People of Faith and Substitute Decision-Making

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Introduction

When someone signs a power of attorney for personal care, representation agreement, advance health care directive, personal directive or living will, there is always a risk that his or her wishes will not be honoured. This is especially the case where the person holds a religious view of the primacy and sanctity of life that is not shared by the attendant physicians or all members of the person's family. Notwithstanding the fact that our law prioritizes the autonomy of the individual in making health care decisions,[1] the wishes of people of faith are sometimes overruled or ignored. For the drafting solicitor, this poses a special challenge. How does one insulate the wishes of the client from attack? How does one advise an attorney for personal care, substitute decision-maker, representative or delegate (hereinafter, a "decision-maker") who is trying to respect the incapable person's personal autonomy while being mindful of his or her best

[1] See, e.g., *Carter* v. *Canada (Attorney General)*, 2015 CarswellBC 227 (S.C.C.); *Health Care Consent Act*, *1996*, S.O. 1996, c. 2, Sched. A, s. 1.

interests? Problems can arise in crisis situations involving end-of-life decisions, or where the client suspects the incapable person is being victimized by a predator.

For lawyers advising a decision-maker, the client's duties may be codified in the applicable provincial legislation,[2]and may include such things as acting in good faith, seeking to foster personal contact with supportive family members, and making decisions in accordance with the incapable person's wishes expressed while capable.[3] For the decision-maker who is himself or herself a person of faith, there might be an added tension in trying to comply with his or her own religious precepts and moral compass.

This paper reviews two types of situations that might be faced by decision-makers: (i) where difficult end-of-life decisions need to be made; and (ii) where the decision-maker suspects the grantor is being victimized by a sexual predator.

Decisions on behalf of incapable people: who decides on medical treatment?

Canada has a greying demographic. This means that the median age of our population is rising and that there is a growing proportion of elderly citizens. Typically, if our elders have good legal advice, they grant powers of attorney for personal care, or advanced health care directives, or representation agreements (depending upon the Canadian jurisdiction). To most non-lawyers, these documents are referred to generically as "living wills." These living wills are intended to give one or more specified people an indication of what the client wants in terms of his or her future care. This is important because, in most Canadian jurisdictions, such written wishes have legal significance.[4]

For example, in British Columbia, a person may execute an advance directive as well as a representation agreement. Under section 11 of the *Health Care (Consent) and Care Facility (Admission) Act* (the "HCCFA"), a health care provider may provide health care to an adult without the adult's consent if:

(a) the health care provider is of the opinion that the adult needs the health care and is incapable of giving or refusing consent, and
(b) the adult's personal guardian or representative
 (i) has authority to consent to the health care,
 (ii) is capable of giving consent, and
 (iii) gives substitute consent.[5]

Under section 19.7, subject to certain exceptions, a health care provider is forbidden from providing health care to an adult if the adult has refused consent in his or her advance directive.[6]

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[2] For example, in British Columbia, see the *Representation Agreement Act*, R.S.B.C. 1996, c. 405, s. 16; in Nova Scotia, see the *Personal Directives Act*, S.N.S. 2008, c. 8, s. 15; in Saskatchewan, see the *Health Care Directives and Substitute Health Care Decision Makers Act*, 2015, S.S. 2015, c. H-0.002, s. 5; in Manitoba, see the *Health Care Directives Act*, C.C.S.M., c. H27, s.13.
[3] *Substitute Decisions Act, 1992*, S.O. 1992, c. 30, s. 66-68; see also, *Health Care Consent Act, 1996*, SO 1996, c 2, Sch A.
[4] There are numerous nuances to this obligation, such as the need to consider the grantor's "best interests" in some defined situations under Ontario's *Substitute Decisions Act, 1992*, S.O. 1992, c. 30.
[5] *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c. 181, s. 11.
[6] *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c. 181, s. 19.7.

In Ontario, under the *Health Care Consent Act, 1996* (the "HCCA"),[7] an attorney for personal care may be empowered to act as substitute decision-maker ("SDM") for the grantor.[8] Under the legislation, the attorney ranks in priority to spouses or partners, children, parents, siblings and any other relatives.[9]

The HCCA further provides as follows:

> 1 The purposes of this Act are,
> […]
> (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,
> […]
> (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;
>
> 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).

In Nova Scotia, an individual may sign a personal directive appointing a delegate to make decisions concerning his or her health care. The *Personal Directives Act* ("PDA")[10] describes the roles and responsibilities of delegates, including how their decisions are to be made. According to section 15:

> (2) In making any decision, a delegate shall
>
> (a) follow any instructions in a personal directive unless
>
> (i) there were expressions of a contrary wish made subsequently by the maker who had capacity,
> (ii) technological changes or medical advances make the instruction inappropriate in a way that is contrary to the intentions of the maker, or
> (iii) circumstances exist that would have caused the maker to set out different instructions had the circumstances been known based on what the delegate

[7] S.O. 1996, c. 2, Sched. A.
[8] A guardian of the person with authority to give or refuse consent to the treatment ranks higher than an attorney for personal care, but guardians must be appointed by the court.
[9] See details under *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A, s. 20.
[10] *Personal Directives Act*, SNS 2008, c 8.

knows of the values and beliefs of the maker and from any other written or oral instructions;

(b) in the absence of instructions, act according to what the delegate believes the wishes of the maker would be based on what the delegate knows of the values and beliefs of the maker and from any other written or oral instructions; and

(c) where the delegate does not know the wishes, values and beliefs of the maker, make the personal-care decision that the delegate believes would be in the best interests of the maker.[11]

All of these statutes appear to enshrine patient autonomy, including the right of patients to select their decision-makers. It's just not that simple.

The DNR dilemma

In end-of-life situations, some people of faith look to religion for guidance. A decision-maker, who is arguably a fiduciary, with statutory and common law obligations might feel a certain tension between his or her legal duties and his or her faith. Lawyers who deal with decision-maker disputes are all too familiar with the scenario where more than one child is appointed as a decision-maker and there is no consensus over whether to institute a "do not resuscitate" order (DNR). Should the incapable person be permitted to die a natural death or should extraordinary measures such as CPR be employed to keep him or her alive? Similar questions arise in the context of feeding tubes and ventilators.

