

The Consent and Capacity Board: Little Known and Seldom Used

Robert Sibbald, Clinical Ethics



Case #1

- 83 year old patient suffered acute respiratory failure due to COPD
- Hx: dementia, impaired kidney functions, atrial fibrillation, diabetes, smoker, alcohol abuse
- Ventilated, PEG tube, hourly suction
- Physical restraints because of attempts to remove tubes
- Extubation failed twice
- Proposal: attempt extubation, if unsuccessful, ensure comfort and best palliative care (this accorded with the patient's POA)
- Children (SDMs) refused to consent

Re: Mr. G.A. 2007 CanLII 32891

Case #2

- Amish girl, 5yo, severely burned
 - ▣ (3rd degree > 60% BSA)
- Family requests use of homemade topical remedy
 - ▣ Honey based, aloe, burdock leaves
- Team proposed debridement and multiple skin grafts
- Parents refuse to consent
- Two days pass and still unable to obtain consent despite several family meetings, involvement of multiple medical teams, 2nd opinions, social work, ethics, etc.

Re: L., 2008 CanLII 46902

Case #3

- 84yo man, massive stroke, aphasic with moderate weakness, lack of insight, and agitation
- Advanced dementia; not capable
- 6 weeks post stroke, still aphasic, confused, and restless (pulled out GJ twice), required total care
- No prior wishes
- Three children acting as SDM, none can agree on a plan of care, one only agreed to earlier GJ after being badgered by siblings

Health Care Consent Act [1996]

- Sets standards for all regulated healthcare professions
- Informed consent required for 'any' treatment
- "treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan

Where we tend to struggle...

- Capacity Assessment
 - Psychiatric consult to assess capability
 - Failing to 'presume' capability
- Obtaining Consent (improperly)
 - Informing SDM of legal obligations
 - Identifying appropriate SDM
 - Appropriate consideration of prior expressed wishes
 - Interpreting 'best interests'

HCCA [1996]

10. (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

- (a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or
- (b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).

Consent and Capacity Board

- Quasi-judicial tribunal, authorized by the HCCA
- Approx 140 members:
 - lawyers, psychiatrists, public members
- 1. Adjudicates the substitute decision making rights of persons who may be or are incapable of making their own healthcare decisions
- 2. Reviews detention of involuntary psychiatric patients and findings of incapacity

What they do

- Review findings of incapacity (form A)
- Appoint appropriate substitute decision makers (forms B and C)
- Give direction if prior wishes are unclear or not applicable (form D)
- Authorize departure from prior capable wish (form E)
- Determine compliance with principles for substitute decision making (form G)

Details

- Hearings take place in hospital
- Must be within 7 days of application (but can occur sooner in emergent situations)
- Usually 4-8 hrs, decision must come within 24 hrs (but again, can come sooner)
 - ▣ Physician presence may take an hour
- Legal representation
- Decisions

CCB is NOT a panacea

- It takes time/support
- It is a legal process
 - ▣ Amenable to appeal, and appeal, and appeal
- It can come between physician and SDM

HCCA and CCB can...

- Remind us of our roles (who proposes treatment, who consents)
- Provide an independent, fair, and transparent process for irresolvable disputes
- Assist us in determining 'best interests'
- Assist us in determining which SDM ought to make decisions
- Assist us in making sense of prior wishes
- Bring a sense of urgency/reason to SDMs that may avoid a hearing all together

Gaining Experience Across ON

LHSC Experience

- Mental Health (on-going)
- Prior to 2008 – 1 acute care case
- Mid 2008 - PCCU case
 - ▣ No hospital support (legal), No CMPA support
- Since
 - ▣ Paeds x 2
 - ▣ Medicine x 3
 - ▣ ICU x 1

Case #1

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- Ve
- Pa
- tu
- Extubation failed twice
- Proposal: attempt extubation, if unsuccessful, ensure comfort and best palliative care (this accorded with the patient's POA)
- Children (SDMs) refused to consent

Options:

1. Unilateral withdrawal – Illegal
2. Continue to treat – harms the patient
3. Apply to CCB – Form G, SDM not following principles

Re: Mr. G.A. 2007 CanLII 32891

Case #2

- Amish girl, 5yo, severely burned
 - (3rd degree > 60% BSA)
 - Fa
 - Te
 - Pa
 - Tv
- despite several family meetings, involvement of multiple medical teams, 2nd opinions, social work, ethics, etc.

