both her mental disorder and her physical ailments would be properly managed. She would have the opportunity to interact with other people in a safe, secure and clean environment. Her alternative was returning home to a cycle of declining self-care, inability to comply with her medication regimen, increasing paranoia and isolation most likely resulting in another admission to a psychiatric facility. Mrs. D.H. could afford the best facility suitable to her needs. Admission to a care facility was the more dignified, safer and overall less restrictive choice. It was a significantly better result than her return home.

I concluded that, were Mrs. D.H. capable at the time of this Hearing, she would probably have consented to her admission to a care facility. While her culture included the tradition of families caring for their elderly relatives, Mrs. D.H. previously contemplated the prospect of her admission when she and Ms T.C. went to Boston and looked at some care facilities.

RESULT

I held that the wish Mrs. D.H. expressed in her Power of Attorney for Personal Care was not a capable wish. In the alternative, I granted Ms T.C. authority to depart from it and consent to Mrs. D.H.'s admission to a care facility.

Dated at Toronto, Ontario this 7th day of August 2007.

Mark Handelman, Vice Chair
Presiding Member