Often, one decision-maker seeks to maintain a certain quality of life for the incapable parent, while the other seeks to extend the incapable parent's life for religious or conscientious reasons. In these situations, counsel should explain the duties that arise in the applicable provincial legislation. For instance, in Ontario, section 21 of the HCCA provides:

- An SDM is statutorily bound to consider first any "wish applicable to the circumstances that the incapable person expressed while capable" before making a decision as SDM.
- But, if the incapable person did not make his or her wishes known, then the incapable person's "best interests" govern.
- In determining best interests, the attorney must consider
  - 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;
  - any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection 21(1) (meaning, wishes expressed that are not fully applicable in the circumstances, or wishes expressed while incapable, or while under the age of 16);
  - quality of life issues, including whether the treatment is likely to improve the patient's condition.

[11] PDA, s. 15.

Some decision-makers hold a religious belief that life itself has sanctity. Everyone is eventually going to die; medical intervention is just postponing the inevitable. For these decision-makers, even one additional moment of life is of infinite value, and that view might lead to conflict with other family members or treating physicians.

What if the health care workers disagree with the decision-maker?

Conflict often arises where health care workers advocate a certain medical treatment that is contrary to the wishes of the patient. The case law is clear that health care workers cannot blithely override the decisions of a patient or decision-maker.

In *Malette* v. *Shulman*,[12] the Ontario Court of Appeal found a doctor liable under the tort of battery for administering a blood transfusion to a patient against her wishes. A nurse had found a card on the patient indicating that the patient was a Jehovah's Witness and that she requested "no blood or blood products be administered to [her] under any circumstances."[13] Despite the doctor's knowledge of this direction, the doctor personally administered a blood transfusion. The Ontario Court of Appeal emphasized that the right of a person to control his or her own body is a concept that has long been recognized at common law, and the tort of battery protects the interest in bodily security from unwanted physical interference.[14] Importantly, the Court of Appeal found that a doctor is not free to disregard a patient's advance instructions made while the patient is capable.

A different result was reached in the British Columbia Court of Appeal case of *Bentley* v. *Maplewood*.[15] The case involved an 83-year old woman named Mrs. Bentley who was in the final stages of Alzheimer's Disease. Mrs. Bentley had been a nurse and had seen patients in "vegetative" states before. She advised her family that she did not want this to happen to her, and signed a document directing that, if the time came when there was "no reasonable expectation of [her] recovery from extreme physical or mental disability," she be "allowed to die and not be kept alive by artificial means or 'heroic measures'."

Mrs. Bentley's loving family sought to honour her wishes, and they filed a petition to the Supreme Court of British Columbia in August, 2013, seeking an order that would prohibit Mrs. Bentley's care facility from giving her food and water, with the inevitable result that she would pass away shortly thereafter. The petition included the request for a declaration that prompting Mrs. Bentley to eat by holding a spoon or glass to her mouth constituted the tort of battery.

The chambers judge held that Mrs. Bentley's actions in showing a preference for some food over others, and in refusing foods when she was presumably full, indicated that she was an adult capable of making decisions regarding whether she wanted to eat or not. The judge found that Mrs. Bentley's previously expressed wishes were therefore not valid in the face of her current consent.[16] In the alternative, the chambers judge found that "feeding" fell under the definition of "personal care" and not under "health care" as defined in the HCCFA. There was no guidance as

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[12] 1990 CarswellOnt 642 (C.A.).
[13] *Malette v Shulman*, 1990 CarswellOnt 642 (C.A.) at para 4.
[14] *Malette v Shulman*, 1990 CarswellOnt 642 (C.A.) at para 17.
[15] *Bentley v Maplewood*, 2015 BCCA 91.
[16] *Bentley*, at para 7.

to what authority an SDM should have for decisions relating to "personal care". With no representative able to refuse personal care and with little guidance from unclear documents written by Mrs. Bentley, the chambers judge found that the withdrawal of food and water from someone incapable of making that decision would constitute neglect under the *Adult Guardianship Act*, RSBC 1996, c 6.[17]

In Ontario, when there is a disagreement between the doctor and the SDM, the proper process is as follows. First, the doctor must seek consent to treatment from the SDM. If the SDM does not consent and the doctor believes that the SDM is not acting in accordance with section 21 of the HCCA, the doctor can refer the matter to an administrative tribunal called the Consent and Capacity Board (the "CCB"). The CCB is empowered to substitute its own opinion or give directions in applying section 21. If either the SDM or the doctor disagree with the holding of the CCB, he or she can appeal the decision to the Superior Court of Justice on a questions of law or fact or both.

Case study: *Rasouli* and the withdrawal of life support

There is a genuine concern among some faith-based communities that their autonomy in health-related matters is under attack. Rightly or wrongly, they feel there is a tendency among physicians to impose secular values in medical decision-making, such as by prioritizing "quality of life" over other values like the "sanctity of life." One prominent example of this clash of values was the case of *Cuthbertson* v. *Rasouli*, which was appealed up to the Supreme Court of Canada ("SCC").[18]

Hassan Rasouli was a man who went to the Sunnybrook Health Sciences Centre for a benign brain tumour. He developed an infection that caused brain damage and was diagnosed as being in a persistent vegetative state. Rasouli's physicians proposed withdrawing the ventilator and only providing palliative care, as they said continuing life support would not be of any medical benefit to the patient. The physicians argued that if a treatment is not medically warranted, the relevant legislation does not compel them to offer said treatment. It is a very logical argument. The legal status of "withdrawal of life support" was not entirely clear at the time, and the physicians also took the position that withdrawal was different than administration of treatment, and therefore that consent from the SDM was not required and there was no obligation to refer it to the CCB. Hence, the doctors argued that they could unilaterally withdraw life support.

Rasouli's wife and SDM, Ms. Salasel, believed that, as a devout Shia Muslim, Rasouli would wish to be kept alive. Salasel brought an application for a court order prohibiting the physicians from withdrawing life support, and the matter was eventually appealed to the SCC. The SCC agreed with Salasel, holding that "treatment" under the HCCA included the withdrawal of life support.

A summary of the SCC's decision regarding steps to take when an SDM and a physician disagree on the withdrawal of life support can be found at paragraph 116 of the decision:

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[17] *Bentley*, at para 7.
[18] *Cuthbertson* v. *Rasouli*, 2013 SCC 53.