Options:

1. Follow Family Wishes – will harm the patient
2. Call CAS – can only change treatment if take custody
3. Apply to CCB

Re: L., 2008 CanLII 46902

Case #3

- 84yo man, massive stroke, aphasic with moderate weakness, lack of insight, and agitation

- **Options:**
 1. Continue to meet with children, hoping for compromise –
 2. Ignore children, go to Public Guardian and Trustee
 3. They apply to CCB – Form C, to determine who should act as sole SDM
- Plan of care, one only agreed to earlier on after being badgered by siblings

Bottom Line

- CCB is not a substitute for quality discussion/dialogue
- Engaging the CCB is sometimes an ethical/legal obligation (we owe to the patient)
- The CCB is not the first choice, but neither should it always be the last
- Making applications requires organizational support – that we have



Best interests at end of life: A review of decisions made by the Consent and Capacity Board of Ontario

Robert W. Sibbald MSc^{a,*}, Paula Chidwick PhD^b

^aLondon Health Sciences Centre, PO Box 5375, London ON, Canada N6A 4G5

^bWilliam Osler Health Centre, Brampton, ON L6R 3J7

Keywords:

End of life;
Conflict;
Best interests;
Consent and Capacity Board;
Decision making;
Legal decisions.

Abstract

Purpose: When patients are unable to communicate their own wishes, surrogates are commonly used to aid in decision making. Although each jurisdiction has its own rules or legislation governing how surrogates are to make health care decisions, many rely on the notion of “best interests” when no prior expressed wishes are known.

Methods: We purposively sampled written decisions of the Ontario Consent and Capacity Board that focused on the best interests of patients at the end of life. Interpretive content analysis was performed independently by 2 reviewers, and themes that were identified by consensus as describing best interests were contrasted, as well as the characteristics of an end-of-life dispute that may be most appropriately handled by an application to the Consent and Capacity Board.

Results: We found that many substitute decision makers rely on an appeal to religion or God in their interpretation of best interests, whereas physicians focused narrowly on the clinical condition of the patient in their interpretations.

Conclusions: Several lessons are drawn for the benefit of health care teams engaged in end-of-life conflicts with substitute decision makers over the best interests of patients.

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1. Introduction

In the health care setting, informed consent is necessary to legally and ethically provide treatment to patients. When a patient is no longer capable of making decisions, a substitute decision maker (SDM), surrogate, or proxy is asked to step in to make decisions on behalf of the incapable person. Rules to

guide how decisions are made for incapable patients vary. In Ontario, the Health Care Consent Act (HCCA) [1] stipulates that the SDM is required to base decisions on prior capable expressed wishes of the patient, and if these wishes no longer apply, are impossible to comply with, or are not known, then the law stipulates that the SDM shall act in the incapable person’s “best interests” (see Box 1). This is a common approach used in many jurisdictions in Canada and elsewhere [2–6].

Best interests are generally invoked when it is necessary to provide the means of decision making for persons who are not capable. Although not perfect, some argue that appealing

* Corresponding author.
E-mail address: robert.sibbald@lhsc.on.ca (R. W. Sibbald).

Additional Benefit

Case	Hearing date	Treatment (plan) in disagreement ^a	At issue	Board decision
1. G. (Re) ^b	February 2009	Wean from ventilator and DNR order	Best interests	A tracheotomy and feeding tube were not in the best interests of the patient.
2. B. (Re) ^b	January 2009	Wean from ventilator and DNR order	Prior wishes AND best interests	Weaning from the ventilator and a DNR order were in the best interests of the patient.
3. M.B. (Re)	December 2007	Feeding (PEG) tube	Best interests	A feeding tube was not in the best interests of the patient. (This decision was the result of a form C hearing, and so technically, the board’s decision was to appoint an SDM whom they felt would make decisions in the best interests of the patient.)
4. E.J.G. (Re)	September 2007	Wean from ventilator and DNR order	Best interests	Weaning from the ventilator and a DNR order were in the best interests of the patient.
5. C.D. (Re)	July 2007	Withdraw nutrition/hydration	Best interests	Withdrawal of nutrition/hydration and a DNR order were in best interests of the patient.
6. G.A. (Re)	July 2007	DNR order	Prior wishes AND best interests	DNR order was consistent with patient’s prior expressed wishes and was also in their best interests.
7. K.M.S. (Re)	June 2007	Withdraw nutrition/hydration	Prior wishes AND best interests	Withdrawal of nutrition/hydration was consistent with patient’s prior expressed wishes and best interests.
8. E.B. (Re)	February 2007	No feeding tube	Best interests	A feeding tube was not in the best interests of the patient.
9. B. (Re)	March 2006	Wean from ventilator and DNR order	Prior wishes AND best interests	Weaning and DNR order were consistent with patient’s prior expressed wishes and were also in their best interests.
10. P. (Re)	June 2005	DNR order	Best interests	DNR order was in best interests of the patient.
11. I.A. (Re)	April 2004	Dialysis	Best interests	Dialysis was not in the best interests of the patient. (This decision was the result of a form C hearing, and so technically, the board’s decision was to appoint an SDM whom they felt would make decisions in the best interests of the patient.)
12. H.J. (Re) ^c	October 2003	No ventilatory support, inotropic support, resuscitation, or readmission to ICU	Best interests	No ventilatory support, inotropic support, resuscitation, or readmission to ICU was in the best interests of the patient.