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 SDM and seeks her consent to withdraw the treatment;
3. The SDM 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 SDM consents, the health practitioner withdraws life support;
5. If the SDM refuses consent to withdrawal of life support, the health practitioner may challenge the SDM's refusal by applying to the CCB: s. 37;
6. If the CCB 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 SDM, and permit withdrawal of life support.[19]

But the *Rasouli* case is about more than just the meaning of "treatment" or the proper procedure for adjudicating life-support disputes in Ontario. It exemplifies a situation where people with different values clash over what to do in end-of-life situations. These disputes continue to be fought over in our courts in new and complex ways.[20]

It's the values and beliefs of the grantor – not institutionalized religion

When addressing issues of faith and end-of-life decisions, we find it useful to remember Justice Cullity's comments in *Scardoni* v. *Hawryluck.*[21] The case involved an 81-year-old woman who was suffering from Alzheimer's Disease. She was in a permanent vegetative state and had been placed on a ventilator. Her doctor believed that the treatment was taking a terrible toll and sought to withdraw life support. The two attorneys for personal care disagreed because their mother, who was a Catholic, had always expressed the sentiment to them that "where there is life, there is hope." The matter went before the CCB and was then appealed to the Ontario Superior Court of Justice. When discussing the issue of faith and its impact on this case, Justice Cullity said, in part:

> With, I believe, some justification, Ms. Chan was heavily critical of the Board's rejection of the relevance of Mrs. Holland's religious beliefs. The question, in her submission, was not whether Mrs. Holland's beliefs coincided with the official views of the Roman Catholic Church or were otherwise soundly based in its tenets, the question was whether – and, if so, how strongly – she held them. Sections 21(2)(a) and (b) reflect legislative acceptance that a person's personal beliefs, values and

[19] *Rasouli*, at para. 116.
[20] For example, consider the case of Shalom Ouanounou, who was declared dead by physicians on the basis of the cessation of neurological activity despite the fact that his heart continued to beat:
http://www.cbc.ca/news/canada/toronto/shalom-ouanounou-arguments-1.4536864
https://www.ctvnews.ca/family-of-toronto-man-declared-brain-dead-says-finding-goes-against-his-religion-1.3658380
[21] 2004 CarswellOnt 424 (S.C.).

> wishes are relevant to the statutory concept of their best interests. The provisions recognize, and reflect, the value to be attributed to personal autonomy by allowing the Board to look at the question of a patient's best interests from the viewpoint of the patient. As Sharpe J.A. stated in *Conway*, inferences as to the decision the patient would have made in the changed circumstances if then capable are relevant under s. 21(2). <u>*The fact that a person's beliefs, values or wishes represent, or do not represent, institutionalized views, or that they are, or are not, shared by anyone else is irrelevant*</u> …(emphasis added).[22]

Below we will review some of the institutionalized views held by major religious groups when it comes to end-of-life issues. This does not suggest that adherents of any particular faith necessarily follow the institutional policy. Nonetheless, it is a useful exercise for the lawyer providing clients of faith with advice on these issues.

(a) Catholicism

Generally, the Roman Catholic Church strongly opposes physician-assisted suicide and euthanasia. The Church teaches that life should not be prematurely shortened as it is a gift from God. However, the Church recognizes that a dying person has the option to refuse extraordinary treatments that only minimally prolong life.[23]

The Catholic Health Alliance of Canada released a document titled "A Catholic Perspective on Health Decisions and Care at the End of Life."[24] This document provides some guidance for Catholic individuals looking to make decisions in accordance with their faith. The document points out that the moral tradition of the Catholic Church provides the following guidance:

> "Life and physical health are precious gifts entrusted to us by God. We must take <u>reasonable care</u> of them, taking into account the needs of others and the common good."[25] "If morality requires respect for the life of the body, it doesn't make it an absolute value."[26]

It is noted that "reasonable care" would include interventions that are readily available, effective, and not excessively burdensome. It is also pointed out that the balancing of benefits and burdens for available interventions rests with the individual.

A further helpful resource in this regard is a document released by the Canadian Conference of Catholic Bishops setting out its position on the giving of assistance in dying, which was submitted to the Expert Panel on Options for a Legislative Response[27] to the *Carter* v. *Canada (Attorney General)* SCC decision, which effectively decriminalized physician-assisted suicide.[28]

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[22] See *Scardoni* v. *Hawryluck*, 2004 CarswellOnt 424 (S.C.) at para. 83.
[23] Pew Research Center, November 2013, "Religious groups' views on end-of-life issues" available at: http://www.pewforum.org/2013/11/21/religious-groups-views-on-end-of-life-issues/ ("Pew Research")
[24] See: http://www.chac.ca/homepage/Catholic%20Perspective.pdf
[25] Catechism of the Catholic Church, no. 2288.
[26] Catechism of the Catholic Church, no. 2289.
[27] See: http://www.cccb.ca/site/images/stories/pdf/Submission_to_the_Expert_Panel_on_assisted_suicide_-_EN.pdf
[28] *Carter* v. *Canada (Attorney General)*, 2015 CarswellBC 227 (S.C.C.)

(b) Islam

Preservation of life is one of the primary goals of Islamic law, and Islamic teachings are opposed to physician-assisted suicide and euthanasia. Muslims are of the belief that life is sacred and comes from God, and it is a sin to take life.[29] These views are influenced by a belief that suffering and other difficulties may be beneficial. End-of-life suffering can be seen as a way to purify previous sins prior to the time one meets with God.[30]

As per the Islamic Fiqh Assembly of the Organization of the Islamic Conference, it is obligatory to seek medical treatment in certain situations, such as where refraining from doing so will lead to significant harm or a long-term handicap, and cases in which the patient's disease may be transmitted to others and result in significant harm to them or to society.[31] With respect to artificial nutrition or hydration, these procedures are viewed as forms of medical treatment as they are done with the purpose of extending life. The doctor must therefore weigh the risks of the treatment with individual patients.[32]

(c) Judaism

Under Jewish law (*Halacha*), the preservation of human life will generally outweigh other considerations, including the desire to alleviate pain and suffering. Judaism teaches that life is a precious gift from God. A person's life belongs to God and therefore, deciding when it ends should be left to God. All three major Jewish movements: Orthodox, Conservative and Reform, prohibit suicide and assisted suicide, even in painful, terminal cases.[33]

Jewish teachings have been found to allow a person to forgo medical treatment if that person's life is about to end and the person is suffering.[34]

(d) Buddhism

Buddhists are taught to have great respect for life, and generally oppose assisted suicide and euthanasia. Buddhist religious teachings say that it is morally wrong to destroy human life, even if the intention is to end suffering. However, one does not need to go to extraordinary lengths to preserve a person's life when the person is dying. Treatment can be refused that is futile or unduly burdensome.[35]

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[29] Pew Research
[30] Pew Research.
[31] Maryam Sultan, "Pulling the plug: The Islamic perspectives on end-of-life care", *Yaqeen Institute for Islamic Research*, November 13, 2017. Also see Mohammad Zafir al-Shahri, MD, and Abdullah al-Khenaizan, MD, "Palliative care for Muslim patients" . *Journal of Supportive Oncology*, Volume 3, Number 6, November/December 2005.
[32] Pew Research.
[33] It is beyond the scope of this paper to fully explore these issues. For the interested reader, we recommend:
Steven H. Resnicoff, "Jewish Law Perspectives on Suicide and Physician-Assisted Dying," *DePaul University College of Law, Journal of Law and Religion*, Vol. 13, No. 2, 1998-1999.
See also Rabbi Mordechai Torczyner's discussion of physician-assisted suicide available on-line at:
http://www.yutorah.org/lectures/lecture.cfm/830798/Rabbi_Mordechai_Torczyner/Medical_Ethics:_Physician-Assisted_Suicide
C. Wagner, "Jewish physicians' freedom of conscience and religion and the *Carter* case" available on-line at:
https://www.wagnersidlofsky.com/assisted-suicide-and-halacha
[34] Pew Research.
[35] *Ibid.*

It is evident from the above sample of religious perspectives on end-of-life care that extending life is a common theme. It is therefore important for people of faith to prepare properly beforehand so that their perspectives can be easily obtained and implemented by a decision-maker should the need arise.

What if a religious person does not specify his or her wishes?

Where a religious person fails to specify his or her wishes in a signed power of attorney for personal care, representation agreement, advance health care directive, personal directive or living will, it creates an evidentiary problem for the family members.

In the Ontario case of *JEP, Re*,[36] the physicians made an application to the CCB pursuant to section 37 of the HCCA. The patient, JEP, was 86 years old, and had received advanced medical therapy for months in the hospital. He had been placed in the intensive care unit twice. The physicians believed that a palliative care plan was appropriate given JEP's condition and that it would be in JEP's best interests. Three of JEP's children were his SDMs and they refused on the basis of their knowledge that JEP was a devout Catholic.

The problem was with JEP's power of attorney for personal care, which did not contain any written directive concerning his future care. This forced his family to gather evidence from all corners, which the CCB reviewed in a 104-paragraph-long decision. The family adduced evidence that, among other things:

(a) JEP was a Catholic with a clear and unwavering belief, expressed to many people, that medically assisted death was abhorrent;
(b) JEP and his late wife fought against his wife's terminal cancer, against the advice of physicians at the Ottawa Hospital, selling the family home to finance experimental treatments in Germany;
(c) JEP's seventh child was born premature with what was believed to be terminal cancer and, notwithstanding medical advice to let the boy die peacefully, JEP flew the newborn to the United States to obtain experimental and extreme treatments that ultimately saved the child's life;
(d) JEP was a retired pathologist who authored over 150 publications related to biomedical and educational issues.

The CCB ultimately decided that JEP had expressed a prior applicable wish when capable to remain alive even in the face of pain and suffering. Had the evidence been less overwhelming, the decision might have gone the other way.

What if the evidence about the religious person's wishes is unclear?

The case of *Re F(F)*,[37] was an appeal made to the Superior Court of Justice of a decision made by the CCB. The appellants were the children and attorneys for personal care of the respondent, Mrs. F, who was 86 years old. At the time of the decisions, Mrs. F was a patient at Baycrest

[36] 2017 CarswellOnt 11895.
[37] 2013 ONSC 960.

Hospital in Toronto. While vacationing, she had suffered cardiac arrest and sustained serious anoxic brain injuries. A tracheostomy was performed and a feeding tube was inserted into her stomach. She did not regain consciousness after the injury, and was described as being in a persistent vegetative state.

Mrs. F's power of attorney for personal care contained the following end-of-life clause:

> The following are my instructions to my attorneys, and my wishes, with respect to the giving or refusing of consent to specified kinds of treatment under specified circumstances:
>
> I hereby instruct that if there is no reasonable expectation of my recovery from physical or mental disability, I be allowed to die and not be kept alive by artificial or heroic measures. I do, however, instruct that medication be mercifully administrated to me to alleviate suffering even though this may shorten my remaining life.[38]

The problem was that this clause was completely contrary to what her family knew to be her wishes as a person observing Orthodox Judaism during her entire lifetime. The appellants provided evidence regarding Mrs. F's devout religious lifestyle, including keeping kosher and observing Shabbat, and led evidence from Mrs. F's Rabbi. The following is some of the evidence provided by Rabbi Ochs:

> Rabbi Ochs explained the common Orthodox Jewish approach to end of life care. He noted that in Orthodox Judaism the terms "heroic" or "artificial" are not meaningful in the end of life context. All medical interventions available to prolong life must be performed, unless the person is in extreme pain. "Pulling the plug" is considered tantamount to murder. Although noting some variance of opinion respecting the initiation of life-preserving measures, Rabbi Ochs stated that this was the consensus view of the Orthodox Jewish community.[39]

Interestingly, evidence from the drafting lawyer was that it was not her practice to canvass her clients' religious beliefs in drafting powers of attorney for personal care.

On this conflicting evidence, the CCB found that Mrs. F had deliberately signed the POA directing that her life not be prolonged. The Superior Court then reversed that decision, holding that there was sufficient evidence to doubt whether Mrs. F fully understood the contents and effects of the provisions POA that she signed, particularly as it was a boilerplate provision.

What if the court decides the wish is not applicable in the circumstance?

Even if a patient has a document that clearly describes his or her wishes, there is still wiggle room for a court or tribunal to override what is written. In Ontario, the wiggle room comes in the form of the word "applicable" under section 21(1)1 in the HCCA.

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[38] *F. (F.), Re*, at para. 8.
[39] *F. (F.)*, at para. 31.

Consider the case of Mary Grover, whose power of attorney for personal care stated unequivocally that, in the event she became "seriously ill with a life threatening condition," her level of care should include "everything possible to cure my illness and prolong my life including heroic measures." At the age of 81, after suffering three strokes, Mrs. Grover was left confined to the intensive care unit at the London Health Sciences Centre on a feeding tube and ventilator. She was quadriplegic and non-communicative. Her treating physicians recommended withdrawal of life support and Mrs. Grover's attorney, her daughter, refused.

The CCB held that Mrs. Grover had not made a wish applicable under the circumstances. The CCB reasoned:

> The comments attributable to G were not precise and lacked particularity. There was no evidence of statements meant that she should be kept alive despite any levels of pain, loss of autonomy or personal dignity. […] We found no evidence G had her current circumstances in mind when she made any of those comments. Holding that her statements are applicable to her devastating current circumstance would be too mechanical or literal application of her words with complete disregard for changes in her circumstances.

The decision of the CCB was appealed to the Ontario Superior Court of Justice in *Grover* v. *Grover*[40] and the court dismissed the appeal, citing the observation by the court of appeal in *Conway* v. *Jacques*, that:

> [e]ven wishes expressed in categorical or absolute terms must be interpreted in light of the circumstances prevailing at the time the wish was expressed.[41]

Had the case been decided in Nova Scotia, the court might have reached the same result by referencing subparagraph 15(2)(a)(vii) of the PDA, which directs the delegate to follow any instructions in a personal directive unless "circumstances exist that would have caused the maker to set out different instructions had the circumstances been known based on what the delegate knows of the values and beliefs of the maker and from any other written or oral instructions."

Can one ensure that the end-of-life wishes of the client will be complied with?

There does not seem to be any fool-proof way to guarantee that someone's end-of-life wishes will be respected. No matter how specific the written instructions, some party can always argue that there was no way the client could have known how difficult or dire his circumstances would become and, therefore, his best interests should govern.

Let's see how some people have attempted to ensure the client's end-of-life wishes will be complied with. Attached hereto as **Appendix "A"** is a sample advance health care directive designed for Catholic individuals in Saskatchewan. The sample directive clearly states that the individual does not accept termination of life by way of euthanasia or assisted suicide. Attached hereto as **Appendix "B"** is a power of attorney for personal case for Orthodox Jewish

[40] *Grover* v. *Grover*, 2009 CarswellOnt 1944 (S.C.).
[41] *Conway* v. *Jacques*, 2002 CarswellOnt 1920 (C.A.).

individuals in Ontario prepared by the Vaad Harabonim of Toronto. The sample document lists end-of-life situations and provides a formula involving asking the rabbi to advise whether the treatment contemplated complies with Jewish law.[42]

Notwithstanding their detailed lists of end-of-life scenarios, these documents are still open to the same kind of attack that was illustrated in the case of Mrs. Grover. Her wishes seemed quite clear. Nonetheless the CCB and Ontario's Superior Court felt that "[e]ven wishes expressed in categorical or absolute terms must be interpreted in light of the circumstances prevailing at the time the wish was expressed." Query whether the "ask the rabbi" formula would be viewed as an inappropriate attempt to oust the jurisdiction of the court and tribunal.

Consider also an alternative approach illustrated by the following power of attorney for personal care used by an Orthodox Jewish grantor. It builds on section 1 of the HCCA and the idea of patient autonomy. It relies on section 21 of the HCCA's premise that the SDM must comply with the wishes of the person expressed while capable.

> The following are wishes and desires with respect to the giving or refusing of consent to specified kinds of treatment under specified circumstances. For greater certainty, in expressing these wishes it is not my intention to fetter the discretion of my attorney in any way:
>
> I strongly believe in the primacy of life. My wish is that all possible steps be taken to extend my life as long as possible unless the level of my suffering and/or pain makes my situation a prolongation of dying. If my attorney decides on a certain medical treatment or to continue or discontinue medical treatment, I desire, as much as possible, for it to be done in accordance with Jewish religious law ("halacha").
>
> Notwithstanding anything to the contrary in the *Health Care Consent Act, 1996*, or any successor legislation and in the absence of my known wishes for unanticipated situations arising out of my personal care, it is my express wish that the judgment and decision of my attorney be honoured. I have absolute trust in the judgment of those appointed as my attorney who know me best and understand what my wishes would be in every instance. I trust my attorney to know and decide what is in my best interests. My wish in those end of life instances is that the attorney appointed be

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[42] Query whether the requirement under the proposed power of attorney for personal care for Orthodox Jewish individuals to consult a rabbi and be bound by his decision constitutes a delegation. If so, this may be a concern given that a fiduciary is not permitted to delegate his or her authority. *Rogers, Re* is the only Canadian case the authors have found where the courts reviewed the validity and enforced an express clause in a trust instrument that granted the trustee authority to delegate a particular power. The case also set out the conditions under which the trustee's authority could be delegated. In *Waters' Law of Trusts in Canada*, the learned authors point out that the modern description of such as person is a "protector" who owes a fiduciary duty of loyalty. Some of the issues to be considered in regards to the naming of a protector are as follows.

1. *Successor must be named*. The protector (in our scenario, the rabbi) might die or become incapable before being able to exercise his delegated authority. Therefore, the instrument must provide for successors.
2. *Roles of fiduciary*. If the protector has a fiduciary duty, the instrument must provide for the following:
    a. Succession.
    b. Capacity.
    c. Retirement.
    d. Removal
    e. Duties and powers
    f. Indicate what will happen if the protector is unreasonable, obstructive, absent, or negligent.

> permitted to make those choices necessary. I specifically do not want any doctor to make those decisions on my behalf nor do I want the Consent and Capacity Board to determine what is in my best interest.

How would the CCB or the Ontario Superior Court of Justice view this power of attorney for personal care? The wording might go too far in attempting to oust the jurisdiction of the CCB, but it leaves very little wiggle-room. What we can say with certainty is that section 21(1)1 of the HCCA requires the SDM to make decisions in accordance with the wishes applicable in the circumstances that the incapable person expressed while capable. When assessing this draft document, what remains in question is:

- Does the express provision that the SDM knows best what the grantor would want to do in every circumstance suffice?
- Will it pre-empt a physician from referring the matter to the CCB and alleging that the SDM does not know the grantor's wish in this instance and is not acting in the patient's best interest?
- If the adjudicator determines that the grantor's wish under these circumstances is unknown, does the express wish that the SDM's view of best interests be complied with suffice?

How to advise the decision-maker about the tension between his or her moral compass and fiduciary duty in end-of-life situations

Being a decision-maker for an incapable person is an incredible responsibility. Arguably, it makes one into a fiduciary. If fulfilling the duties of a decision-maker conflicts with one's personal moral compass, then one should seriously consider resigning. We often see conflict arise in end-of-life situations where two decision-makers cannot agree, not because of the incapable person's beliefs, but because of the moral and religious beliefs of the decision-makers. This also happens when decision-makers and doctors find themselves at crossroads. One might believe in the sanctity of life while the other believes in the quality of life. It behooves counsel to tell their clients that their personal beliefs are, from a legal perspective, irrelevant. As Justice Brown said of litigation under the *Substitute Decisions Act, 1992* (the "SDA"):

> Proceedings under the SDA are not designed to enable disputing family members to litigate their mutual hostility in a public court. Guardianship litigation has only one focus – the assessment of the capacity and best interests of the person whose condition is in issue …[43]

Protecting the vulnerable incapable person

We have had the opportunity to review the draft of Ms. Kimberly Whaley and Professor Albert Oosterhoff's STEP paper on Predatory Marriages. It is an excellent. Their perspective that the capacity to marry is tied to the capacity to manage property was vindicated by the Ontario

[43] *Abrams* v. *Abrams*, 54 ETR (3d) 283; [2010] OJ No 787 (QL) paragraph 35.

Superior Court of Justice in *Hunt v. Worrod*.[44] In that case, Justice Koke approached the test for capacity to marry with the financial and legal duties that marriage creates, and the capacity to understand those duties, firmly in mind. This is very different than the test Justice Cullity applied in *Banton* v. *Banton*.[45]

Tying capacity to marry to the ability to manage property is a decision that many might applaud because it allows the courts to protect vulnerable people from predatory marriages. But it requires some reflection. Do we really want to prevent people who are incapable of managing property from being able to marry? This question was raised by Justice Cullity in *Banton*. Theoretically, there are many conditions that might impact on one's ability to manage one's property without necessarily impairing one's ability to understand the contract of marriage.[46] These could include neurodevelopmental disorders like mild intellectual disability, autism spectrum disorders and even specific learning disorders. There are also specific acquired disorders such as major neurocognitive disorders, Alzheimer's Disease, vascular dementia, and traumatic brain injury. Finally, severe psychotic disorders like schizophrenia could also affect one type of capacity and not necessarily the other. Theoretically, two senior citizens who understand and want to be committed to one another might no longer be able to marry.

Given the property rights that flow from marriage there is a compelling logic to the argument that people who cannot make decisions about property should not be permitted to marry. However, there is an equally compelling argument that marriage is more than just about property. As stated by the Court of Appeal for Ontario:

> Marriage is, without dispute, one of the most significant forms of personal relationships. For centuries, marriage has been a basic element of social organization in societies around the world. Through the institution of marriage, individuals can publicly express their love and commitment to each other. Through this institution, society publicly recognize expressions of love and commitment between individuals, granting them respect and legitimacy as a couple. This public recognition and sanction of marital relationships reflect society's approbation of the personal hopes, desires and aspirations that underlie loving, committed conjugal relationships. This can only enhance an individual's sense of self-worth and dignity.[47]

We can all agree that protecting the vulnerable incapable person from a predatory marriage makes sense. But, raising the threshold for marriage creates other problems. For the incapable person of faith, it means living with someone without the approval of the state or religious authorities. For many, that would be a non-starter. When representing clients who wish to

[44] 2017 CarswellOnt 19671.
[45] *Banton* v. *Banton*, 1998 CarswellOnt 3423 (S.C. Gen. Div.).
[46] The authors are referring to the legal scheme that one enters into through the institution of marriage and not a specific domestic or cohabitation contract.
[47] *Halpern* v. *Canada (Attorney General)*, 2003 CanLII 26403 (ON CA). The case involved gay and lesbian couples who were denied the right to marry. Several excerpts of the case relate to our discussion.

marry, but do not have the capacity under the test articulated in *Hunt v. Worrod,* it is open for counsel to argue that the case is persuasive authority and not binding. We must wait until the Court of Appeal adjudicates on whether the *Banton* test or the *Hunt v. Worrod* test for capacity to marry prevails as the current test in Ontario.

The role of the decision-maker in protecting the incapable person is equally difficult when it comes to interpersonal relationships outside of marriage.

The role of the decision-maker in dealing with sexual activity

As part of the Osgoode Elder Law Certificate 2017 program, Judith Wahl presented on the topic of "Sexuality Issues in Long Term Care Homes." She explained that there is a challenge in these settings to managing the sexual behaviours of people who lack capacity to consent. It is beyond the scope of this paper to deal with the legal obligations of long-term care homes to their residents. We would like to address the rights and obligations of the decision-makers in these circumstances, and how the lawyers representing them might properly advise their clients.

Consider the following situation from the perspective of the decision-maker:

> An elderly mother has lived her entire life adhering to a religion that forbids sex outside of marriage. She appoints her son as her decision-maker. The mother develops dementia and is forced to live in a long-term care facility. While in the care facility, the mother begins having a sexual liaison with a man, despite the fact that she is still married.

What are the rights and obligations of the son? Of the mother? In our hypothetical scenario, the son's moral compass might be offended by the thought of his elderly mother having sex outside of marriage, or with someone other than her husband. However, if the mother is capable of consenting to sexual activity, it is beyond the son's scope authority to restrict that activity.[48] Equally important, if mother does not have capacity to consent to sex, the son cannot consent on her behalf and might have an obligation to intercede.[49]

First step – does the incapable person have capacity to consent?

We all agree that compelling someone to engage in non-consensual sex is a crime.[50] Continuous consent is required of all parties in order for sexual activity to be lawful. "Consent" is defined in section 273.1 of the *Criminal Code* as follows (the word "complainant" refers to the victim of an alleged offence):

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[48] Judith Wahl, Sex in LTC – Osgoode Elder Law Certificate Program 2017.
[49] Judith Wahl, *ibid*, p. 20. Also see Canadian *Criminal Code* sections relating to sexual exploitation and sexual assault, as well as *R* v. *J(A)*, 2011 SCC 28.
[50] *Criminal Code*, RSC 1985, c C-46, ss. 271-273.2.

Meaning of consent

273.1(1) Subject to subsection (2) and subsection 265(3) *consent* means, for the purposes of sections 271, 272 and 273, the voluntary agreement of the complainant to engage in the sexual activity in question.

Where no consent obtained

(2) No consent is obtained, for the purposes of sections 271, 272 and 273, where

(a) the agreement is expressed by the words or conduct of a person other than the complainant;
(b) the complainant is incapable of consenting to the activity;
(c) the accused induces the complainant to engage in the activity by abusing a position of trust, power or authority;
(d) the complainant expresses, by words or conduct, a lack of agreement to engage in the activity; or
(e) the complainant, having consented to engage in sexual activity, expresses, by words or conduct, a lack of agreement to continue to engage in the activity.

Relevant case law on consent to having sex

There are two lines of cases on the issue of capacity to consent to sex. The first is a line of sexual assault cases involving complainants who are either intoxicated, drugged, unconscious or suffering from intellectual disabilities. The second are the cases commenced by attorneys, representatives, delegates or guardians for incapable people.

(a) Sexual assault cases

One of the leading cases on consent to sex is *R* v. *J(A)*.[51] The case involved a complainant who consented to her asphyxiation during sex and consented, in advance, to her partner continuing to have sex with her after she became unconscious. The majority of the SCC held that the complainant's partner had committed sexual assault because the complainant's consent was vitiated when she fell unconscious for a few minutes.[52] According to Chief Justice McLachlin, consent requires a "conscious, operating mind, capable of granting, revoking or withholding consent to each and every sexual act."[53] The decision is useful in that it illustrates that consent must be continuous and cannot be given in advance, but it does not describe with precision what "capable" means.

The more recent case of *R* v. *HL* offers a more in-depth analysis. In that case, the accused, who was 21 years old, had sexual intercourse with a 14 year old with intellectual disabilities. The court was asked to determine whether the complainant was capable of consenting. Fortunately, there was a wealth of evidence before the court, including an expert report, texts and Facebook messages, video statements, and rigorous cross-examination at trial. Justice Harris found it relevant that the complainant:

[51] 2011 SCC 28
[52] Three judges of the SCC dissented, saying that it was sufficient for the complainant to have consented in advance.
[53] 2011 SCC 28 at para. 44.

(i) communicated on a very elementary level that lacked coherence,
(ii) lied about being pregnant for no discernible reason,
(iii) had a very poor sense of time and could not remember when she had had sex with the accused (even though it was only three days before),
(iv) could barely explain what sex was ("dick on my vagina"),
(v) could not explain what a condom was ("means that girls do to boys to put his stuff on his penis"),
(vi) did not know what sperm was,
(vii) did not know how the decision to have sex is made or who makes it,
(viii) did not know how babies are made,
(ix) did not know that people can contract illnesses from sex,
(x) did not know why women have periods,
(xi) was found by an expert to have comprehension levels at the age 4 to 5 level, and
(xii) lived a sheltered life with her parents.

The court held that the complainant was incapable of consenting the sex and that the accused was guilty of sexual interference.

R v. *HL* was not difficult case from a legal perspective. It seemed fairly clear on the evidence that the complainant did not understand what sex was. The more difficult cases are those where the complainant understands what sex is, but does not understand all of the potential consequences of engaging in sexual activity. The case of *R* v. *Comeau*[54] is very interesting. In *R* v. *Comeau*, the accused worked at a continuing care facility. He received a sexual advance from a resident and there was sexual activity between them. The Crown endeavoured to prove that the complainant did not have the capacity to consent by relying upon the expert evidence of Dr. Meehan. Here are some excerpts from the case that are relevant to our discussion:

> On July 8, 2015, Dr. Meehan was again asked to provide her opinion as to Ms. W's capacity to give informed consent to sexual activity. <u>Dr. Meehan's view was and is that Ms. W. could not provide informed consent as she lacked insight, judgment and reasoning necessary to make a safe decision to engage in sexual activity. She had no short-term memory and her midterm memory was impaired. These are functions that are necessary to make safe decisions and therefore she believes that Ms. W. would not understand the consequences of engaging in sexual activity</u> …
>
> Ms. W. exhibits symptoms of dementia with vascular aspects that affect the frontal cortex of the brain. A patient with this condition has a less impaired memory but also is less inhibited in their conduct. <u>As such, she would be unable to inhibit her inappropriate sexual behaviors</u> …
>
> Dr. Meehan differentiated between the capacity to appreciate conduct and the capacity to give consent. <u>In Ms. W's case it was her lack of an appreciation of the consequences of her activity which formed the basis for Dr. Meehan's conclusions.</u>

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[54] 2017 CarswellNS 223.

> Therefore, a person such as Ms. W. can say that "yes this is what they want to do but they cannot appreciate the outcome of it." She agreed that this would not necessarily be visible to a lay person who does not have access to the medical records or experience that she does.
>
> Ms. W. must have been subjectively consenting to the activity and to be valid it must be the consent of a conscious and operating mind. Dr. Meehan's opinion is that for there to be informed consent the participants must not only understand the sexual activity and communicate their agreement to that activity but also must be able to understand the potential consequences of the activity. She believes that Ms. W. lacked the necessary insight as to the consequences of her sexual activity to have the capacity to give informed consent and that she was disinhibited by her cognitive impairment, not by a conscious and operating mind.
>
> I accept Dr. Meehan's opinion and the facts upon which it is based. Ms. W. was unable to understand the risks and consequences associated with the activity she engaged in with Mr. Comeau. Therefore, I am satisfied beyond a reasonable doubt that Ms. W. lacked the necessary capacity to consent to the sexual activity that she engaged in with Mr. Comeau.

R v. *Comeau* seems to stand for the proposition that a higher level of awareness is essential to the capacity to consent to sex.

(b) Decision-maker cases

In Ontario, the SDA provides that 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.[55]

Although the section makes no reference to sex, the case law on consent to sex in the context of attorneyships and guardianships in Ontario focuses on the ability of the person to appreciate the reasonably foreseeable consequences of sex, including the potential risks.

The case of *Salzman* v. *Salzman* is instructive.[56] In this Ontario case a 93-year-old woman with severe dementia began a sexual relationship with a man nearly 30 years her junior named Dennis Balak. The relationship was against the wishes of Mrs. Salzman's son who was concerned for her safety. Mr. Balak had previously been convicted for sexual interference with a 4-year-old girl and his "relationship" with Mrs. Salzman involved anal intercourse.

[55] SDA, 1992, c. 30, s. 45.
[56] *Salzman* v. *Salzman*, 2011 CarswellOnt 15786 (S.C.)

Mrs. Salzman was resolute in her position that she be allowed to continue "dating" Mr. Balak, and her position was defended by a lawyer court-appointed under the SDA as her representative (referred to in Ontario as "section 3 counsel").

The court heard evidence from Mrs. Salzman's colon and rectal surgeon, Dr. Gryfe:

> .. Suzanne Salzman does not possess cognitive abilities to insightfully consent to or refuse sexual activity. She lacks insight to understand potential risks of any sexual behaviour such as infectious diseases or trauma. In addition to these risks stemming from Suzanne Salzman's cognitive impairments, I believe that she would be at increased risk of traumatic injury from sexual activity due to her frailty (she is 93 years old) and her chronic aspirin use which inhibits blood clotting putting her at increased risk for significant bleeding.[57]

Section 3 counsel's position was set out as follows:

> … Section 3 counsel's primary objection is that Ms. Salzman should be able to continue a relationship with Mr. Balak, as she has stated she wishes to do […] Section 3 counsel argues that no weight should be given to Dr. Gryfe's opinion because he did not conduct a full capacity assessment.

On this evidence, the court appointed the son as guardian and issued a permanent restraining order against Mr. Balak.[58]

The takeaway from the *Salzman* case appears to be that if a person lacks insight to understand the potential risks of any sexual behaviour, he or she does not have the ability to consent.

What is the duty of the decision-maker?

Returning to our hypothetical situation, the response of the son should depend on whether or not his mother is capable of consenting to sex.[59] If she does not have the insight necessary to understand information that is relevant to making a decision concerning sex, as described in the case law above, the son must act to prevent further sexual encounters, even if his mother wishes for those encounters to continue (like Mrs. Salzman). The son might consider moving his mother to another facility, or enlisting the help of the existing long-term care facility to intervene. Or he might seek a restraining order.

If, on the other hand, the mother is capable of consenting to sex, then the son has a positive duty to protect his mother while permitting her to express herself sexually. For example, in *Re L.*

[57] *Salzman* v. *Salzman*, 2011 CarswellOnt 15786 (S.C.) at para. 10.
[58] *Salzman* v. *Salzman*, 2011 CarswellOnt 15786 (S.C.) at para. 19.
[59] In Ontario, there is a statutory presumption that people 16 years of age or more are capable of giving or refusing consent to personal care, and this likely includes consent to sexual expression. The evidence to override this subsection must be very persuasive. As the court stated in *Re Koch*, 33 OR (3d) 485 at para 219, [1997] OJ no 1487 (QL):

> "Compelling evidence is required to override the presumption of capacity found in s. 2(2) of the *SDA* and s. 4(1) of the *HCCA*. The nature and degree of the alleged incapacity must be demonstrated to be sufficient to warrant depriving the appellant of her right to live as she chooses. Notwithstanding the presence of some degree of impairment, the question to be asked is whether the appellant has retained sufficient capacity to satisfy the statutes."

(C.M.), the Public Guardian in Saskatchewan sought court approval for its decision to have an IUD inserted into a woman under guardianship.[60] The court held that the Public Guardian had a responsibility to take this course of action given that the woman in question: (i) was capable of consenting to sex, (ii) had expressed the desire not to become pregnant, and (iii) was having unprotected sex with strangers. The court observed that the Public Guardian had a duty to consult with the woman, make the decision to receive an IUD on her behalf, and explain to her the risks of sexually transmitted diseases.[61]

In our view, it always boils down to capacity. Cases like *Salzman* v. *Salzman* and *R* v. *Comeau* stand for the proposition that a person must understand all of the potential consequences of engaging in sexual behaviour. Arguably, this might include the social, cultural and religious consequences of such behaviour. If the mother is no longer capable of understanding information that she would once have considered relevant to making a decision about sex, perhaps she is incapable.

How to advise the decision-maker about the tension between his or her moral compass and legal duties in situations involving sex

Our laws are designed to protect vulnerable people from abuse. Our laws are not designed to let people holding powers of attorney for personal care or similar documents deprive clients of their sexual autonomy. If the client is a person of faith who suddenly begins acting outside the tenets of his or her religion, this might be an indication of reduced capacity. But it is not sufficient grounds for the decision-maker to block access to the new boyfriend or girlfriend. If the decision-maker is a person of faith who cannot in good conscience carry out the duty to ascertain whether the client has capacity to consent to sex, and respect the client's capable decisions, then the decision-maker should consider refusing the appointment or resigning, if possible.

Conclusion

Lawyers drafting powers of attorney for personal care, advance health care directives, personal directives and living wills for people of faith need to document their clients' specific end-of-life wishes. Thorough documentation will give the client the best possible chance that his or her wishes will be honoured. Clearly articulated wishes will also assist the grieving family members and, with luck, preclude the situations that arose in *Re JEP* and *Re F(F)*. Bear in mind, however, that careful drafting might still not be enough. Cases like *Bentley* v. *Maplewood* and *Grover* v. *Grover* illustrate the ability and willingness of courts to disregard clear written wishes.

We are unaware of any studies in Canada[62] on the prevalence of sexual aggression against older adults in long-term care facilities. Anecdotally, we understand that lawyers have been called upon to assist in protecting people from unwanted sex in these settings. It is beyond the scope of this paper to provide constructive suggestions about how to address what appears to be a systemic problem. For the individual decision-maker, the steps to be taken begin with having the

[60] L (CM), Re, 2001 CarswellAlta 323 (Q.B.)
[61] At paras. 27 and 31-32.
[62] See Tony Rosen, MD, MPH, Mark S. Lachs, MD, MPH, Karl Pillemer, PhD, "Sexual aggression between residents in nursing homes: Literature synthesis of an underrecognized problem," *Journal of Amercian Geriatrics Society*, Volume 58, Issue 10. "Seniors have sex – and the STI rates to prove it" available on-line at: https://globalnews.ca/news/3802497/canada-sti-rates-seniors/

allegedly incapable person's capacity to consent to sex assessed. It might be necessary to provide the assessor with a detailed explanation of the factors that go into the court's consideration in determining this type of capacity. If incapacity to consent to sex is established, the decision-maker should employ whatever practical or legal means available to prevent sexual encounters.